Hyperemesis Gravidarum and Severe Nausea and Vomiting in Pregnancy
Clinical Guideline

V3.0

March 2021
**Day case management**

**Consider inpatient admission if:**
- continued N+V and inability to keep down oral anti-emetics after day case admission
- continued N+V associated with weight loss greater than 5% of body weight, despite oral antiemetics
- confirmed or suspected comorbidity (e.g. UTI and inability to tolerate oral antibiotics)

**If not clinically dehydrated +/- 1+ ketones or less:** consider IM anti-emetic and aim to discharge

**Show to Day Case area in DAU (recliner chairs)**

- **Midwife/MSW:** urinalysis +/- MSU, weight, cannula and bloods (FBC, U&E, LFT).
- **SHO:** clerking including current medicines, prescribe EPMA day case bundle and fluids.

**IV rehydration:** 2x 1L Hartmann’s over 2 hours  
(Avoid dextrose containing fluids as may precipitate Wernicke’s encephalopathy)

**IV antiemetic:** prochlorperazine +/- cyclizine (see prescribing guidance)

**Review at 4 hours:** chase bloods, give light snack / oral fluid

- **Tolerating oral intake / N+V settled / normal bloods**
- **Ongoing N+V / abnormal bloods**

**Discharge home**

**TTOs:**
- Antiemetic (see ladder +/- review previous) – advise to take regularly
- Antacid if reflux symptoms (omeprazole)
- Laxatives if on ondansetron +/- suffering with constipation
- Thiamine 50mg PO OD (if severe and/or 2+ attendances)

Dietary advice (see 2.6 Discharge in main guideline)
Direct to Pregnancy Sickness Support

**Admit**

See full guideline for inpatient management

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*When accepting GP/CMW referrals, consider timing of appointment on DAU based on availability of chairs in day case area – i.e. if already in use consider bringing in later on in the day / the following day.*
Prescribing guidance

**Anti-emetics:** use a ladder approach – start at 1st line and add in

| FIRST LINE: | prochlorperazine 5–10 mg 8 hourly PO; 12.5 mg 8 hourly IM |
| SECOND LINE: | cyclizine 50mg PO/IV/IM 8 hourly or promethazine 25mg PO 4-8 hourly |
| THIRD LINE: | ondansetron 4mg PO/IV/IM 8 hourly |
| *Side-effects: constipation* |
| *Risks: if taken between weeks 6 and 12, slightly higher chance of cleft lip and/or palate than unexposed babies (11 in 10,000 background risk, increased to 14 in every 10,000)* |
| FOURTH LINE: | steroids **(Consultant decision)** – initially hydrocortisone 100mg BD. Then 40mg prednisolone OD for 7 days, reduce by 5mg per week (taper until lowest dose required to manage symptoms is reached). |
| *Side-effects: weight gain, mood disturbance* |
| *Risks: ↑ gestational diabetes in long-term use, increased risk of cleft lip/palate* |

**Other considerations:**

**Anti-emetic:** Consider metoclopramide 10mg TDS (only < 5 days as per MHRA). Caution in young women – risk of oculogyric crisis.

**Antacid:** Omeprazole 20mg OD

**Laxatives:** if suffering with constipation or on ondansetron/cyclizine

**Vitamin supplementation:** If 2x attendances or severe hyperemesis, supplement with thiamine 50mg OD

**VTE prophylaxis** if admitted
1. **Aim/Purpose of this Guideline**

1.1. To inform midwives and obstetricians of care pathways and management for women suffering from Hyperemesis Gravidarum (HG) and Nausea and vomiting in pregnancy (NVP).

Nausea and vomiting is experienced by up to 80% of women on a spectrum from very mild to very severe with associated complications. 35% of women experience symptoms of clinical significance for which they seek medical aid. Onset of NVP is in the first trimester and if the onset is after 10+6 weeks gestation, other causes should be considered (RCOG 2015).

