

Nausea and vomiting in pregnancy

Assessment and management

I welcome direct GP referrals and calls for advice.

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AT A GLANCE

- Affects 70–80% of pregnancies. Hyperemesis gravidarum affects roughly 0.3–3%.
- **Under-treatment is the norm.** Most women are told to wait it out. Effective treatment exists and should be offered early.
- Score it with **PUQE-24**, weigh her, and treat by severity — not by how stoic she seems.
- Step up quickly. **Combining agents from different classes** works better than escalating a single drug.
- Treat early — symptoms are easier to control before dehydration and ketosis set in.

HYPEREMESIS GRAVIDARUM (HG) — WINDSOR DEFINITION

All four required:

- Symptoms starting **before 16 weeks**
- Severe nausea and vomiting
- Inability to eat or drink normally
- Strongly limiting daily activities

Weight loss supports the diagnosis but is not required. HG is severe by definition — not a spectrum label.

Onset after 9–10 weeks, or new symptoms in the second half of pregnancy, should prompt you to look for another cause.

FIGURE 1 · PUQE-24 SCORING CARD

Score the last 24 hours. Three items, 1–5 points each.

Hours of nausea	0	≤1	2–3	4–6	>6
Episodes of vomiting	0	1–2	3–4	5–6	≥7
Episodes of dry retching	0	1–2	3–4	5–6	≥7
points	1	2	3	4	5

≤6

Mild

7–12

Moderate

≥13

Severe

HG is **not** diagnosed on PUQE.

It tracks severity and response — repeat it at review.

Assessment

Weight, and percentage loss from pre-pregnancy weight

Hydration — postural BP, mucous membranes, skin turgor, urine output and colour

Mental health. Depression and anxiety rates are high in HG and social isolation is a major risk factor. Screen at first presentation and repeat

Abdominal tenderness or peritonism; neck stiffness or features of raised intracranial pressure

Ability to keep down fluids, tablets and regular medications. A woman with type 1 diabetes or epilepsy who cannot keep her medication down is an urgent problem

INVESTIGATIONS

Mild–moderate NVP	None required.
Severe NVP or HG (PUQE ≥13)	UEC including magnesium, calcium and phosphate LFTs, FBE, urinalysis Ultrasound to exclude multiple or molar pregnancy TFTs only if clinically thyrotoxic

Interpret an abnormal TSH with care — **gestational hyperthyroxinaemia** is a transient, self-limiting biochemical thyrotoxicosis of early pregnancy that resolves before 20 weeks and does not need antithyroid treatment.

FIGURE 2 · STEPWISE MANAGEMENT

Combine classes rather than escalating one drug. Offer non-pharmacological measures alongside, not instead of, medication.

STEP 1 Mild · PUQE ≤6	Ginger 250 mg three to four times daily (max 1000 mg/day) · Pyridoxine 10–25 mg three to four times daily (max 200 mg/day)
STEP 2 If symptoms persist after 24–48h on Step 1 — add an antihistamine or dopamine antagonist	Doxylamine 6.25–25 mg TDS (max 50 mg/day). OTC as 25 mg tablets. Pyridoxine up to 25 mg QID (max 100 mg/day). Commonly combine doxylamine (25 mg daily) with pyridoxine (12.5 mg mane/midi + 25 mg nocte). Cyclizine 12.5–50 mg TDS (max 150 mg/day) Promethazine 25 mg TDS (max 75 mg/day, sedating) Metoclopramide 10 mg TDS (max 30 mg/day) — widely over-relied upon as a sole agent; counsel on extrapyramidal effects and limit prolonged use Prochlorperazine 5–10 mg orally 6-hourly or 10–25 mg PR 6-hourly (useful when nothing stays down)
STEP 3 Moderate–severe · PUQE 7–12+	Ondansetron 4–8 mg orally or IV, up to TDS (max 16 mg/day) Parenteral antihistamine or dopamine antagonist until oral intake is tolerated Add acid suppression for all moderate–severe cases — Omeprazole 20 mg once or twice daily. Reflux is a large and frequently missed contributor. Manage ondansetron-related constipation from the outset
STEP 4 Refractory HG · specialist	Corticosteroids — prednisone 40–50 mg daily, or hydrocortisone 100 mg IV BD, then wean to 10–12.5 mg/day over 7–10 days and by 2.5 mg every 3 days to the minimum effective dose. Increase folate to 5 mg daily if steroids are used in the first trimester. Continuous subcutaneous or IV infusions of metoclopramide or ondansetron. Enteral or parenteral nutrition, with attention to refeeding syndrome

On ondansetron. Earlier meta-analyses reported a small increase in ventricular septal defects and orofacial clefting with first-trimester exposure; the most recent systematic review found no association with either. The absolute risk, if any, is very small. It should not be first-line, and it should not be withheld from a woman with significant HG. Document the discussion.

Non-pharmacological: small frequent low-fat meals, whatever she can keep down rather than what she "should" eat, fluids separate from solids, cold over hot, trigger avoidance, P6 acupressure bands. Withhold iron supplements temporarily and continue folic acid alone.

THIAMINE BEFORE DEXTROSE. ALWAYS.

Prolonged vomiting depletes thiamine, and a glucose load can precipitate Wernicke's encephalopathy. Use 200–300 mg IV where deficiency is suspected; oral thiamine 100 mg daily is reasonable prophylaxis for anyone vomiting more than a couple of weeks.

Fluids: 0.9% sodium chloride 1–2 L, initial rate 1 L/hour. Add potassium chloride 30–40 mmol/L as required, maximum 10 mmol/hour. Day-stay units and Hospital in the Home are the right setting for most women needing rehydration — admission is not automatically required.

CRITERIA FOR ADMISSION

- Unable to keep down oral fluids or antiemetics despite adequate outpatient treatment
- Significant electrolyte disturbance, e.g. potassium <3.0 mmol/L
- Acute kidney injury or significant renal impairment
- Continuing weight loss or malnutrition despite therapy
- Significant comorbidity — type 1 diabetes, epilepsy, transplant recipient — where medications cannot be taken
- Complications: haematemesis, suspected refeeding syndrome, suspected Wernicke's encephalopathy
- Inadequate support at home, or significant mental health concern

REFER TO / DISCUSS WITH THE OBSTETRICIAN

PUQE ≥13, or any woman meeting the HG definition

Weight loss >5% of pre-pregnancy weight

Failure to respond to step 2 treatment

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Symptoms starting after 10 weeks, or new symptoms after 20 weeks

Any woman raising termination because of her symptoms — she needs a comprehensive treatment attempt, specialist and psychological input, and to be taken seriously

Previous HG, ideally **before** the next pregnancy — recurrence is common and pre-emptive treatment works better than rescue

Sources: SOMANZ Position Statement on the Management of Nausea and Vomiting in Pregnancy and Hyperemesis Gravidarum, updated October 2023; RACGP guidance on managing NVP in primary care; Windsor consensus definition of hyperemesis gravidarum.