Guideline

Identification and management of nausea and vomiting of pregnancy and hyperemesis gravidarum.

Document Number: SWSLHD_GL2020_Allocation

Functional Sub-Group: Clinical Governance

Summary: To provide evidence based guidance on the identification and management of nausea and vomiting in pregnancy in emergency departments and ambulatory settings.

Approved by:

Publication (Issue) Date: [Month] 2020

Next Review Date: [Month] 2025

Replaces Existing Document: New guideline

Previous Review Dates: N/A

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Review Process

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Search Terms for Document	Pregnancy, hyperemesis, nausea, vomiting, gravidarum

Approval Process

All committee endorsement/approval must be noted in the table below. Once stakeholder / Committee(s) sign off obtained, forward policy document to SWSLHD-Policy@health.nsw.gov.au.

Committee Name	Endorsement/Approval Date

Revision History

Version	Amendment Notes

Date Document Number	Update next in 2025

1. Introduction

This guideline aims to provide consistent information in the identification and management of nausea and vomiting in pregnancy and hyperemesis gravidarum (HG), aiming to assist with management in ambulatory and community services, while aligning with international guidelines released in 2019.

Nausea and vomiting of pregnancy (NVP) is usually experienced between six and 16 weeks gestation although some women (20%) experience NVP up to 20 weeks or longer (Matthews et al 2015). NVP and HG have the potential to adversely affect quality of life, workforce participation and health care costs (ACOG 2018).

The prevalence of NVP is reported as high as 50-80% (ACOG 2018; Campbell et al 2016; Ebrahimi et al 2009; Matthews et al 2015; RCOG GtG No.69) of pregnant women and reaching as high as 50% (ACOG 2018; Matthews et al 2015). Women who have had NVP previously have an incidence of NVP in their next pregnancies of 15-81% (ACOG 2018). HG has a reported incidence of 0.3-3.6% (ACOG 2018; Matthews et al 2015; RCOG GtG No.69) and is stated by Tsakiridis et al (2019) as the leading cause of hospital admission in early pregnancy.

There has been a lack of clear guidance in the Australian context for the management of NVP and HG. The Society of Obstetric Medicine of Australia and New Zealand (SOMANZ) published a guideline in 2019 for identification and management of nausea and vomiting in pregnancy and hyperemesis gravidarum. This guideline is based upon the SOMANZ guideline with modifications to allow for application within the SWSLHD.

Definitions of NVP and HG vary and their causes are largely unknown (ACOG 2018; Tsakiridis et al 2019). SOMANZ (2019) proposes a definition of NVP as “nausea, vomiting and/or dry retching caused by pregnancy, with symptoms commencing in the first trimester, without an alternate diagnosis.” This is consistent with the definition stated in the Royal College of Obstetricians and Gynaecologists (RCOG) Green top Guideline no.69. The definition of hyperemesis gravidarum offered by SOMANZ is “nausea and/or vomiting caused by pregnancy leading to significant reduction of oral intake and weight loss of at least 5% compared with pre-pregnancy, with or without dehydration and/or electrolyte abnormalities.” This definition is consistent with the Matthews *et al* (2015) Cochrane review, which further expands on this to include the potential for hospital admission.

In view of the high prevalence of NVP, health professionals and women require clear and consistent information around safe and effective management in order to improve women’s experience of health care in early pregnancy (Matthews et al 2015). Implementing consistent classification and definitions of NVP and HG using the Pregnancy-Unique Quantification of Emesis (PUQE 24) scale and appropriate management algorithms, will lead to efficient and effective experiences of integrated care in early pregnancy.

Between 1st of January 2019 and the 2nd of March 2020, 2092 pregnant women presented to Emergency Departments (ED) across SWSLHD. They ranged in age from 15 to 49 years (mean 29.11 years). 633 (30%) of these women presented with nausea and vomiting. Of these

women, 456 (21.8%) had a diagnosis of NVP or HG. In the remaining 177 (8.5%) nausea and vomiting was caused by other factors.

The disposition across SWSLHD of women with NVP or HG was; 285 (62.5%) went home, 113 (24.8%) were admitted, 53 (11.6%) left against medical advice, 4 (0.9%) did not wait to be seen and 1 was transferred to another facility. Women who presented with NVP or HG were more likely to re-present four or more times in their pregnancy.

The risk addressed by this guideline:

- Missed or misdiagnosis of hyperemesis gravidarum.
- Inappropriate care provision contrary to SOMANZ guidelines and evidence based practice.

2. The Aims / Expected Outcome of this guideline:

To ensure:

- Accepted district-wide definition of NVP and HG.
- Evidenced-based investigations of NVP or HG.
- Evidence-based treatment strategies for NVP and HG.
- Evidence-based management strategies for NVP and HG.
- Improved quality of life for women with NVP and HG.
- Appropriate admission of women with severe NVP and HG.
- Appropriate use of community based and ambulatory care services.
- Appropriate identification of adverse reactions / complications.

3. Principles

- Identification of women with mild to moderate NVP who can be appropriately managed in the community or ambulatory care settings, in consultation with women.
- Appropriately determine the need for inpatient treatment of severe NVP and HG.
- Establish appropriate review and follow up, in consultation with women.
- Improve NVP and HG health literacy.

4. Procedure

Women presenting to the Emergency Department will be triaged according to the Australasian Triage Scale and allocated a triage category and treatment location aligning with the presenting complaint and symptomatology.

Clinical assessment by the appropriate medical officer or nurse practitioner will include utilisation of the PUQE-24 score and investigations as per table below.

A history (using an interpreter as per PD2017_044) and physical examination should be undertaken as per usual practice. The assessment should be directed towards the potential identification of any alternate diagnosis. The physical examination should include:

- Temperature, pulse and BP.
- Abdominal examination and an assessment of hydration status.
- CNS assessment for any signs of raised intracranial pressure or meningism.
- PUQE-24 score (Attachment 3 or search PUQE-24 in pre completed notes in eMR*).
- Urinalysis.