HG is an extreme form of nausea and vomiting which affects 1.5% of women and is the most common indication for hospital admission among pregnant women. HG can be diagnosed when there is protracted NVP with the triad of more than 5% pre-pregnancy weight loss, dehydration and electrolyte imbalance (RCOG 2016).

1.2. Our role is also to manage expectations and be honest. Treatment is about managing rather than curing; none of the treatments are curative and some have unpleasant side effects. The overall aim will be to work as a team to manage the condition.

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2. **The Guidance**

2.1. **Complications**

**MATERNAL**

- Physical: Weight loss, dehydration, electrolyte disturbance, vitamin deficiencies, acidosis, Mallory-Weiss tear or oesophageal rupture, depression and social isolation, pressure damage to skin tissue, venous thromboembolism, re-feeding syndrome.
- Psychological: peri-natal depression, loss of identity, isolation
- Social: unable to work and maintain household, financial hardship, relationship difficulties, concerns over care of other children.

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**Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation**

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We cannot rely on opt out, it must be opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the *Information Use Framework Policy* or contact the Information Governance Team

rch-tr.infogov@nhs.net
FETAL
- Small for Gestational Age (SGA), Low birth weight and prematurity. As a last resort, a mother may choose to terminate the pregnancy.

2.2. Referral Criteria
Women with mild NVP should be managed in the community with antiemetics. Day-case admission should be used when community/primary care measures have failed (NICE 2015)

2.2.1. Day-Case Admission
- Unable to maintain adequate hydration orally at home
- Vomiting > 24hours
- Moderate ketosis on urinalysis

2.2.2. Consider Inpatient Admission
- Continued nausea and vomiting and inability to keep down oral antiemetics after day case admission
- Continued nausea and vomiting associated with weight loss (greater than 5% of body weight), despite oral antiemetics
- Confirmed or suspected comorbidity (such as urinary tract infection and inability to tolerate oral antibiotics). (RCOG 2016)
- Haematemesis
- Significantly abnormal U+E’s (Na<120mmol/l)
- 3 previous attendances for day cases
- The threshold for admission or seeking specialist advice should be lower for women with co-existing conditions

2.3. Initial Assessment and Investigation
- Assess for clinical dehydration – dry mucus membranes, tachycardia, weight loss, concentrated urine
- History: Previous history of NVP/HG
  Onset, duration and frequency of nausea and vomiting
  Whether food and drink are being tolerated
  Associated symptoms
  Co-existing conditions
  Effect on quality of life
- Weigh patient on admission
- MEOWS score
- Urine analysis. MSU – to exclude UTI. **NB: if glycosuria as well as ketones consider diabetes**
  - Full blood count (FBC) – haematocrit is usually raised
  - Blood glucose monitoring (exclude diabetic ketosis if diabetic)
  - U +E’s- occasionally reveals hyponatremia, hypokalaemia and high serum urea
  - Check magnesium if hyperemesis severe , or if potassium <3.0 mmol/l
  - LFTS’s – abnormal in 40% of women with HG - usual mild elevations in serum transaminases. Bilirubin levels and amylase levels can be slightly raised
2.4. Differential Diagnosis

2.4.1. Findings which may suggest an alternative diagnosis include:
- Severe abdominal or epigastric pain (may require further investigation of serum amylase levels and an abdominal ultrasound and possibly oesophageal gastroduodenoscopy
- Onset of symptoms after 11 weeks gestation
- Fever
- Headache or abnormal neurological examination
- Goitre

2.4.2. Conditions causing nausea and vomiting in pregnancy:
- Genito-urinary conditions – UTI, uraemia, pyelonephritis, ovarian torsion
- Metabolic disorders and endocrine conditions – hypercalcaemia, thyrotoxicosis, diabetic ketoacidosis, Addison`s disease
- Gastrointestinal conditions – gastritis, peptic ulcer, pancreatitis, bowel obstruction, hepatitis, appendicitis
- ENT conditions e.g. labyrinthitis
- Neurological disorders – vestibular disease, migraine
- Other pregnancy-related conditions – acute fatty liver of pregnancy, pre-eclampsia (consider pre-eclampsia if the onset is of NVP is in second half of pregnancy)
- Drug induced vomiting – e.g. iron or opioids
- Psychological disorders – e.g. eating disorders

