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January 2023

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Treatment of Nausea and Vomiting in Pregnancy

Nausea, with or without vomiting, is common in pregnancy, affecting up to 80% of women. Symptoms usually begin between four and seven weeks, peak at nine weeks, and resolve by 16 to 20 weeks. Up to 2% of women develop hyperemesis gravidarum, where persistent vomiting may lead to dehydration, weight loss and biochemical abnormalities. Once other causes have been excluded, treatment can be approached in a stepwise manner based on the severity of symptoms and response to treatment. Combination treatment is useful in some women. There is no convincing evidence of superiority for any particular antiemetic.

Non-pharmacological options

- Avoid triggers such as dehydration, hunger, heat and strong smells
- Have a snack before getting out of bed
- Eat before or as soon as feeling hungry
- Eat small, frequent meals
- Choose bland, dry snacks such as nuts, crackers or toast
- Ginger: in foods such as tea or biscuits, or in supplements (1-2 g per day)
- Acupressure wrist bands: limited evidence for benefit

First-line pharmacological options

- Large body of safety and efficacy data to support the use of:
  - Pyridoxine (vitamin B6) 25 mg three times daily (oral)
  - Cyclizine 50 mg up to three times daily (oral, IM or IV)
  - Metoclopramide 10 mg up to three times daily (oral, IM or IV)
  - Prochlorperazine 5-10 mg up to three times daily (oral); 3-6 mg up to twice daily (buccal); 12.5 mg up to four times daily (IM)
  - Promethazine 25 mg up to four times daily (oral or IV)

Second-line pharmacological options

- If a combination of first-line options have failed, ondansetron 4-8 mg up to twice daily (oral, IM or IV) may be reasonable
- Most available data suggest no association with congenital malformations; however, there may be small increased risks that should be weighed against the consequences of untreated nausea and vomiting:
  - ventricular septal defect (6 additional cases per 10,000 women treated; 0.3% increased risk above baseline risk of 0.3%)
  - oral cleft (3 additional cases per 10,000 women treated; 0.03% increased risk above baseline risk of 0.17%)

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