If there are any signs or symptoms of thyrotoxicosis (e.g. heat intolerance, palpitations, new anxiety, tremor, weight loss or lid lag), a thyroid stimulating hormone (TSH) assay should be performed.

Once other diagnoses are excluded, women with mild to moderate nausea and vomiting of pregnancy (PUQE-24 score 3 to 12) do not need any further investigations performed. All women should be given 'Sickness (nausea) and vomiting in pregnancy' and 'My sickness in Pregnancy Plan' (Attachment 2) in the appropriate available language and English.

Women with severe NVP or HG (PUQE-24 which is 13 to 15) should have the following investigations undertaken:

1. Electrolytes, Urea & Creatinine (EUC), Calcium, Magnesium, Phosphate (CMP)
    a. In pregnancy a creatinine of >70umol/L suggests significant dehydration
2. Liver function tests (LFT)
    a. Elevated in NVP and HG due to starvation, but rarely more than 4 times the upper limit of normal (ULN). Further investigation may be required if above this level.
3. Obstetric ultrasound (US):
    a. This should be undertaken to assess for multiple gestation or trophoblastic disease unless an US has recently been undertaken.
4. Thyroid stimulating hormone (TSH):
    a. Should only be measured in those with HG or NVP which is refractory to treatment or where there are signs or symptoms of thyrotoxicosis.
    b. If abnormal FT4 and FT3 will need to be assessed

Tests to exclude alternate diagnoses as suggested by the clinical assessment (see table regarding differential diagnosis)

*** PUQE – 24 SCORING template in eMR**

1. Open required patient on EMR
2. Select **documents**
3. Select +**ADD** (new note)
4. Select **pre completed**
5. Search **PUQE – 24** (this will appear in title or select in search)
6. Add to **favorites** for future use
7. Select **OK** to continue as a patient note

4.1 Differential diagnosis of nausea and vomiting in pregnancy

Gastrointestinal	Gastroenteritis Gastro-oesophageal reflux disease Hepatitis Pancreatitis Biliary tract disease Peptic ulcer disease - Helicobacter pylori Bowel obstruction Gastroparesis Appendicitis Peritonitis
Genitourinary	Urinary tract infection including pyelonephritis Ovarian torsion Nephrolithiasis
Metabolic or Toxic	Drugs-including pregnancy vitamins Use and/or withdrawal of cannabinoids or other illicit drugs Diabetic ketoacidosis Addison's disease Thyrotoxicosis Non-infectious hepatitis Hypercalcemia Eating Disorders
Central nervous system disease	Migraine Infection Tumours Raised intracranial pressure Vestibular system pathology: Labyrinthitis, Meniere's Disease

(Lowe et al, 2019)

4.2 Investigations to be undertaken according to PUQE-24 score

Investigations aim to exclude alternate diagnosis from history and examination. Assess hydration, nutritional status and weight. Attend PUQE-24.					
PUQE-24 score: 3 to 12 Mild to moderate nausea or vomiting of pregnancy and no suspicion of alternate diagnosis	No investigations required.	TSH if signs and symptoms of thyrotoxicosis.	Consider management at home.		
PUQE-24 score: 13 to 15 Severe NVP or HG	Sodium, potassium, chloride, bicarbonate, calcium, magnesium, urea and creatinine (EUC, CMP)	Bilirubin, ALT, AST, Albumin (LFTs)	Obstetric ultrasound (exclude multiple pregnancy or trophoblastic disease)	TSH if treatment for NVPHG is providing no relief	Consider admission if community manage-ment is not feasible.

(Lowe et al, 2019)

Women who may require admission are those who have severe HG (PUQE-24 score 13 to 15) or have:

1. Underlying medical issues e.g. Type 1 diabetes mellitus, high risk conditions (short bowel syndrome or previous bariatric surgery) or those requiring continuity of essential medications e.g. (severe epilepsy or renal transplant patient)
2. Severe electrolyte disturbances
3. Acute kidney injury (creatinine $\geq$90umol/L)
4. Malnutrition, or starvation ketoacidosis
5. Other associated complications needing inpatient management eg. Mallory Weiss tear

Optimally women with a PUQE- 24 score 3 to 12 can be managed in the community with ongoing care. For those women who require ongoing IVF, this is best managed in an ambulatory care, hospital-in-the-home or day stay setting as relevant to each hospital within the SWSLHD.

4.3 Management

The overarching principles of therapy are that a holistic approach achieves the best results. This is comprised of a management plan that addresses:

1. Interventions to reduce nausea, retching and vomiting (Tables 1.1 to 1.3)
2. Gastric dysmotility, GORD (Table 2)

3. Constipation (Table 3)
4. Maintenance of hydration and electrolyte replacement

The targets of therapy are the ability to eat and drink adequately – **complete resolution** of symptoms is less likely in the short term. There is some evidence that ceasing prenatal vitamins helps with NVP symptoms- however if possible, folic acid (0.5mg/day) and iodine (150ug/day) should be continued.

As a general rule, if an antiemetic is not effective at maximal dose, discontinue before commencing an alternate agent. If partially effective, optimise dosing before adding a second agent.

Use the 'Sickness (nausea) and vomiting in pregnancy' and 'My sickness in Pregnancy Plan' (Attachment 2), in the appropriate language and English, to assist with management of symptoms in the community after discharge.