2.5. Management

2.5.1. Fluid and Electrolyte Replacement
- Avoid dextrose containing fluids – carbohydrate rich fluids may precipitate Wernicke`s Encephalopathy
- 2000ml Hartman`s solution given over 4 hours
- Additional fluid and electrolyte requirements should be adapted based on urinalysis and U+E`s
  - Potassium is almost always required with subsequent IV fluids
  - Caution when replacing sodium – risk of central pontine myelinolysis if replaced too rapidly

2.5.2. Anti-emetic Therapy
No anti-emetics are currently licensed for use in pregnancy in the UK.
- Withhold non-essential medications associated with NVP e.g. oral iron
- Give first dose IM/ IV
• Continued regular prescription of anti-emetics is essential.
• A combination of medications may be required
• Prescribe at times which give maximum effect at meal times
• Consider which anti-emetics have had an adverse effect or been most effective for the woman historically

2.5.3. First line Anti-emetic therapy
• Phenothiazines – Prochlorperazine (Stemetil) 12.5mg 8-hourly IM, 5-10mg 8-hourly PO

2.5.4. Second line Anti-emetic
In addition to a first line drug
• Antihistamines - Cyclizine 50mg by IM/IV/PO 8-hourly

2.5.5. Third line Anti-emetic
• Ondansetron – 4mg IV/PO 8-hourly
• Metoclopramide - 10mg 3x daily
  Risk of oculogyric crises in young women. Emergency treatment is IV PROCYLIDINE 10MG STAT which can be repeated after 20 minutes if necessary.
  MHRA advises use for no longer than 5 days, therefore consider use as inpatient but not as TTO / for long-term treatment.

2.5.6. Fourth line Anti-emetic
Following Consultant review consider Hydrocortisone 100mg bd initially followed by Prednisolone 40mg BD for 7 days, with the dose reduced by 5mg weekly thereafter.
Steroids are reserved for cases where the above treatments including repeated inpatient admissions have failed and should be commenced as an inpatient.

2.5.7. Nutrition
• Encourage oral fluids when they can be tolerated
• Record fluid balance
• Encourage frequent snacks of “safe foods” when able to eat
• Use MUST (Nutrition Assessment) tool in severe cases
• Assistance to eat when required
• Consider referral to Dietician in severe cases

2.5.8. Vitamins
• If unable to tolerate oral diet and fluid, Pabrinex should be administered according to medication information leaflet given and EPMA
• For those tolerating oral diet and fluid, Oral Thiamine 50mg x 3 daily should be routinely given to all women admitted to hospital with severe prolonged vomiting or 2+ attendances for day case treatment.

2.5.9. Thromboprophylaxis
A VTE assessment must be completed on admission and anti-
embolic stockings / LMWH given to all clinically dehydrated patients on bedrest.

2.6. Midwifery Care

- Urinalysis on every specimen
- Accurate fluid balance for inpatients
- MEOWS 4 hourly
- Weigh woman on each admission or weekly if she remains an inpatient
- Women report that sensory stimulation is a trigger for vomiting therefore nurse in a side room if possible.
- Staff should not smell of smoke or use perfume
- Women should have easy access to a supply of clean vomit bowls
- Used vomit bowls should be cleared away promptly
- Ensure timely medication administration to enable stable blood levels of anti-emetics
- Assist women with personal hygiene
- Staff should ask before discussing food with woman in case it triggers further vomiting
- Do not suggest use of ginger, sea bands etc. as are ineffective for severe NVP and HG and inaccurate information may cause mistrust in healthcare professionals
- Encourage rest
- Give written information/ support groups (Pregnancy Sickness Support)
- Advise women to seek early treatment for constipation caused by dehydration. Malnutrition, immobility or medication (Ondansetron)
- Emotional and psychological support. Ensure that the woman feels that she is listened to and her symptoms believed. In extreme cases refer woman to the Perinatal Mental Health Team if appropriate.
- Regular bloods (U+Es) as per obstetric plan, to assess the need for further supplements such as potassium (RCOG)

