NAUSEA AND VOMITING DURING PREGNANCY

- Usually mild and self-limited
- Etiology: unclear, likely multifactorial: hormonal, GI
- 80% of pregnant women have nausea and vomiting "morning sickness"
- Onset of symptoms usually between 4-7 weeks gestational age
- Symptoms resolve by 20 weeks for 90% of patients
- If onset after 9 weeks gestational age, consider causes other than pregnancy

Treatment:

- Non-pharmacological approach:
    - Small, bland meals, avoid greasy and spicy foods
    - Crackers before getting out of bed in the morning; protein snack QHS
    - Ginger 250 mg capsule QID (or drink ginger tea)
    - Acupressure (P6 acupressure)-Sea Bands, Relief Bands sold in stores
    - Dietitian referral (especially with weight loss or poor weight gain)

- Medications:
    - First line Unisom 25-50 mg PO QHS and Pyridoxine (Vitamin B6) 25 mg PO Q8 hours

    Antihistamines
    - Meclizine (Antivert) 25-50 mg PO Q6 hours OR
    - Hydroxyzine (Atarax/Vistaril) 25-50 mg PO Q6 hours OR
    - Diphenhydramine (Benadryl) 25-50 mg PO Q6 hours OR

    Antiemetics
    - Promethazine (Phenergan)12.5- 25mg q 4hrs PO/PR OR
    - Prochlorperazine (Compazine) 25 mg PR Q12 hours OR
    - Prochlorperazine (Compazine) 5-10 mg PO Q6 hours OR
    - Ondansetron (Zofran) 4-8 mg PO Q12 hours ($$$$ not first line)

    Other
    - IV hydration
    - TPN

REFERENCES:
ACOG Practice Bulletin No. 52
American Family Physician July 1, 2003
e Medicine April 2007
Up to Date

HYPEREMESIS GRAVIDARUM

Definition: A clinical diagnosis; persistent nausea/vomiting, dehydration, ketosis, electrolyte disturbances and weight loss > 5% of prepregancy weight abdominal pain is not usual

Incidence: 1/200

Risk factors: multiple gestation, gestational trophoblastic disease, triploidy, trisomy 21, female fetus, hx hyperemesis gravidarum in previous pregnancy, hx of motion sickness, hx migraines

Maternal complications: splenic avulsion, esophageal rupture, pneumothorax, peripheral neuropathy, preeclampsia

Fetal complications: IUGR

Lab:
- UA: for ketones
- Serum lytes: usually low Na, low K, Low Cl. Bicarb can be elevated or low depending on the volume status. (BUN will not fully reflect dehydration)
- LFTs: with elevated ALT/AST and total Bili
- Amylase and Lipase: elevated 2-3 times normal
- TSH: almost always < 2.5
- Magnesium, phosphorus, and potassium: may need replacement
- Hematocrit: increased due to hemoconcentration
- Ultrasound to rule out twins or molar pregnancy

Treatment:
- Hospitalize, consult hospital dietician, consider OB consult
- IV fluids (LR) until ketones cleared, no longer orthostatic, give IV thiamine 100mg IV for 2-3days if vomiting > 3 weeks. Be sure thiamine is on board before switching to D5
- Anti-emetics IM or PR, switch to PO when able
- MVI 1 amp IV q day, change to PO when able
- Start Unisom + B6, as above
- Methylprednisone (Prednisone) 12-16 mg TID with tapering over 2 weeks can be used up to 6 weeks in severe cases
- Enteral nutrition with NG tube
- TPN in exceptional cases
- Referral to clinic dietician after discharge
    - May need home IV therapy