Pharmacological management of NVP & HG:

Mild to moderate NVP: Treatment can commence with ginger, with or without B6.
  - An oral antihistamine or dopamine antagonist can be added if required.
- If the response to initial therapy is inadequate or NVP is moderate to severe:
  - Consider IV or IM antihistamine or dopamine antagonist.
- If sedation is considered excessive or NVP is not brought to acceptable levels;
  - Add or substitute an oral or IV serotonin antagonist during the day.
  - Include acid suppression.
- If NVP or HG remains refractory
  - Consider corticosteroids along with antiemetics.
  - Increase acid suppression
  - IV Thiamine (prevention of Wernickes encephalopathy)
- Manage and prevent constipation.
- Management is guided by the severity of symptoms. It would be reasonable to commence a therapy, but if it does not improve the patient symptoms, then the agent should be ceased and another commenced.
- Inform the woman about ongoing care and self-assessment with provision of patient handout (Available in four languages English, Vietnamese, Arabic and Cambodian)

Suggested regimens for commencement of therapy based on severity are as follows:

Table 1.1 Interventions to reduce nausea, retching and vomiting if PUQE-24 score 3 to 12 (mild-moderate NVP)

Medication	Mechanism	Evidence	Contraindications	Dose	MIMS AIDH link
Ginger	Increases Gastro intestinal (GI) motility	Reduces N but not V (LOE II)	Increase risk of bleeding and hypoglycaemia	Up to 1200mg /day (250mg qid)	Therapeutic Research Centre – Natural medicines
Vit B6 (pyridoxine)	Inhibits H1 receptor, acts indirectly on vestibular system. Muscarinic inhibition decreases vomiting centre stimulation.	Reduces N but not V (LOE I)		10-25mg tds/qid Up to 200mg/day **OR** 37.5mg with ginger 600mg bd	
Antihistamines	Indirect vestibular system decreases vomiting centre stimulation.	Doxylamine, reduces N (LOE II) Dimenhydrinate or Diphenhydramine or Cyclizine (LOE III)	Anticholinergic effects may worsen – GI and bladder obstruction	Varied	AMH

Metoclopramide	Increases upper GI motility. Acts on CNS vomiting centre.	equal to ondansetron for N but less effective for V (LOE II)	Phaeochromocytoma Parkinson's disease Epilepsy (can induce an extrapyramidal movement disorder)	10mg tds	AMH eMIMS
Prochlorperazine	Central and peripheral Dopamine antagonist	Superior to placebo for NVP (LOE I)	CNS depression Parkinson's disease	5-10 mg tds	AMH eMIMS Drugs in Pregnancy and Lactation(Briggs)
Chlorpromazine	Central and peripheral Dopamine antagonist	LOE III	CNS depression Bone marrow depression Phaeochromocytoma	10-25mg tds	AMH eMIMS Drugs in Pregnancy and Lactation(Briggs)

Table 1.2 Interventions to reduce nausea, retching and vomiting if PUQE-24 score 13 to 15 (severe NVP)

Medication	Mechanism	Evidence	Contraindications	Dose	MIMS AIDH link
Ondansetron	Central & peripheral serotonin receptor blocker	Superior to Doxylamine/B6 for reduces N&V. Superior to Metoclopramide for reduced V but not N in HG.	Phenylketonuria. Use with Apomorphine is contraindicated, avoid if QT prolonged	4-8mg up to tds	AMH eMIMS
Corticosteroids (if critically unwell with intractable vomiting and not responding to above measures)	Anti-emetic effect on chemoreceptor trigger zone in brain stem.	No difference in readmission or LOS compared to placebo. = to promethazine, reduced side effects. (LOE I). Superior to IV Metoclopramide (LOE I)	Phaeochromocytoma Myasthenia gravis Precaution: Latent TB Peptic ulcer disease	Prednisone 40-50 mg/day IV hydrocortisone 100mg bd	AMH eMIMS

IV Fluid administration is in its own right is an important adjunct to therapy for both inpatients and outpatients. Studies have demonstrated a significant improvement in nausea with IVF alone, without the use of antiemetics. Below are some recommended fluid regimens for the replacement of IV fluids and electrolytes.

Table 1.3 IV fluid administration

IV fluid	Volume and rate	Comment
sodium chloride 0.9%	1-2 L. 1st litre 1 L/hr	Following IV fluids can be given at 1-2L/hr or slower to correct dehydration and electrolytes.
sodium chloride 0.18% and dextrose 4% or dextrose 5%	1 L. 1st litre 1 L/2 hours	**Exclude hyponatremia and correct thiamine deficiency prior to commencing**. Consider if unable to tolerate oral fluids, starvation or nausea is uncontrolled.
Add electrolytes as required		
Potassium chloride	Administer as per local protocol with caution.	Premixed 1 L bag of 30mmol in sodium chloride 0.9% is preferred. Use a large peripheral vein or central venous access only.
Magnesium sulphate	10-20 mmol/day, infused at 10mmol/hr.	Magnesium can be added to IV fluid or diluted in 100ml of sodium chloride 0.9%. Use a large peripheral vein or central venous access only.

<u>If IV Dextrose is used give IV Thiamine prior to IVF to prevent Wernicke's encephalopathy in women with thiamine deficiency.</u>

Table 2. Acid suppression and gastric dysmotility therapeutic options

Medication	**Mechanism**	**Evidence**	**Contraindications**	**Dose**	**MIMS AIDH link**
1st line **Mg,Ca,Al Antacids**	Neutralise hydrochloric acid secreted by gastric parietal cells	TGA listed as Cat A	Renal insufficiency; accumulation of absorbed magnesium ion, may lead to CNS depression and other symptoms of hypermagnesemia	10-20mL PO PRN	AMH UpToDate
2nd line **H2 Antagonists**	Inhibition of pentagastrin induced gastric acid secretion	TGA listed as Cat B1		Varied eg. Famotidine 20-40mg PO daily	AMH eMIMS
3rd line **Proton pump inhibitors**	Inhibition of H+/K+-ATPase, leads to the suppression of basal and stimulated gastric acid secretion	TGA listed as Cat B3	Proton pump inhibitors (PPIs) may decrease the absorption of certain human immunodeficiency virus (HIV) protease inhibitors.	Varied eg. Omeprazole 20-40mg PO daily	eTG eMIMS UpToDate