2.7. Discharge

- Give TTO anti-emetics orally or PR even if the woman is well on discharge. Ensure that the woman is aware that Thiamine is needed as a vitamin supplement if she continues to vomit.
- Give dietary advice
  - Eat dry biscuits, bread or cereal before getting up in the morning; get out of bed slowly and avoid sudden movements
  - Drink fluid between meals rather than with meals to reduce volume of intake
  - Avoid large, greasy or spicy meals
  - Keep rooms well ventilated and odour free
- Women with severe hyperemesis or nausea and vomiting in pregnancy who have continued symptoms into the late second or third trimester should be offered serial growth scans to monitor fetal growth (RCOG)
- If the woman’s symptoms were severe enough to require medication, inform her Community Midwife of discharge and arrange follow up after 24 hours to check for ketones in the urine, signs of dehydration(e.g. infrequent urination, dry mucous membranes, light-headedness) and assess response to medication.
• Please provide with a discharge letter (see Appendix 3) that will inform both the community midwife of the admission, but also advise the GP which medications have been commenced and that an ongoing prescription from them will be required.

3. Compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>The audit will take into account record keeping by midwives and medical staff. The audit will be registered with RCHT’s Audit Department.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Antenatal Ward Manager</td>
</tr>
<tr>
<td>Tool</td>
<td>• Was the correct referral pathway followed?</td>
</tr>
<tr>
<td></td>
<td>• On admission was the first dose of antiemetic given IM/IV?</td>
</tr>
<tr>
<td></td>
<td>• Was an adequate fluid balance chart kept on all patients?</td>
</tr>
<tr>
<td></td>
<td>• With severe prolonged vomiting was the patient prescribed Thiamine 50mgs TDS?</td>
</tr>
<tr>
<td></td>
<td>• Did the patient have 4 hourly MEOWS?</td>
</tr>
<tr>
<td></td>
<td>• Was a urinalysis taken for each specimen of urine?</td>
</tr>
<tr>
<td>Frequency</td>
<td>1% or 10 sets of notes, whichever is greatest, of all health records of patients admitted with hyperemesis gravidarum</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>• A formal report of the results will be received annually at the Obstetric Patient Safety Forum and at the Clinical Audit Forum, as per the audit plan.</td>
</tr>
<tr>
<td></td>
<td>• During the process if the audit compliance is &lt;75% or other deficiencies identified, this will be highlighted at the next Obstetric Maternity Patient Safety Forum and Clinical Audit Forum and an action plan agreed.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>• Any deficiencies identified will be discussed at the Obstetric Patient Safety Forum and Clinical Audit Forum and an action plan developed.</td>
</tr>
<tr>
<td></td>
<td>• Action leads will be identified and a time frame for action to be completed.</td>
</tr>
<tr>
<td></td>
<td>• The action plan will be monitored by the Audit Midwife until all actions are complete.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>• Required changes to practice will be identified and actioned within a time frame agreed on the action plan.</td>
</tr>
<tr>
<td></td>
<td>• A lead member of the forum will be identified to take each change forward.</td>
</tr>
<tr>
<td></td>
<td>• The results of the audits will be distributed to all staff through the Patient Safety Newsletter.</td>
</tr>
</tbody>
</table>

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Diversity & Human Rights Policy’ or the Equality and Diversity website.

