

Information for you

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Pregnancy sickness (nausea and vomiting of pregnancy and hyperemesis gravidarum)

About this information

This information is for you if you want to know more about nausea and vomiting of pregnancy or about hyperemesis gravidarum, which is the most severe form of the condition. It may also be helpful if you are a relative or friend of someone who is in this situation.

What is nausea and vomiting of pregnancy?

Nausea and vomiting is a symptom of pregnancy and affects most women to some degree. It begins early in pregnancy, most commonly between the 4th and



7th week. It usually settles by 12–14 weeks, although in some women it may last longer. It is often called ‘morning sickness’ but it can occur at any time of the day or night.

The cause is thought to be pregnancy hormones but it is unclear why some women get it worse than others. However, it is more likely if:

- you have had it before
- you are having more than one baby (twins or triplets)
- you have a molar pregnancy (a rare condition where the placenta overgrows and the baby does not form correctly).

It is important that other causes of vomiting are considered and looked into, particularly if you are unwell, have pain in your tummy or your vomiting only starts after 10 weeks of pregnancy. Possible other causes include gastritis (inflammation of the stomach), a kidney infection, appendicitis or gastroenteritis.

What is hyperemesis gravidarum?

If the nausea and vomiting becomes so severe that it leads to dehydration and significant weight loss, it is known as hyperemesis gravidarum. It may affect 1 to 3 in 100 pregnant women. Signs of dehydration include feeling ‘dry’ or very thirsty, becoming drowsy or unwell, or your urine changing from a light yellow to a dark yellow or brown colour. Women with this condition may need to be admitted to hospital.

In severe cases, vomiting can last up to 20 weeks. Occasionally, it can last until the end of pregnancy.

How will it make me feel?

Nausea and vomiting of pregnancy can be a difficult problem to cope with. It can affect your mood, your work, your home situation and your ability to care for your family. Support from family and friends can help. In some women, the symptoms can be so severe that they become depressed and need extra support such as counselling. If you find that

you persistently feel down then you should speak to your healthcare professional.

Will it harm my baby?

There is no evidence that nausea and vomiting has a harmful effect on your baby. In fact, you have a slightly lower risk of miscarriage.

Women with severe nausea and vomiting or with hyperemesis gravidarum may, however, have a baby with a lower than expected birthweight. You may be offered scans to monitor the growth of your baby.

What can I do to help?

Most women with nausea and vomiting of pregnancy will be able to manage their symptoms themselves. You should:

- eat small amounts often – meals that are high in carbohydrate and low in fat, such as potato, rice and pasta, are easier to tolerate; try plain biscuits or crackers
- avoid any foods or smells that trigger symptoms.

Some women find eating or drinking ginger products helps. However, these may sometimes irritate your stomach. Complementary therapies such as acupuncture or acupressure may also be helpful.

If your symptoms do not settle or if they prevent you doing your day-to-day activities, see your GP, who will prescribe anti-sickness medication. This is safe to take in pregnancy.

What if my symptoms do not settle with these measures?

Contact your GP or your midwife. They will arrange for you to be seen in the assessment unit at your hospital. This may be in the maternity department or be part of the gynaecology unit.

What happens on the assessment unit?

You will have a check-up that may include:

- a discussion about how long you have had your symptoms for and whether:
 - you are keeping fluids and food down
 - you have tried any medication
 - you have lost weight
 - you have any other symptoms
 - you have had this in a previous pregnancy
- a check of your general health including your temperature, pulse, respiratory rate and blood pressure; you will have your weight measured and an assessment of whether you are dehydrated
- urine tests
- blood tests
- an ultrasound scan. This is to check how many weeks pregnant you are. It will also check for twins and rule out a molar pregnancy.

If you are able to tolerate some fluids but are unable to drink enough, you should be offered fluids through a drip in your arm over a short period of time. This is called rapid rehydration. You will also be given anti-sickness medication. Many women feel much better after this and are able to go home.

Will I need to be admitted to hospital?

Admission to hospital may be advised if you:

- are dehydrated; having ketones in your urine is a sign of dehydration
- have severe vomiting and are unable to tolerate any fluids
- have abnormal blood tests
- have lost weight
- have a medical condition such as a heart or kidney problem or diabetes.

What happens in hospital?

You will be given the fluids you need through a drip in your arm. This will be continued until you are able to drink fluids without vomiting.

Each day your fluid intake and how much urine you are passing will be recorded. Your temperature, blood pressure, pulse, respiratory rate and weight will also be recorded.