Table 3. Bowel management therapeutic options

Medication	Mechanism	Evidence	Contraindications	Dose	MIMS AIDH link
1st line **Dietary fibre**	Absorb water in the colon to increase faecal bulk, stimulating peristaltic activity		-Intestinal obstruction, partial or complete -Colonic atony **Avoid Use:** -Dysphagia - oesophageal obstruction may occur -Fluid restriction, immobility	Varied eg. Psyllium husk powder (Metamucil) 2 spoonsful 1-3 times daily	AMH eMIMs
2nd Line **Stool softeners**	Softens stool by assisting mixture of water into faeces. May also increase intestinal fluid secretion	TGA listed as Cat A	Prolonged use may lead to dependence	Varied eg. Docusate 50–150mg once or twice daily (up to 500 mg/day)	AMH eMIMs
3rd line **Stimulant laxatives**	Increase intestinal motility	TGA listed as Cat A	Intestinal obstruction, partial or complete -Acute abdominal conditions, e.g. appendicitis -Inflammatory bowel condition **Precaution:** Dehydration, hypokalaemia	Varied eg. Bisacodyl 5-15mg at night	AMH eMIMs

4.4 Disposition Planning:

PUQE-24: score less than or equal to ≤12 (3 to 12)			
and IV fluid not required	Discharge with GP follow up.	Discuss booking into local birthing hospital	Electrolytes if conditions worsens
and repeat IV fluids required	Discharge home with Ambulatory care or HITH follow up.	Daily electrolytes until stable	If liver enzymes are more than 4 times the upper limit of normal for pregnancy. Conduct further investigations.
Women with diabetes or other significant pre-existing condition	+/- Admission. Refer to dietician.	Daily electrolytes	
PUQE-24: score 13 to 15			
Admission	Admit to ward	Daily electrolytes until stable. Refer to dietician	If liver enzymes are more than 4 times the upper limit of normal for pregnancy. Conduct further investigations.

4.5 Local Management

Please refer to your local ambulatory care or HITH guidelines.

5. Definitions and Acronyms

ALT	Alanine Aminotransferase test
AST	Aspartate transaminase test
BP	Blood pressure
CKD	Chronic kidney disease
CMP	Calcium, magnesium, phosphate
CNS	Central nervous system
ED	Emergency Department
EPIC	Emergency Protocol Initiating Care
EUC	Electrolytes, urea, creatinine
HG	Hyperemesis gravidarum
GI	Gastrointestinal
GORD	Gastro-oesophageal reflux disease
GP	General Practitioner
HITH	Hospital In The Home
IVF	Intravenous fluid
LFT	Liver function test
LOE	Level of evidence
MACS	Macarthur Ambulatory Care Service
MCHS	Multi-cultural health services
NVP	Nausea and vomiting of pregnancy
O&G	Obstetrics and Gynaecology
PRN	Pro re nata (as required)
PUQE	Pregnancy-Unique Quantification of Emesis
SOMANZ	Society of Obstetric Medicine of Australia and New Zealand
TGA	Therapeutic Goods Administration
Triple I	Intake Information and Intervention
TSH	Thyroid stimulating hormone
ULN	Upper limit of normal
US	Ultrasound
WHITU	Women's Health Initiative Translational Unit

6. References and Links

.Related Policy Directives / Guidelines

MoH - PD2016_049	NSW Health Policy Directives and Other Policy Documents	Link
SWSLHD_PD2015_009	Corporate and Clinical Policy Directive and Guideline Development and Management	Link
PD2012_022	Maternity- Management of Early Pregnancy Complications	Link
PD2019_008	The First 2000 Days Framework	Link
	Gestational trophoblastic Disease (currently under review)	
GL2015_011	Maternity- Rh (D) Immunoglobulin (Anti D)	Link
NSW Nursing EPIC	Nausea and vomiting in pregnancy (currently under review)	

Articles / Research / Resources

• ACOG Practice Bulletin No. 189: Nausea and Vomiting Of Pregnancy. Obstetrics & Gynecology January 2018;131(1):e15-e30 Online ACOG Publications.	Link
• Campbell, K., Rowe, H., Azzam, H & Lane, CA. 2016, 'The management of nausea and vomiting of pregnancy', *Journal of Obstetrics and Gynaecology Canada,* Vol.38, No. 2, pp 1127-1137.	Link
• Ebrahimi, N., Maltepe, C., Bournissen, F.G. & Koren, G. 2009, 'Nausea and Vomiting of Pregnancy: Using the 24-hour Pregnancy-Unique Quantification of Emesis (PUQE-24) Scale', *Journal of Obstetrics and Gynaecology Canada*, vol. 31, no. 9, pp. 803-7.	Link
• Fiaschi, L., Nelson-Piercy, C, Deb, C, King, R, & Tataa,L,J. 2019, 'Clinical management of nausea and vomiting in pregnancy and hyperemesis gravidarum across primary and secondary care: a population-based study', *BJOG*, pp. 1201-12.	Link
• Lowe SA, Bowyer L, Beech A, Robinson H, Armstrong G, Marnoch C, & Grzeskowiak L. 2019, Guideline for the management of Nausea and vomiting in pregnancy and Hyperemesis gravidarum Executive Summary SOMANZ Society of Obstetric Medicine of Australia and New Zealand.	Link
• Matthews, A., Haas, D.M., O'Mathuna, D.P. & Dowswell, T. 2015, 'Interventions for nausea and vomiting in early pregnancy', *Cochrane Database Syst Rev*, no. 9, p. CD007575.	Link
• NICE 2019, *Doxylamine pyridoxine NICe evidence review 2019*.	Link
• NICE 2008, *Antenatal care for uncomplicated pregnancies*, National Institute for Health Care Excellence, UK.	Link
• RCOG The Management of Nausea and Vomitting in Pregnancy and Hyperemesis Gravidarum. Gree-top Guide No.69, July 2016.	
• Tsakiridis, I., Mamopoulos,A., Athanasiadis, A., & Dagklis, T. 2019, 'The Management of Nausea and Vomiting of Pregnancy: A Synthesis of National Guidelines', *Obsterical and Gynecological Survey*, vol. 74, no. 3.	Link