4.2. Equality Impact Assessment
   The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th><strong>Document Title</strong></th>
<th>Hyperemesis Gravidarum and Severe Nausea and Vomiting in Pregnancy Clinical Guideline V3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>This document replaces (exact title of previous version):</strong></td>
<td>Hyperemesis Gravidarum and Severe Nausea and Vomiting in Pregnancy Clinical Guideline V2.0</td>
</tr>
<tr>
<td><strong>Date Issued/Approved:</strong></td>
<td>March 2021</td>
</tr>
<tr>
<td><strong>Date Valid From:</strong></td>
<td>March 2021</td>
</tr>
<tr>
<td><strong>Date Valid To:</strong></td>
<td>March 2024</td>
</tr>
<tr>
<td><strong>Directorate / Department responsible (author/owner):</strong></td>
<td>Magda Kudas, Antenatal Ward Manager Obs and Gynae Directorate</td>
</tr>
<tr>
<td><strong>Contact details:</strong></td>
<td>01872 252149</td>
</tr>
<tr>
<td><strong>Brief summary of contents</strong></td>
<td>To inform midwives and obstetricians of care pathways and management for women suffering from Moderate - Severe Nausea and Vomiting in pregnancy (NVP) and Hyperemesis Gravidarum (HG).</td>
</tr>
<tr>
<td><strong>Suggested Keywords:</strong></td>
<td>Hyperemesis, Gravidarum, nausea, sickness, pregnancy, vomiting, severe</td>
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<tr>
<td><strong>Target Audience</strong></td>
<td>RCHT</td>
</tr>
<tr>
<td></td>
<td>✔</td>
</tr>
<tr>
<td><strong>Executive Director responsible for Policy:</strong></td>
<td>Medical Director</td>
</tr>
<tr>
<td><strong>Approval route (names of committees)/consultation:</strong></td>
<td>Maternity Guidelines Group Obs and Gynae Directorate Care Group Board</td>
</tr>
<tr>
<td><strong>General Manager confirming approval processes:</strong></td>
<td>Mary Baulch</td>
</tr>
<tr>
<td><strong>Name of Governance Lead confirming approval by specialty and care group management meetings</strong></td>
<td>Caroline Amuskusana</td>
</tr>
<tr>
<td><strong>Links to key external standards</strong></td>
<td>None</td>
</tr>
</tbody>
</table>
| **Related Documents:** | • Dean C., Shortman A (2014) Hyperemesis Gravidarum: The Definitive Guide  
• NICE (2017) |
The Management of nausea and Vomiting of Pregnancy and Hyperemesis Gravidarum RCOG Green-top Guideline No. 60 (2016)

Training Need Identified? No

Publication Location (refer to Policy on Policies – Approvals and Ratification):
Internet & Intranet ✓ Intranet Only

Document Library Folder/Sub Folder Midwifery and Obstetrics

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tbody>
<tr>
<td>31st July 2015</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Karen Stoyles Antenatal Ward &amp; Day Assessment Unit Manager</td>
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</table>
| 15th June 2018 | V2.0       | Amendments  
2.2 Re-formatting complications with additions  
2.6 Frequency of anti-emetics  
2.6.4 Ondansetron 2nd line therapy  
Additions  
2.3 Additions to management  
2.6.4 Metoclopramide  
2.6.7 Vitamins  
2.7 Daily blood samples  
2.8 Serial Growth Scans | Katie Letcher Antenatal Midwife |
| February 2021  | V3.0       | Full version update  
Amendments:  
Addition of Day Case Management flow chart and clear prescribing guidance  
Update to information re complications of HG and reasons for admission  
Metoclopramide to be reserved for short-term use  
Addition of Appendix 3 – discharge letter for CMW/GP for ongoing care in community | Emma Shephard ST3 O&G |
# Appendix 2. Initial Equality Impact Assessment

## Section 1: Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Hyperemesis Gravidarum and Severe Nausea and Vomiting in Pregnancy Clinical Guideline V3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorate and service area:</strong></td>
<td>Obs &amp; Gynae Directorate</td>
</tr>
<tr>
<td><strong>New or existing document:</strong></td>
<td>Existing</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong></td>
<td>Emma Shephard</td>
</tr>
<tr>
<td><strong>Telephone:</strong></td>
<td>01872 252149</td>
</tr>
</tbody>
</table>

### 1. Policy Aim

Who is the strategy / policy / proposal / service function aimed at?

To inform midwives and obstetricians of care pathways and management for women suffering from: Hyperemesis Gravidarum (HG) Moderate or severe nausea and vomiting in pregnancy (NVP).