You should be offered:

- anti-sickness medication and a B vitamin called thiamine; both of these can be given through the drip in your arm if you are unable to keep tablets down
- special stockings (graduated elastic compression stockings) to help prevent blood clots
- heparin injections (to thin your blood). Pregnant women are at increased risk of developing blood clots in their legs, called deep vein thrombosis (DVT) or in their lungs (called pulmonary embolism). Being dehydrated and not being mobile increases this risk further. Heparin injections reduce this risk. You will be advised to continue these until you leave hospital and sometimes for longer. For further information, see the RCOG patient information *Reducing the risk of venous thrombosis in pregnancy and after birth* (www.rcog.org.uk/en/patients/patient-leaflets/reducing-the-risk-of-venous-thrombosis-in-pregnancy-and-after-birth)

If you are taking iron medication, this will be stopped because it can make sickness worse.

When you are feeling better, you can start to drink and eat small amounts and slowly build up to a normal diet.

What anti-sickness medication will I be offered?

There are a variety of anti-sickness medicines that you may be offered. Not all of the medicines listed below are licensed for use in pregnancy, but there is no evidence that they are harmful to your baby. It is worth considering taking them if other measures have not helped.

- Cyclizine is the medication that is usually given first. It can be taken in tablet form or by an injection. Prochlorperazine and metoclopramide can be tried if cyclizine has not worked. All three of these medications are considered to be safe in pregnancy.
- Ondansetron is another medication that may be prescribed for nausea and vomiting and can be taken by mouth or by injection.
- Corticosteroids may be considered if:
 - you are still suffering from hyperemesis gravidarum despite fluids being given through a drip
 - the above anti-sickness medication has not helped
 - you have lost a lot of weight.
- Corticosteroids are successful in many women where all other measures have failed. Most women will be able to stop corticosteroids by 18–20 weeks but 1 in 5 women will need to continue them at a low dose for the rest of the pregnancy. Only a tiny amount of the corticosteroids used to treat hyperemesis gravidarum passes from you to your baby and they are generally considered safe for use in pregnancy.

If hyperemesis gravidarum is not treated, it may cause more harm to the baby than any possible effects of a medicine recommended by your doctor.

After discharge

You will be given anti-sickness tablets to take home. If you feel better, you can cut down the number of tablets. If your vomiting gets worse, stop eating but try to keep sipping fluids and taking the anti-sickness tablets until you start to feel better. Ask your GP for a repeat prescription before your tablets run out.

Your symptoms may return and you may become dehydrated. If this happens, contact your midwife, GP or maternity unit to be assessed again.

Although this can be a difficult situation for you and may affect you throughout your pregnancy, the symptoms usually resolve or improve after your baby is born. If you have any ongoing concerns, contact your midwife or GP for advice and support.

Key points

- Nausea and vomiting of pregnancy is a common condition that usually settles by 12–14 weeks of pregnancy.
- Hyperemesis gravidarum is a severe form of this condition and can affect up to 1 to 3 in 100 pregnant women.
- Nausea and vomiting and hyperemesis gravidarum can affect your mood, your work, your home situation and your ability to care for your family. Extra support from family, friends and healthcare professionals can help you.
- While most women can be treated at home or as outpatients in hospitals, some may need admission to hospital for treatment.
- A variety of anti-sickness medicines are available that may help your symptoms. While some of these medicines may not be licensed for use in pregnancy, there is no evidence that they are harmful to your baby.

Further information

NHS Choices: *Nausea and morning sickness* (www.nhs.uk/conditions/pregnancy-and-baby/pages/morning-sickness-nausea.aspx)

Pregnancy Sickness Support: www.pregnancysicknesssupport.org.uk

For further information on molar pregnancy, see the RCOG patient information *Gestational trophoblastic disease* (www.rcog.org.uk/en/patients/patient-leaflets/gestational-trophoblastic-disease-gtd).

Making a choice

Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.



Ask 3 Questions

To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

* Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. *Patient Education and Counselling*, 2011;84: 379-85



<https://www.aquanw.nhs.uk/SDM>

Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the RCOG Green-top Clinical Guideline *The Management of Nausea and Vomiting of Pregnancy and Hyperemesis Gravidarum* which you can find online at: www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg69.

This leaflet was reviewed before publication by women attending Birmingham Women's Hospital, by the RCOG Women's Network and by the RCOG Women's Voices Involvement Panel.

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

A glossary of all medical terms is available on the RCOG website at: www.rcog.org.uk/en/patients/medical-terms.

A final note

The Royal College of Obstetricians and Gynaecologists produces patient information for the public. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of the clinical data presented and the diagnostic and treatment options available. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

All RCOG guidelines are subject to review and both minor and major amendments on an ongoing basis. Please always visit www.rcog.org.uk for the most up-to-date version of this guideline.