7. Background Information/Educational Material

https://www.swsphn.com.au/healthpathways
https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/Pages/having-a-baby.aspx
https://www.seslhd.health.nsw.gov.au/royal-hospital-for-women/services-clinics/directory/mothersafe

Forms
The following forms are available by following the link:

[Form Number] AMR…	[Name of Form]	Link or paper
	My sickness in Pregnancy Plan (Nausea or vomiting) (Attachment 2) Available in English, Vietnamese, Cambodian and Arabic	
	PUQE-24 (Attachment 3)	
	Ambulatory care days of treatment form (Attachment 4)	

8. Resources

The following resources are available by following the link:

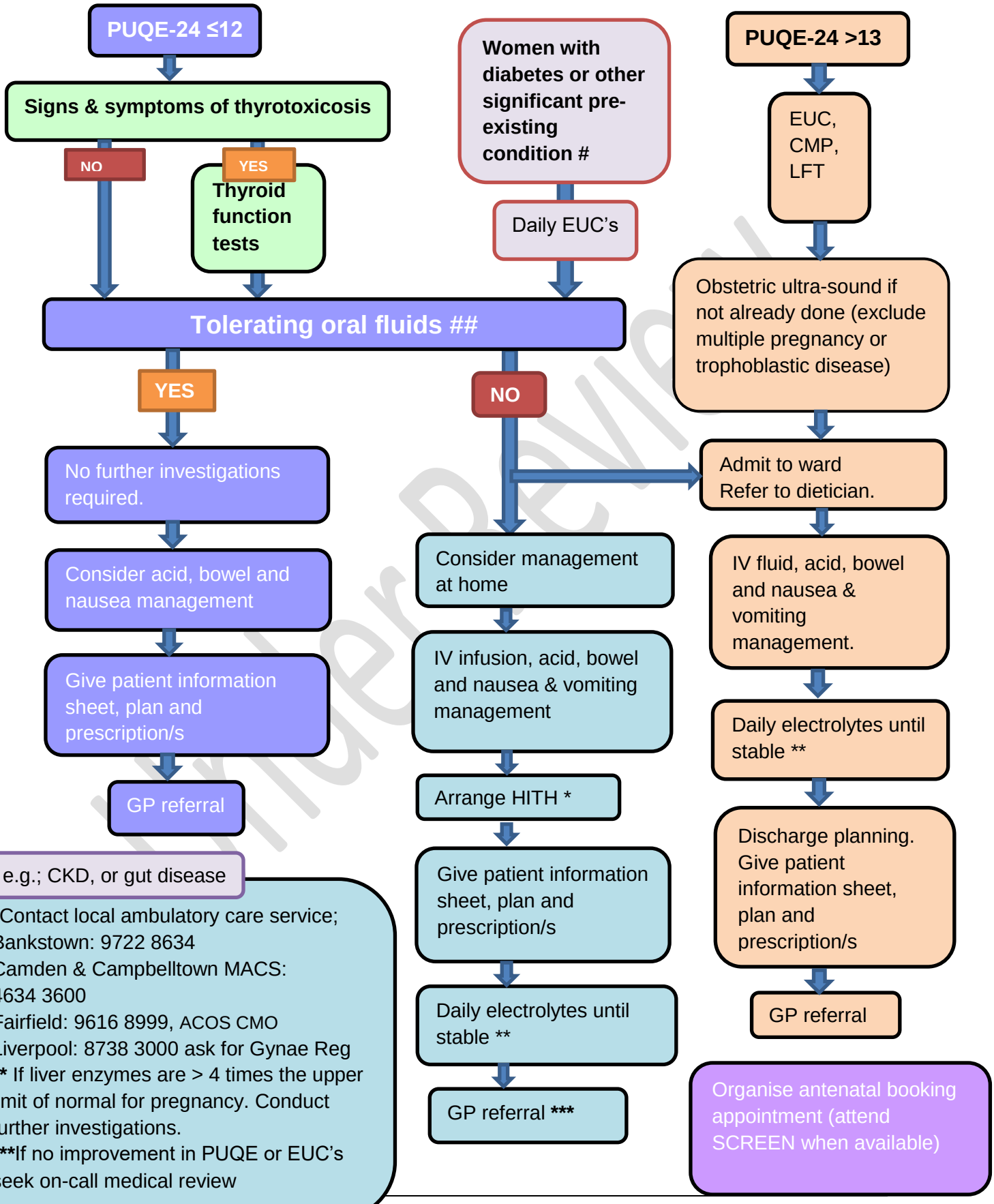
Fact Sheet	Sickness (nausea) and vomiting in pregnancy, Patient Information. My sickness in Pregnancy Plan (Nausea or vomiting) Available in English, Vietnamese, Cambodian and Arabic	Link
User Guide	[Name of User Guide]	Link

9. Attachments

Attachment 1- Management Flowchart
Attachment 2 –Patient Information Sheet
Attachment 3 - PUQE assessment
Attachment 4 – SWSLHD Ambulatory care procedures.