### 2. Policy Objectives

To ensure that pregnant women with Hyperemesis Gravidarum or Severe Nausea and Vomiting in pregnancy receive the appropriate level of care.

### 3. Policy – intended Outcomes

Improved maternal experience for pregnant women with Hyperemesis Gravidarum or Severe Nausea and Vomiting.

### 4. How will you measure the outcome?

Compliance Monitoring Tool

### 5. Who is intended to benefit from the policy?

Pregnant women with Hyperemesis Gravidarum

### 6a). Who did you consult with?

- Workforce
- Patients
- Local groups
- External organisations
- Other

- X

**Please record specific names of groups**
- Maternity Guidelines Group
- Maternity Governance
- Obstetrics and Gynaecology Directorate
- Care Group Board for approval

### 6b). Please identify the groups who have been consulted about this procedure.

- Guideline agreed
7. The Impact
Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

Are there concerns that the policy **could** have a positive / negative impact on:

<table>
<thead>
<tr>
<th>Protected characteristics:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Sex (male, female, non-binary, asexual etc.)</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women</td>
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<tr>
<td>Disability - Learning disability, physical disability, sensory impairment, mental health problems and some long term health conditions.</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>X</td>
<td></td>
<td></td>
<td>This guideline will have a beneficial effect</td>
</tr>
<tr>
<td>Sexual Orientation, (bisexual, gay, heterosexual, lesbian)</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
</tbody>
</table>

If all characteristics are ticked ‘no’, and this is not a major working service change, you can end the assessment here as long as you have a robust rationale in place.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Emma Shephard

If you have ticked ‘yes’ to any characteristic above OR this is a major working or service change, you will need to complete section 2 of the EIA form available here: [Section 2. Full Equality Analysis](#)

For guidance please refer to the Equality Impact Assessments Policy (available from the document library) or contact the Human Rights, Equality and Inclusion Lead debby.lewis@nhs.net

Hyperemesis Gravidarum and Severe Nausea and Vomiting Clinical Guideline V3.0
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Appendix 3. Discharge letter for use with women with NVP/HG

Wheal Rose Ward / Day Assessment Unit
Royal Cornwall Hospital
Truro
TR1 3LJ

Dear Dr.

This is to inform you that one of your patients has attended with nausea & vomiting in pregnancy / hyperemesis gravidarum and will require an ongoing repeat prescription.

Gestation: ____/40

Day case admission / Inpatient admission (circle) Attendance number: _____

Discharge medication: (circle)

<table>
<thead>
<tr>
<th>Anti-emetics</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prochlorperazine 5mg PO TDS</td>
<td>Lactulose</td>
</tr>
<tr>
<td>Cyclizine 50mg PO TDS</td>
<td>Laxido</td>
</tr>
<tr>
<td>Ondansetron 4mg PO TDS</td>
<td>Omeprazole 20mg BD</td>
</tr>
<tr>
<td>Metoclopramide 10mg PO TDS</td>
<td>Thiamine 50mg OD TDS</td>
</tr>
<tr>
<td>Ondansetron 16mg PR OD</td>
<td>Steroid reducing dose regime (see separate TTO)</td>
</tr>
</tbody>
</table>

General advice:
- Combinations of anti-emetic medication are likely to be required to manage symptoms – please add in further medication as above if required.
- Dietary advice:
  - Eat dry biscuits, bread or cereal before getting up in the morning; get out of bed slowly and avoid sudden movements
  - Drink fluid between meals rather than with meals to reduce volume of intake
  - Avoid large, greasy or spicy meals
  - Keep rooms well ventilated and odour free

For further support, see Pregnancy Sickness Support (www.pregnancysicknesssupport.org.uk) - provides a helpline, forum, 1:1 support and lots of useful information.

Many thanks for your ongoing care.

For any questions or concerns please contact us:
Wheal Rose Ward 01872 252149
Day Assessment Unit 01872 255980
On-call Obstetric SpR Via switch

Signature:

Name: Date: