key points

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Nausea and vomiting in pregnancy is very common and affects up to 80% of women. It is usually mild and resolves during the first half of pregnancy. However, in a small proportion of women (0.3–3.6%), symptoms are so severe that they lead to dehydration, electrolyte imbalance and weight loss. This is known as hyperemesis gravidarum. A history of hyperemesis gravidarum in a previous pregnancy is the strongest independent risk factor with a recurrence rate of 26%. Increased pregnancy hormone levels caused by a multiple or molar pregnancy and preexisting medical conditions such as diabetes, hyperthyroidism, gastrointestinal disorders (specifically being seropositive for *H. pylori*) and psychiatric illness also increase risk.

Symptoms typically start between the 4th and 7th weeks of gestation, peak around the 9th week and resolve by the 20th week. If the onset of symptoms occurs after 10 weeks' gestation, the symptoms are unremitting or the presentation is atypical, the possibility of a different clinical condition needs to be considered. An alternative diagnosis may also be suggested by vaginal bleeding, symptoms of systemic infection, severe abdominal pain, haematemesis, urinary or bowel symptoms, significant headache or confusion.

It is important to enquire about the onset, duration and frequency of nausea and vomiting, symptoms of dehydration (e.g. oliguria, dark urine), and the response to antiemetic treatment if used. Check for signs of significant dehydration and/or muscle wasting, sepsis, hypokalaemia (muscle weakness), hypocalcaemia, thyrotoxicosis and abdominal pathology. Monitor weight weekly, test the urine for evidence of infection, calculate VTE risk and organise an ultrasound in the early pregnancy unit.

Urgent referral to secondary care, for intravenous fluids, electrolyte and vitamin replacement, should be considered for those women with: persistent severe symptoms despite oral antiemetic treatment; a PUQE score >7; weight loss > 5% of the prepregnancy weight; medical comorbidities requiring oral treatment and/or any clinical concerns needing specialist input. Hyperemesis scores 3 points on the maternity VTE assessment tool, so any further risk factor is an indication to consider thromboprophylaxis.

Most women with mild nausea and vomiting should be managed with lifestyle and dietary modifications. If these are ineffective and symptoms are persistent, antiemetic treatment should be considered. The RCOG recommends using antihistamines (cyclizine, promethazine) or phenothiazines (prochlorperazine, chlorpromazine) first line. Second-line medications include dopamine antagonists (metoclopramide and domperidone) and ondansetron. If polytherapy with second-line agents is ineffective and symptoms are severe, steroids can be considered. Women who have persistent symptoms into the second trimester of pregnancy should have consultant-led antenatal care and serial fetal growth ultrasound.