Torbay and South Devon
NHS Foundation Trust

Email: foi.tsdft@nhs.net
Our Ref: TSD10950

20 October 2026

Dear Sir/Madam

Request for Information

We are writing to confirm that we have now completed our search for the information you requested.

A copy of the information is below:

1. **A copy of your current clinical guideline or protocol for the management of nausea and vomiting in pregnancy and hyperemesis gravidarum, including its publication and review dates. If it is published online, a link is sufficient. If you do not have one, please say so.**
   Please see 'Hyperemesis Gravidarum (G0869) guideline shown below

2. **Whether you offer ambulatory (day-case) treatment for hyperemesis gravidarum, such as IV fluids without overnight admission. A yes or no answer is sufficient.**
   Yes

The information supplied to you continues to be protected by the Copyright, Designs and Patents Act 1988. You are free to use it for your own purposes, including any non-commercial research you are doing and for the purposes of news reporting.

If you wish to discuss any of the above, please contact us, quoting the FOI reference number above.

If you are unhappy with the way in which we have handled your request, please contact the Data Protection and Freedom of Information Lead in the first instance. If you wish to make a formal complaint, you should write to our Information Governance Team at Information Governance and Data Protection, Belmont Court, Torbay and South Devon NHS Foundation Trust, Torquay, TQ2 7AA or by email to tsdft.igteam@nhs.net

If you are not content with the outcome of your complaint or the internal review, you may apply directly to the Information Commissioner for a decision. Generally, the Information Commissioner will only make a decision once you have exhausted the complaints and/or internal review process provided by us. The Information Commissioner can be contacted

at: The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF or through this link https://ico.org.uk/global/contact-us/

Yours sincerely,

Freedom of Information Team

Document Type:	Guideline	
Reference Number : **0869**	Version Number: **6**	Next Review Date: **13 October 2026**
Title:	**Hyperemesis Gravidarum**	
Document Author:	Consultant Obstetrician and Gynaecologist	
Applicability:	As Indicated	

Introduction

Nausea and vomiting are common in pregnancy (NVP), with 3/4 of pregnant women being affected. Hyperemesis gravidarum (HG) is defined as persistent vomiting in pregnancy, resulting in the inability to maintain adequate hydration and fluid and electrolyte levels. HG can be diagnosed when there is protracted NVP with the triad of more than 5% pre-pregnancy weight loss, dehydration and electrolyte imbalance. It occurs in 1-2 per 100 pregnancies. If inadequately or inappropriately treated (in severe cases) it can lead to Wernicke's encephalopathy, central pontine myelinolysis and maternal death. There is also an increased risk of intrauterine growth restriction if severe and persistent. All women should initially be managed on an outpatient basis. Only those who have co-morbidities, contra-indications or have severe disease should be admitted as inpatients.

Clinical features

- Protracted vomiting with onset in the 1st trimester
  - Onset typically before 9 weeks and peaks around 11 weeks gestation
  - NVP starting over 12/40 unlikely to be HG
  - Longevity of symptoms > than 48 hours will exclude a group of women presenting with NVP secondary to viral gastroenteritis.
- Ketonuria (>!+)
- May be ptyalism (inability to swallow saliva) and spitting
- Signs of dehydration – tachycardia and postural hypotension

Sequaelae

- Haematemesis due to Mallory Weiss tears
- Malnutrition
- Weight loss (>5%) and muscle wasting
- Thromboembolism
- Increased levels of anxiety and depression
- Socioeconomic consequences

Initial assessment

- Clinical history
  - Frequency of vomiting and micturition in the last 12 hours
  - Medication tried
- Assess for dehydration with pulse and blood pressure : postural hypotension, tachycardia, dry mucous membranes
- Urinalysis + MSU – no indication for IV fluids if normal urine output and no ketones.
- Ketonuria (>!+) requires hydration.
  - Reflects switch to lipolysis in starvation states
  - Indicator of dehydration/poor oral intake
  - Not a marker of severity

Investigations

- Bloods – U+Es & FBC
  - Hypokalaemia and hyponatraemia
- Do not check LFTs, TFTs or HCG
  - Unless clinical signs of hyperthyroidism. Transient thyrotoxicosis is common & self-limiting
  - Up to 50% have transaminitis which is mild & self-limiting (mild: ALT up to 250U/L)
  - A recent meta-analysis of biomarkers in HG has shown that that hormone levels are not helpful in diagnosis.
- Ultrasound scan – once only on first admission from 6 weeks to exclude multiple pregnancy or hydatiform mole.
  - Not if the woman has had one in this pregnancy before or is due to have one in the next week. This may be as an outpatient in EPMS.

Management

Aim to treat and discharge the same day with rapid rehydration and review. This is supported by a patient information leaflet and fast track access to gynaecology for re-assessment as required.

- Admit to the Gynaecology assessment Unit on the Acute Medical Unit (AMU)
- Urinalysis for ketones/nitrites
  - Insignificant ketonuria & normal urine output: IV fluids & blood tests are not required
  - Provide patient information, anti-emetics may be considered:
  - One off IM anti-emetic then oral TTO.
- Significant ketonuria (>1+) or inadequate urine output
  - IV access, bloods tests & IV anti-emetics
- Identification of suitability for rapid fluid replacement in the majority of patients
  - Patients in whom it would be contraindicated include:
  - Women with cardiac conditions who require admission and inpatient management for slower rehydration.
  - Confirmed or suspected comorbidity (such as urinary tract infection and inability to tolerate oral antibiotics)
  - Diabetics at risk of diabetic ketoacidosis (require blood glucose monitoring).
- AVOID fluids containing dextrose as may precipitate Wernicke's encephalopathy.

Routine rapid rehydration

- 1 litre Hartmann's over 2 hours followed by 1 litre 0.9% saline with 20mmols KCL over 2 hours
- Fluid balance chart
- IV anti-emetics
- Review after 2 litre hydration

Slower rehydration – Aim to give 3 litres in 24 hours

- Start with 1 litre Hartmann's over four hours, second over 8 hours and third litre over 12 hours. Swap to sodium chloride (0.9%) ± potassium chloride (according to K level) Fluid and electrolyte regimens must be adapted daily and titrated against daily measurements of serum sodium and potassium.
- Fluid balance chart

If admission required

- Thiamine supplementation – should be given routinely to all patients admitted with HG for prophylaxis of thiamine (vitamin B1) deficiency, which, if untreated, leads to Wernicke's encephalopathy.
    - Dose – Thiamine 50mgs TDS orally if able to tolerate after 24 hours.
    - If unable to tolerate orally, give 2mls of IM Pabrinex No1 (this gives 100mg of thiamine) but no more than once a week if prolonged or frequent admissions. If the patient is exhibiting symptoms of Wernickes encephalopathy then give IV Pabrinex No1 2 mls over 10 minutes (this gives 100mg of thiamine but IV administration can cause anaphylaxis, see CSM advice in BNF)
- Folic acid 5mg once daily PO
- Consider proton pump inhibitors
- ***TEDS and heparin prophylaxis*** for an increased risk of thromboembolism
- Check weight
- Clear documentation of all care provided.
- Ensure hyperemesis is correctly identified on discharge summary.

Anti-emetics

Systemic administration should be offered until oral intake is tolerated, followed by medication suitable for use at home. Use drugs from different classes if the first drug is not effective.

<u>First line</u>: anti-histamines and phenothiazides

No evidence of teratogenicity

Sedation, neurological SEs

- Cyclizine 50 mg PO, IM or IV 8 hourly
- Prochlorperazine 5–10 mg 6–8 hourly PO; buccal (bucastem) 3-6mgs bd; 12.5 mg 8 hourly IM; 25 mg PR daily.
- Promethazine 12.5–25 mg 4–8 hourly PO, IM, IV .
- Chlorpromazine 10–25 mg 4–6 hourly PO, or IM; or 50–100 mg 6–8 hourly PR.

<u>Second line</u>

- Metoclopramide 5–10 mg 8 hourly PO, IV or IM.
    - No evidence of teratogenicity

    - Maximum 5 days treatment to reduce neurological SEs eg acute dystonias , oculogyric crisis
    - Emergency treatment is with procyclidine 5 mg IM or IV.
- Domperidone 10 mg 8 hourly PO; 30–60 mg 8 hourly PR .
    - Maximum treatment duration 1 week
    - Domperidone is now contraindicated in people:
        - with conditions where cardiac conduction is, or could be, impaired
        - with underlying cardiac diseases such as congestive heart failure
        - receiving other medications known to prolong QT interval or potent CYP3A4 inhibitors
        - with severe hepatic impairment
- Ondansetron 4–8 mg 6–8 hourly PO; 8 mg over 15 minutes 12 hourly IV
    - No increase in adverse fetal outcomes (Pasternak, 2013, NEJM)
    - Prolonged Q-T syndrome, especially in electrolyte imbalance

Give at least 24 hours of IV ondansetron, followed by oral treatment with ondansetron once tolerated.
The absolute risk to any fetus is low but studies are limited and prescription is off-licence. As with all medications, the risks and benefits should be weighed in each case. Check magnesium level if considering IV use. Hypokalaemia and hypomagnesaemia should be corrected before ondansetron administration.
Ondansetron should be avoided in patients with congenital long QT syndrome.
Caution must be used if administering ondansetron to patients with risk factors for QT interval prolongation or cardiac arrhythmias. These include: electrolyte abnormalities; use of other medicines that prolong QT interval (including cytotoxic drugs) or that may lead to electrolyte abnormalities; congestive heart failure; bradyarrhythmias; or use of medicines that lower heart rate.

Discharge

- Once ketonuria starts to improve (≤1+), normal urine output is achieved and food is tolerated.
- Anti-emetics and thiamine if required
- Provide written patient information

Non-pharmaceutical interventions

- Provision of emotional support, with frequent reassurance and encouragement, written patient information and sign posting to online self-help. Rarely psychiatric referral may be appropriate.
    - www.pregnancysicknesssupport.org.uk provides information & telephone support
- Dietary advice: small meals, no evidence for NBM
- Acupressure - some evidence for this, uses P6 pressure point

Severe hyperemesis gravidarum

The majority of women with HG improve following rehydration and anti-emetic therapy. If no improvement is made after 72hours of rehydration and 1st line anti-emetics:
Consider other causes & investigations

Infection	Metabolic	Other causes
UTI/pyelonephritis	Addison's disease	Raised intercranial pressure
Viral hepatitis	Hyperglycaemia	Intestinal obstruction
Gastroenteritis	Uraemia	Pancreatitis
Cholecystitis	Thyrotoxicosis	Peptic ulcer
Appendicitis	Acute liver failure	

- LFTs & TFTs
- calcium and phosphate
- Amylase: exclude pancreatitis
- ABG: exclude metabolic disturbances to monitor severity

Third line

Treatment with intravenous corticosteroids are indicated if the patient's condition has not improved or the patient is unable to take oral medication after a further 24 hours of additional treatment with ondansetron. Steroid therapy should *only* be started after discussion with Consultant Obstetrician/Gynaecologist.

- Beneficial in small RCTs
- No increase in malformations (Fraser, Teratology, 1995)
- Intravenous – Hydrocortisone 100mgs bd. Give over 3-10 minutes. Change to prednisolone tablets as soon as possible.
- Histamine H2 receptor antagonists or proton pump inhibitors may be used for women developing gastro-oesophageal reflux disease, oesophagitis or gastritis.
- Oral – Prednisolone 40mg daily PO for three days.
    - Ensure that the second dose is given no later than 6pm as it can have an alerting effect.
    - Taper dose until the lowest maintenance dose that controls the symptoms is reached by 5mgs every 3 days.
    - This will need to be continued to twelve weeks of pregnancy or for two weeks at a time with antenatal clinic review.

Total parenteral nutrition (TPN) (not recommended until steroids and ondansetron have failed). Also consider H. pylori breath test. Discuss with Gastroenterology and, if positive, consider treating prior to TPN. Enteral feeding - may be preferable to TPN.

Consultant Obstetrician/Gynaecologist Review

On day 3 of admission, any woman with HG that is not improving must be reviewed by a Consultant Obstetrician/Gynaecologist and a clear plan of care documented. This plan should be reviewed on a daily basis.

Appendices :

Appendix 1: Hyperemesis Gravidarum Proforma
Appendix 2: Patient information leaflet – Hyperemesis Gravidarum (Pregnancy Sickness)

Appendix 1

HYPEREMESIS GRAVIDARUM PROFORMA

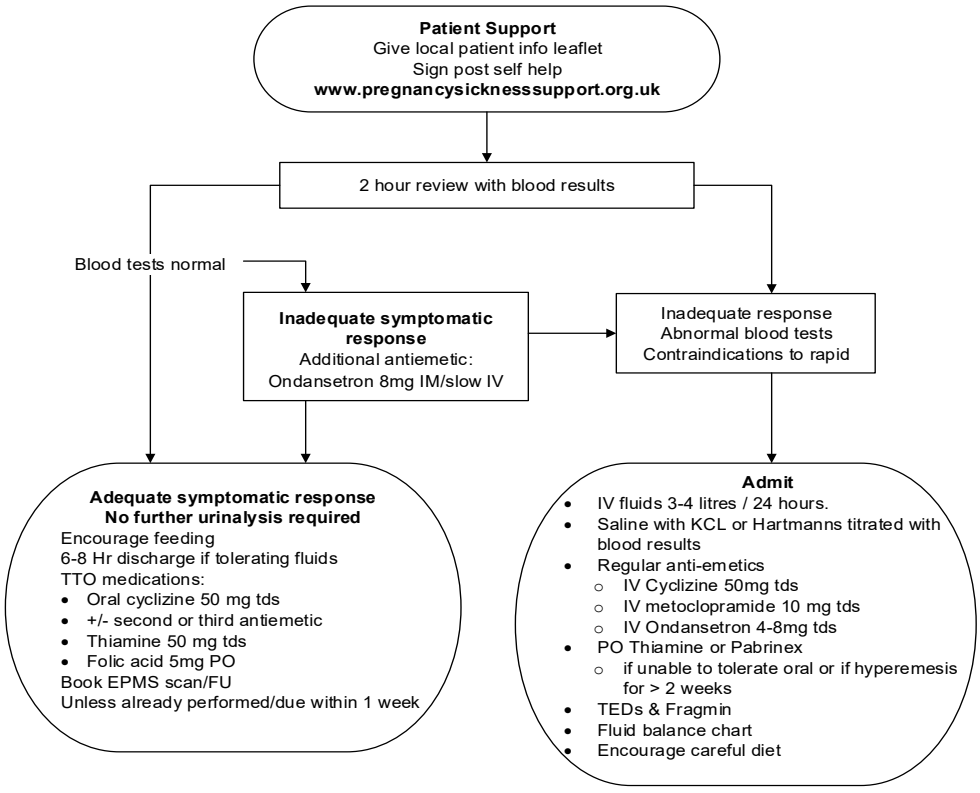
(Linked to www.pregnancysicknesssupport.org.uk)

Initial Assessment

- Baseline observations and urinalysis
- IV access and bloods if significant ketonuria (>1+) or inadequate urine output
- FBC, U&Es
- Assess suitability for rapid rehydration (exclude cardiac conditions)

Rapid Rehydration

- Significant ketonuria (>1+) or inadequate urine output
- IV normal saline with 20mmol KCL or Hartmanns. 2 Litres over 4 hours
- IV antiemetics - give more than one drug if no response to single drug.
  - 1st line IV Cyclizine 50mg stat (followed by TDS)
  - 2nd line IV Metoclopramide 10mg stat (followed by TDS)
- Prochlorperazine 12.5 mg IM stat if delay with IV access



Appendix 2

Linked to Patient Information Leaflet – 25178 Hyperemesis Gravidarum (Pregnancy Sickness)

Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

This guidance has been registered with the Trust. The interpretation and application of guidance will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using clinical guidance after the review date, or outside of the Trust.

Ref No:	0869		
Document title:	Hyperemesis Gravidarum		
Purpose of document:	Guideline		
Date of issue:	13 October 2023	**Next review date:**	13 October 2026
Version:	6	**Last review date:**	
Author:	Consultant Obstetrician & Gynaecologist		
Directorate:	Obstetrics		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Obstetrics and Gynaecology Risk Management Meeting Clinical Director of Pharmacy		
Date approved:	10 October 2023		
Links or overlaps with other policies:			

Have you identified any issues on the Rapid (E)quality Impact Assessment. If so please detail on Rapid (E)QIA form.	Yes ☐	
	Please select *Yes*	*No*
Does this document have implications regarding the Care Act? *If yes please state:*	☐	☐
Does this document have training implications? *If yes please state:*	☐	☐
Does this document have financial implications? *If yes please state:*	☐	☐
Is this document a direct replacement for another?	☐	☐

