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Nausea and Vomiting in Early Pregnancy

By Dr Andrew Pickering, Obstetrician

Nausea and vomiting

Nausea and Vomiting of Pregnancy (NVP) is a common but often debilitating condition of normal pregnancy. With up to 70 percent of pregnant women experiencing NVP but only 1 – 2 percent having symptoms consistent with Hyperemesis Gravidarum (HG) it is important we have a structured approach to minimise the effect of this common condition on women who have often not yet shared the news of their pregnancy. The normalisation of NVP often creates the greatest barrier to women accessing care.

Symptoms

Symptoms of NVP and HG usually start between week 4 and 10 and the majority have resolved by week 20, though 10 percent of HG patients report symptoms throughout pregnancy.

The assessment of severity of the symptoms can be standardised by using the aptly named PUQE-24 (Pregnancy-Unique Quantification of Emesis and Nausea) index.

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)	2-3 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 (2)	3 to 4 (3)	5 to 6 (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 (2)	3 to 4 (3)	5 to 6 (4)	7 or more times (5)

Total score: mild ≤6; moderate 7 to 12; severe ≥13.

Assessment

History and physical examination should be directed towards exclusion of alternate diagnoses, assessment of dehydration and weight and nutritional status.

Women with mild to moderate symptoms (PUQE <13) don't generally need investigation unless another diagnosis is suspected.

Women severe NVP (PUQE ≥13) should have:

1. Sodium, potassium, chloride, bicarbonate, magnesium, urea and creatinine
2. Bilirubin, Alanine Transaminase (ALT), Aspartate Aminotransferase (AST), Albumin
3. Obstetric ultrasound to exclude multi-fetal or gestational trophoblastic disease
4. Thyroid stimulating hormone (TSH) where indicated.

Abnormalities in the above may prompt referral for inpatient management. Women with significant comorbidities such as Type 1 Diabetes or on essential oral medications should have an early referral for specialist management.

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Treatment

Treatment aims will depend on the severity of symptoms being experienced. The primary aim should be to control the symptoms adequately enough to avoid complications that would necessitate inpatient management. It is important to set realistic treatment targets as many women with the most significant symptoms will remain nauseated and continue to vomit well into their second trimester.

Diet

Women will tend to alter their diets to minimise their symptoms and they should be encouraged to eat whatever and whenever they can to maintain nutrition and hydration. Standard recommendations include eating small, more frequent meals that are low in fat.

Most women will present taking a pregnancy multivitamin and these often contain supplements that may contribute to nausea, such Iron, and up to two thirds of women report an improvement when ceasing them. They should be encouraged to continue folic acid and iodine supplement only.

Pharmacological treatments

The use of Pharmacological interventions should be based on history and women should be encouraged to time the use of medication around when symptoms are the worst.

The choice of antiemetic should be individualised, based on the woman's symptoms, previous response to treatment and potential side effects.

If an antiemetic is ineffective at maximal dose, discontinue before commencing an alternate agent. If an antiemetic is partially effective, optimise dosage and timing, and only add additional agents after maximal doses of the first agent have been trialled.

Treatment of NVP and HG may require a range of agents including:

- Antiemetics: herbal/vitamin and prescribed
- Acid suppression
- Laxatives
- Steroids
- Other-supplements.

SOMANZ (Guideline For The Management Of Nausea And Vomiting In Pregnancy And Hyperemesis Gravidarum 2019, Lowe et al) give some example regimes:

Mild-moderate NVP:

- Start with ginger ±B6
- Add oral antihistamine or dopamine antagonist if needed

Moderate-severe NVP or inadequate response to initial treatment:

- Consider IV/IM antihistamine or dopamine antagonist.
- Excessive sedation or inadequate response: add/substitute oral or IV serotonin antagonist at least during daytime
- Add acid suppression therapy

Refractory NVP or HG:

- Consider corticosteroids in addition to other antiemetics
- Intensify acid suppression
- manage/prevent constipation with laxatives.

Psychosocial assessment and support

The symptoms of NVP are very draining and not surprisingly are associated with an increased prevalence of depressive symptoms.

Women experiencing NVP report:

- Reduced quality of life
- Impaired ability to function normally on a daily basis
- Impacts upon relationships
- Financial strain if unable to work.

Women should be screened for symptoms of depression on initial presentation with standardised tools such as the Edinburgh depression scale which should be repeated, especially if symptoms are severe and protracted.

When To Refer

All of Northern Beaches Hospital's Obstetricians and Gynaecologists are happy to offer advice on NVP and assume care where necessary. We have rapid access inpatient services, imaging and other investigations as warranted.

We can admit into our specialist maternity service as required and put in place complex plans to support these women remaining at home.