Attachment 1

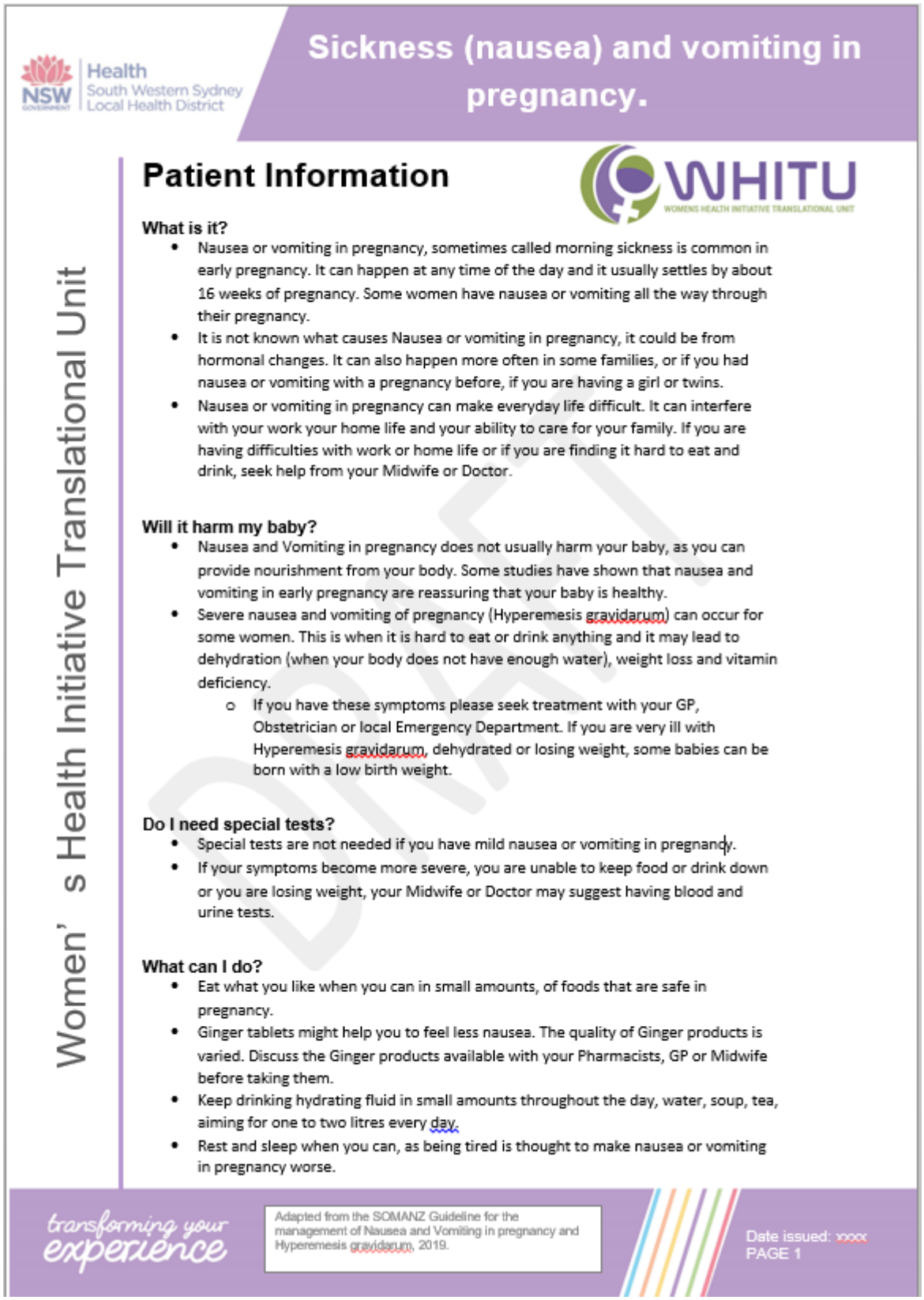
9.1. Management Flowchart for NVP & HG



Attachment 2

9.2. Patient information sheet

Please note this is available in 2 other languages on the policy guidelines webpage. It is also available in Vietnamese and Arabic.



Health
South Western Sydney
Local Health District

Sickness (nausea) and vomiting in pregnancy.

WHITU
WOMENS HEALTH INITIATIVE TRANSLATIONAL UNIT

Women's Health Initiative Translational Unit

Patient Information

What is it?

- Nausea or vomiting in pregnancy, sometimes called morning sickness is common in early pregnancy. It can happen at any time of the day and it usually settles by about 16 weeks of pregnancy. Some women have nausea or vomiting all the way through their pregnancy.
- It is not known what causes Nausea or vomiting in pregnancy, it could be from hormonal changes. It can also happen more often in some families, or if you had nausea or vomiting with a pregnancy before, if you are having a girl or twins.
- Nausea or vomiting in pregnancy can make everyday life difficult. It can interfere with your work your home life and your ability to care for your family. If you are having difficulties with work or home life or if you are finding it hard to eat and drink, seek help from your Midwife or Doctor.

Will it harm my baby?

- Nausea and Vomiting in pregnancy does not usually harm your baby, as you can provide nourishment from your body. Some studies have shown that nausea and vomiting in early pregnancy are reassuring that your baby is healthy.
- Severe nausea and vomiting of pregnancy (Hyperemesis gravidarum) can occur for some women. This is when it is hard to eat or drink anything and it may lead to dehydration (when your body does not have enough water), weight loss and vitamin deficiency.
    - If you have these symptoms please seek treatment with your GP, Obstetrician or local Emergency Department. If you are very ill with Hyperemesis gravidarum, dehydrated or losing weight, some babies can be born with a low birth weight.

Do I need special tests?

- Special tests are not needed if you have mild nausea or vomiting in pregnancy.
- If your symptoms become more severe, you are unable to keep food or drink down or you are losing weight, your Midwife or Doctor may suggest having blood and urine tests.

What can I do?