If yes please state which documents are being replaced:		

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
3 February 2006	1	New	Consultant Lead for Obstetrics and Gynaecology, Medicines Governance Group
7 March 2007	2	Amended	Consultant Lead for Obstetrics and Gynaecology, Medicines Governance Group
22 October 2009	3	Revised	Consultant Lead for Clinical Governance, Clinical Director of Pharmacy
19 August 2010	3	Equality Impact on Document Control added	
12 September 2012	4	Amended	Consultant Lead for Clinical Governance, Clinical Director of Pharmacy
5 February 2016	5	Revised	Clinical Director of Obstetrics Clinical Director of Pharmacy
25 May 2018	6	Revised	Obstetrics and Gynaecology Risk Management Meeting Clinical Director of Pharmacy
13 October 2023	6	Date change	Consultant Obstetrician and Gynaecologist Clinical Director of Pharmacy

The Mental Capacity Act 2005

The Mental Capacity Act 2005 provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future.

It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions.

There is a legal duty placed upon all staff to apply the Mental Capacity Act 2005 in all circumstances where a person is required to consent to 'acts in connection with care and treatment' and where there is reason to doubt the person's mental capacity to do so.

Guidance can be accessed via Pages - Mental Capacity Act (torbayandsouthdevon.nhs.uk)

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

NHS Devon Clinical Commissioning Group

NHS Torbay and South Devon NHS Foundation Trust

Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)		**Version and Date**	
Policy Author			
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
Who may be affected by this document?			
Patients/ Service Users ☐	Staff ☐	Other, please state…	☐
Could the policy treat people from protected groups less favourably than the general population? ***PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below***			
Age	Yes ☐ No☐	Gender Reassignment	Yes ☐ No☐
Race	Yes ☐ No☐	Disability	Yes ☐ No☐
Gender	Yes ☐ No☐	Pregnancy/Maternity	Yes ☐ No☐
Sexual Orientation	Yes ☐ No☐		
Religion/Belief (non)	Yes ☐ No☐		
Marriage/ Civil Partnership	Yes ☐ No☐		
Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☐		
Please provide details for each protected group where you have indicated 'Yes'.			
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion			
Is inclusive language[5] used throughout?	Yes ☐ No☐ NA ☐		
Are the services outlined in the policy fully accessible[6]?	Yes ☐ No☐ NA ☐		
Does the policy encourage individualised and person-centred care?	Yes ☐ No☐ NA ☐		
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐ NA ☐		
EXTERNAL FACTORS			
Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☐		
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)			
Who was consulted when drafting this policy?			
Patients/ Service Users ☐	Trade Unions ☐	Protected Groups (including Trust Equality Groups)	☐
Staff ☐	General Public ☐	Other, please state…	☐
What were the recommendations/suggestions?			
Does this document require a service redesign or substantial amendments to an existing process? ***PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below***	Yes ☐ No☐		
ACTION PLAN: Please list all actions identified to address any impacts			
Action	**Person responsible**	**Completion date**	
AUTHORISATION: **By signing below, I confirm that the named person responsible above is aware of the actions assigned to them**			
Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Please contact the Equalities team for guidance:
For Devon CCG, please email d-ccg.equalityanddiversity@nhs.net & d-ccg.QEIA@nhs.net
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net
This form should be published with the policy and a signed copy sent to your relevant organisation

Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
[2] Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them
[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated
[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives
[6] Consider both physical access to services and how information/ communication in available in an accessible format
[7] Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Clinical and Non-Clinical Policies – Data Protection

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 18) in mind, and therefore provides the reader with assurance of effective information governance practice.

The UK data protection regime intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy. Furthermore, data protection legislation requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data.

Does this policy impact on how personal data is used, stored, shared or processed in your department? Yes ☐ No ☐

If yes has been ticked above it is assured that you must complete a data mapping exercise and possibly a Data Protection Impact Assessment (DPIA). You can find more information on our GDPR page on ICON (intranet)

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdft@nhs.net,
- See TSDFT's Data Protection & Access Policy,
- Visit our Data Protection site on the public internet.