Pregnancy Sickness Support

Preparing for an HG pregnancy

Guidelines for preparing your care plan for a second or subsequent pregnancy with Hyperemesis Gravidarum (HG)

Disclaimer:
None of the information provided on this website is meant to suggest any medical course of action. Instead the information is intended to inform and to raise awareness so that these issues can be discussed by / with qualified Healthcare Professionals with their patients. The responsibility for any medical treatment rests with the prescriber.

Although it is not a guarantee that one hyperemetic pregnancy will lead to suffering HG again in subsequent pregnancies, studies have shown that there is an increased chance of developing hyperemesis gravidarum in subsequent pregnancies if you have had it once already. It is therefore sensible that you prepare for a 'worst case scenario', particularly if you now have a small child at home to care for as well!

A good GP will be willing to make a plan in advance. Many women experiencing HG find they can not advocate for themselves effectively or indeed even communicate well once they are already ill so having a plan in advance ensures that both you and your doctor are happy with the treatment plan and can utilise it if and when required. There is no harm done in making a plan which doesn't need actioning! Take this document along with you to the appointment. If your GP isn't confident with the condition they can contact the charity or they can refer you to a consultantat your local hospital to make the plan instead.

Things to document in advance

- Get a baseline weight so that severity of weight loss can assessed if required
- Take baseline BP and so that measurements during pregnancy are meaningful
- Discuss treatment options, decide on which ones will be tried (based on which ones you are happy to try and your doctor is happy to prescribe) and boundaries for moving onto next step. You can reference the 2024 RCOG Guidelines when making this plan.
- Discuss criteria for admission to hospital and self care at home.
- Document treatment plan

Treatments available

As a first step in a subsequent HG pregnancy there is strong evidence for the use of pre-emptive medication. ***The 2024 RCOG Guidelines on page 13 states 'Women who have experienced severe NVP in a previous pregnancy may benefit from initiating dietary and lifestyle changes, such as arranging childcare to facilitate rest and adjusting to a "little and often" diet, and commencing antiemetics before or immediately at the start of symptoms in a subsequent pregnancy.'***

If the HG still develops and is not controlled there are a number of other medications available which are commonly offered to women in the UK for pregnancy sickness:

APPENDIX III: Recommended antiemetic therapies and dosages

Recommended antiemetic therapies and dosages

First line
Doxylamine and Pyridoxine (vitamin B6) 20/20mg PO at night, increase to additional 10/10 mg in morning and 10/10mg at lunchtime if required.
Cyclizine 50 mg PO, IM or IV 8 hourly
Prochlorperazine 5–10 mg 6–8 hourly PO (or 3 mg buccal); 12.5 mg 8 hourly IM/IV; 25 mg PR daily
Promethazine 12.5–25 mg 4–8 hourly PO, IM or IV
Chlorpromazine 10–25 mg 4–6 hourly PO, IM or IV

Second line
Metoclopramide 5–10 mg 8 hourly PO, IV/IM/SC
Domperidone 10 mg 8 hourly PO; 30 mg 12 hourly PR
Ondansetron 4 mg 8 hourly or 8 mg 12 hourly PO; 8 mg over 15 minutes 12 hourly IV; 16 mg daily PR
(Women taking ondansetron may require laxatives if constipation develops)

Third line
Hydrocortisone 100 mg twice daily IV and once clinical improvement occurs, convert to prednisolone 40–50 mg daily PO, with the dose gradually tapered (by 5-10 mg per week) until the lowest maintenance dose that controls the symptoms is reached
(Corticosteroids should be reserved for cases where standard therapies have failed; when initiated they should be prescribed in addition to previously started effective antiemetics. Women taking corticosteroids should have their blood pressure monitored and a screen for diabetes mellitus)

IM intramuscular; **IV** intravenous; **PO** by mouth; **PR** by rectum.

Managing the condition
How in depth the plan needs to be will partly depend on how severe your condition was last time. For example, if you did not require admission to hospital last time then you are unlikely to need to discuss having TPN in a PICC line this time. However, if you were admitted repeatedly for IV fluids throughout the pregnancy and suffered complications with IV sites and so on then this may be something you would want to discuss, although that is likely to be with a consultant rather than a GP.

Things to think about and discuss/plan with your GP/consultant include:

- At what point you should start initial treatment and at what level of sickness you would consider

a need to increase treatment i.e. vomiting more than 5 times a day? Weight loss of 5% or more of pre-pregnancy weight? Not managing to drink 500ml or more of fluid perday? Other criteria?

- What criteria will you be admitted to hospital for?
- If you need to be admitted what will the procedure be for that? i.e. avoiding having to go via A&E as that can prove distressing. Can you go straight to a ward? If you have been in once before, can you have open access to return?
- Is there the option for IV fluids as a day patient? Is the option of home IV available in your area?
- Is the doctor happy for you to monitor fluid intake/output at home and then to discuss treatment on the phone so as to avoid difficult trips to the surgery which can exacerbates ymptoms? Are home visits available and if deemed necessary what is the best arrangement for the surgery (some surgeries require you phone at a particular time etc)?
- Which other adults do you give permission to discuss your condition with the doctor? E.g. partner, family member, friend?

Would you benefit from talking to a counsellor prior to a subsequent pregnany?

Many women suffer from anxiety and depression during, or as a result of, Hyperemesis Gravidarum due to the intense and debilitating nature of the condition. It is worth considering if you might benefit from support for this. If you suffered Post Traumatic Stress Disorder or post-natal depression after your last pregnancy then it's definitely worth thinking about talking to someone.

Hopefully this plan will not be necessary and you may not experience pregnancy sickness to the same extent as last time but if you do, or it is worse, at least you will not have the added stress of having to research treatments and struggle to be understood by your care providers and your doctor will feel confident that the plan is made with fully informed consent.

As always, the PSS team are available if you have any questions!