- Eat what you like when you can in small amounts, of foods that are safe in pregnancy.
- Ginger tablets might help you to feel less nausea. The quality of Ginger products is varied. Discuss the Ginger products available with your Pharmacists, GP or Midwife before taking them.
- Keep drinking hydrating fluid in small amounts throughout the day, water, soup, tea, aiming for one to two litres every day.
- Rest and sleep when you can, as being tired is thought to make nausea or vomiting in pregnancy worse.

transforming your experience

Adapted from the SOMANZ Guideline for the management of Nausea and Vomiting in pregnancy and Hyperemesis gravidarum, 2019.

Date issued: xxxx
PAGE 1

Health
South Western Sydney Local Health District

Sickness (nausea) and vomiting in pregnancy.

Do I need medication?

If the suggestions above are not working or if your symptoms become more severe you may need medication. Medications that are considered safe in pregnancy for nausea or vomiting include pyroxidine (Vitamin B6), doxylamine, promethazine, cyclizine and prochlorperazine. There is no evidence that these medications will harm a developing baby.

If these medications do not work other medications such as, metoclopramide, ondansetron, ranitidine or rarely prednisolone can be used. Always discuss taking any medication when you are pregnant with you Midwife, Doctor or Pharmacist.

Take medications only when they are needed, for some women this may be several weeks or months until you feel better. Occasionally fluid by an intravenous drip (IV) may need to be given at your local hospital or Day Unit. Rarely some women need to be admitted to hospital if they are too dehydrated or lose weight.

Follow up.

- With your GP to help you keep your medications working for you.
- Book in to your local birthing hospital.
- We have included a table on this sheet to help you work out your level of nausea or vomiting.

You can find more information here.

- Mothersafe https://www.seslhd.health.nsw.gov.au/royal-hospital-for-women/services-clinics/directory/mothersafe
  9382 6539 (Sydney Metropolitan Area) Mon to Friday 9am -5pm
- SOMANZ Guideline for the management of nausea and vomiting in pregnancy. https://www.somanz.org/Index.asp
- Hyperemesis Gravidarum Australia. https://www.hyperemesisaustralia.org.au/

*We cannot recommend individual sites as they do not contain supervised content

Motherisk PUQE-24 scoring system: You can use this PUQE tool to help you work out if you need to seek further treatment or change your treatment plan. Add up your score in brackets from each of the three questions.				
1. In the last 24 hours, for how long have you felt nauseated or sick to your stomach?				
Not at all (1)	1 hour or less (2)	2 to 3 hours (3)	4 to 6 hours (4)	More than 6 hours (5)
2. In the last 24 hours, have you vomited or thrown up?				
I did not throw up (1)	1 to 2 times (2)	3 to 4 times (3)	5 to 6 times (4)	7 or more times (5)
3. In the last 24 hours, how many times have you had retching or dry heaves without throwing up?				
None (1)	1 to 2 times (2)	3 to 4 times (3)	5 to 6 times (4)	7 or more times (5)
Total score: Mild 1-6; Moderate 7 to 12; severe 13-15 (scores in brackets)				

transforming your experience

Adapted from the SOMANZ Guideline for the management of Nausea and Vomiting in pregnancy and Hyperemesis Gravidarum, 2019.

Date issued: xxxx
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Health
South Western Sydney
Local Health District

My sickness in Pregnancy Plan (Nausea or vomiting)

Date:

Doctor:

Contact:

Patient label

My medications for nausea, vomiting or acid reflux. These are the medications you can take and how often you can take them each day.				
Name and dose.	Morning (✓ or ×)	Middle of day (✓ or ×)	Evening (✓ or ×)	Bedtime (✓ or ×)
For nausea, vomiting or retching. (name of medication)				
For acid reflux				
For constipation				
Other				

If you feel worse:_____

_____

_____

_____

If you feel better:_____

_____

_____

_____

Please bring this record to your next appointment, it can help us all work together.

transforming your experience

Date issued: xxxx
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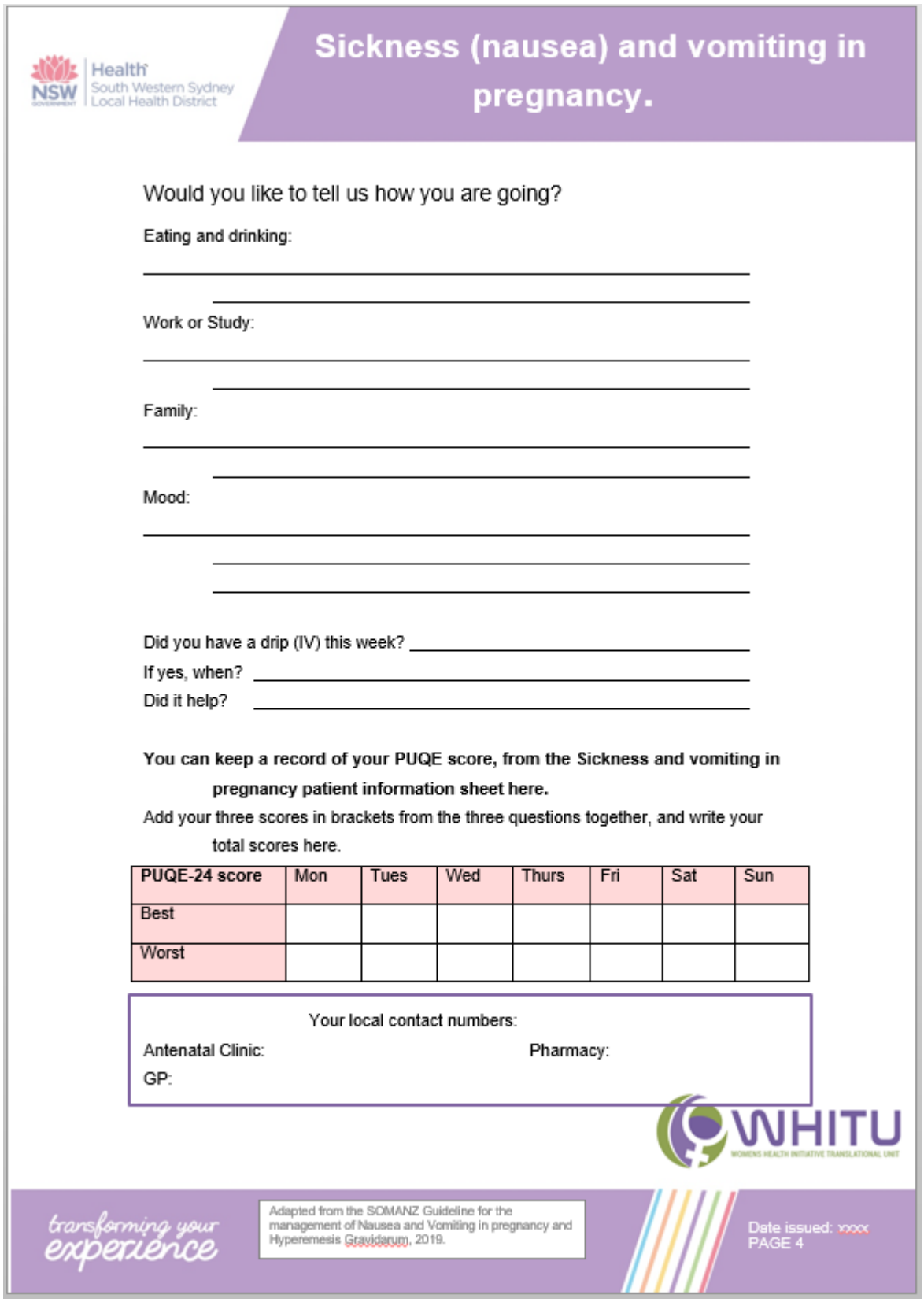

