



# SOGC

## CLINICAL PRACTICE GUIDELINES

### COMMITTEE OPINION

No. 12, November 1995

#### GUIDELINES FOR THE MANAGEMENT OF NAUSEA AND VOMITING IN PREGNANCY

*This Committee Opinion has been prepared by the Clinical Practice - Obstetrics Committee of the Society of Obstetricians and Gynaecologists of Canada and approved by its Council in June 1995.*

Nausea and vomiting affect at least fifty percent of pregnant women. Traditionally, these symptoms have been called "morning sickness" and are most common in the first and early second trimesters. However, the symptoms may be present throughout the day and **may last for** the entire pregnancy. While nausea and vomiting are considered to be a "normal" part of the pregnant state, their effects on the pregnant patient's sense of well-being have probably been underestimated. A descriptive study by O'Brien and Naber showed that eighty-three percent of women felt that these symptoms had affected their ability to perform usual activities, and in **one-third** they were severe enough to affect the women's ability to function in family, social, and occupational spheres.<sup>1</sup>

Hyperemesis gravidarum occurs in about one percent of pregnancies and is defined as vomiting severe enough to produce weight loss, dehydration, acid-base disturbances, ketonuria, and electrolyte imbalances. Each year, a significant number of women are admitted for hyperemesis gravidarum and may require such interventions as total parenteral nutrition. Early recognition and management could therefore have a significant effect on the quality of life during pregnancy, as well as a financial impact on the Health Care System.

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#### **SOGC Clinical Practice - Obstetrics Committee:**

Robert Caddick, MD, FRCSC (Moncton, NB), Irene E. Colliton, MD (Edmonton, AB), Brenda Dushinski, RN (London, ON), Ahmed Ezzat, MD, FRCSC (Saskatoon, SK), Guy-Paul Gagné, MD, FRCSC (LaSalle, QC), Catherine J. MacKinnon, MD, FRCSC (London, ON), Nan Schuurmans (Chair), MD, FRCSC (Edmonton).

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## **MANAGEMENT**

Management of this problem is multi-faceted. It includes early recognition, dietary and lifestyle advice, as well as pharmaceutical and alternative forms of therapeutic interventions.

### **1) EARLY RECOGNITION**

Careful questioning of the patient, early in the pregnancy, about the frequency and intensity of the symptoms of nausea and vomiting allows the practitioner to intervene with diet and lifestyle adjustments as well as medication, with the aim of preventing progression to hyperemesis. Too often, patients are seen after the worst of the symptoms have subsided or intervention is not offered until they are already quite severe.

### **2) DIET**

Traditionally, women with nausea and vomiting of pregnancy, especially hyperemesis, have been told to eat frequent small meals consisting of dry bland foods. Patients admitted with severe symptoms have been starved and given intravenous fluids. When they can eat, they have been given clear fluids only. More recent recommendations suggest that, as soon as they are hungry, women should be encouraged to eat frequent small amounts of whichever foods appeal to **them**<sup>2</sup>. Emphasis is placed on intake rather than content until the symptoms have subsided. Suggestions for foods which appeal to pregnant women because of taste and texture are listed in Table 1 .<sup>2</sup>

### **3) LIFESTYLE**

Fatigue seems to exacerbate nausea and vomiting. Women should be encouraged to increase their rest while they are symptomatic and to seek assistance in such daily activities as child care.

Pregnant women seem to have an increased sensitivity to odours, probably due to the effect of increased levels of estrogen on the area postrema in the brain. Consequently, aromas of cooking food as well as odours in the workplace may initiate nausea (e.g. perfume, smoke). The partner should be encouraged to cook.

It would, therefore, seem appropriate for health care providers to adopt a liberal attitude towards providing letters for leaves-of-absence from work. Such a policy will ultimately shorten the time lost from outside employment.

### **4) THERAPEUTIC INTERVENTION**

#### **a) NON-PHARMACOLOGICAL**

Current public information cautions pregnant women to limit the use of all medications except vitamins. Hence, many pregnant women are hesitant to use any drug even when that drug has been proven to have no harmful effects on the fetus. They may, however, be amenable to alternate forms of treatment.

The Cochrane Pregnancy and Childbirth Group (CPCG) reviewed three controlled trials studying the effect of acupressure at the P6 (Neiguan) point. This point is located on the inner aspect of the wrists, just proximal to the flexor crease. A randomized double-blind cross-over trial comparing placebo using bands with pressure and blunted points showed a significant reduction in the

symptoms of nausea and vomiting.<sup>3</sup> The CPCG concluded there was a significant positive effect and that acupressure was safe.<sup>4</sup> Currently, Sea-Bands are available for patients who wish to try this form of therapy.<sup>1</sup>

The effects of ginger (*Zingiber officinale*) on nausea and vomiting have been studied in patients with hyperemesis gravidarum. A double-blind randomized cross-over trial compared placebo and 250 mg. q.i.d. of powdered ginger root and found a significant beneficial effect on symptoms<sup>6</sup>. However, there is insufficient information about the effects of larger doses of ginger on the fetus, and until further trials are completed, ginger cannot be recommended as a treatment for nausea and vomiting in pregnancy.<sup>7</sup>

Vitamin B6 (pyridoxine) has also been studied as a treatment of nausea in pregnancy. The CPCG reviewed one available trial and found a positive effect.\* More trials are needed.

## **b) PHARMACOLOGICAL**

Doxylamine Succinate 10 mg, in combination with Pyridoxine Hcl 10 mg (Diclectin), were approved for use in the treatment of nausea and vomiting in pregnancy by the Health Protection Branch of Health and Welfare Canada in 1990. To date, this formulation is the only anti-nauseant approved for such use.

Health practitioners and pregnant women who are concerned that this drug has the same formulation as Bendectin which was withdrawn from the market in 1983 in the USA after several unsuccessful lawsuits against it should know that in spite of the most vigorous testing of any drug in pregnancy, no evidence of teratogenicity has been found. In fact, the Australian obstetrician who originally stated the drug was a teratogen has been found guilty of scientific fraud in his experiments related to the drug.<sup>9</sup>

Multiple studies have reviewed Debendox (Bendectin) and concluded that the drug is a safe, effective treatment for nausea and vomiting of pregnancy and that there is no evidence that it is a teratogen.<sup>10,11</sup>

Doxylamine Succinate 10 mg, in combination with Pyridoxine Hcl 10 mg (Diclectin) is a delayed release tablet. Most women experience their symptoms in the morning. Therefore, it is recommended that they should start with two tablets at night before bed. If symptoms are not relieved, one tablet in the morning and another in midafternoon can be added. The dosing regime can also be tailored to fit each woman's peak of symptoms.

## **CONCLUSION**

Nausea and vomiting are frequent symptoms in pregnant women which can affect their quality of life significantly.

It is recommended that all health practitioners should question women early in their pregnancies about the presence of these symptoms and offer intervention with advice about DIET, LIFESTYLE adjustment and MEDICAL treatment.

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TABLE 1

### Suggestions for foods which appeal to pregnant women because of taste and texture

SALTY	CHIPS, PRETZEL
TART/SOUR	PICKLES, LEMONADE
EARTHY	BROWN RICE, MUSHROOM SOUP
CRUNCHY	CELERY STICKS, APPLES
BLAND	MASHED POTATOES
SOFT	BREAD, NOODLES
SWEET	CAKE, SUGARY CEREAL
FRUITY	JUICES, FRUITY POPSICLES
WET	JUICE, SELTZER
DRY	CRACKERS