Health
South Western Sydney
Local Health District

Sickness (nausea) and vomiting in pregnancy.

Would you like to tell us how you are going?

Eating and drinking:

Work or Study:

Family:

Mood:

Did you have a drip (IV) this week? _____

If yes, when? _____

Did it help? _____

You can keep a record of your PUQE score, from the Sickness and vomiting in pregnancy patient information sheet here.

Add your three scores in brackets from the three questions together, and write your total scores here.

PUQE-24 score	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Best							
Worst							

Your local contact numbers:

Antenatal Clinic: Pharmacy:

GP:

WHITU
WOMENS HEALTH INITIATIVE TRANSLATIONAL UNIT

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Adapted from the SOMANZ Guideline for the management of Nausea and Vomiting in pregnancy and Hyperemesis Gravidarum, 2019.

Date issued: xxxx
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Attachment 3

9.3. PUQE-24 assessment.

Health
South Western Sydney
Local Health District

Nausea or Vomiting of Pregnancy and Hyperemesis Gravidarum: PUQE assessment.

Motherisk PUQE-24 scoring system:				
1. In the last 24 hours, for how long have you felt nauseated or sick to your stomach?				
Not at all (1)	1 hour or less (2)	2 to 3 hours (3)	4 to 6 hours (4)	More than 6 hours (5)
2. In the last 24 hours, have you vomited or thrown up?				
I did not throw up (1)	1 to 2 times (2)	3 to 4 times (3)	5 to 6 times (4)	7 or more times (5)
3. In the last 24 hours, how many times have you had retching or dry heaves without throwing up?				
None (1)	1 to 2 times (2)	3 to 4 times (3)	5 to 6 times (4)	7 or more times (5)
Total score (add scores in brackets)				
Mild 3 to 6: Moderate 7 to 12;		Admission not required. Consider repeat IV fluids manage at home. See NVP & HG guideline		
Severe 13 to 15.		Consider admission as per NVP & HG guideline.		

Accessing the **PUQE – 24 SCORING template** in eMR

1. Open required patient on EMR
2. Select **documents**
3. Select +**ADD** (new note)
4. Select **pre completed**
5. Search **PUQE – 24** (this will appear in title or select in search)
6. Add to **favorites** for future use
7. Select **OK** to continue as a patient note

Attachment 4:

9.4. NVP & HG, Ambulatory care procedure.

Health
South Western Sydney
Local Health District

Affix patient ID label here

Nausea or Vomiting of Pregnancy and Hyperemesis Gravidarum, Ambulatory care procedure.

Gestation	
Parity	
Medical History	
Allergies	
Previous hyperemesis	
Weight	

1st visit	**Date**	**2nd visit**	**Date**	**3rd visit**	**Date**
weight		**weight**		**Weight**	
urinalysis		**urinalysis**		**urinalysis**	
Pathology attended		**Pathology attended**		**Pathology attended**	
IV fluids (e.g.; 2L N/Saline over 2 hrs)		**IV fluids** (e.g.; 2L N/Saline over 2 hrs)		**IV fluids** (e.g.; 2L N/Saline over 2 hrs)	
Medication; 10mg metoclopramide IMI		**Medication;** 10mg metoclopramide IMI		**Medication;** 10mg metoclopramide IMI	
Script given for;		**Script given for;**		**Script given for;**	
10mg metoclopramide tds/prn for 48hrs					
Acid suppression: Eg. Nizatidine 300mg bd/prn					
Thiamine 100mg daily					
bowel management					
If PUQE or oral intake not improving arrange ambulatory care or obstetric review (as locally appropriate)					
Arrange ultrasound if not already performed					
Arrange antenatal booking appointment					
Signature					

*Bankstown: 9722 8634. Camden& Campbelltown (MACS): 46343600.
Fairfield: 9616 8999 ACOS CMO. Liverpool: 8738 3000 ask for Gynaecology Registrar.