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THE EFFECTIVE PREVENTIVE MANAGEMENT FOR NAUSEA AND VOMITING IN PREGNANCY AND HYPEREMESIS GRAVIDARUM

Nausea and Vomiting in Pregnancy (NVP) and Hyperemesis Gravidarum (HG) are prevalent yet frequently overlooked conditions during pregnancy. They impact 70-80% of pregnant women to varying degrees, with symptoms often extending beyond the first trimester. NVP affects up to 90% of pregnant women and is one of the most common indications for hospital admission among pregnant women, with typical stays of between three and four days.

In a population based pregnancy cohort using general practice records prevalence of clinically recorded NVP/HG was 9.1%: 2.1% had hospital admissions, 3.4% were treated with antiemetics in primary care only, and 3.6% had only recorded diagnoses.

95% said HG or NVP impacted their emotional health and how they felt day-to-day

50% said HG or NVP negatively impacted their feelings towards their baby during pregnancy

The objective: To determine the preventive management of patients with 1st trimester nausea and vomiting and hyperemesis gravidarum

Material and Methods. A systematic data search was conducted using the databases MEDLINE, PubMed, Cochrane Database of Systematic Reviews and publications in professional publications of Ukraine for 2013–2024. The search was conducted using the terms: pregnancy, hyperemesis, infusion therapy and the safety profile of medications prescribed during pregnancy in various combinations. The investigation was performed at the National Pirogov Memorial Medical University, Vinnytsya, Ukraine, university research paper No. 0122U002435 titled **"Prediction, diagnosis, and prevention of reproductive function disorders in women and girls in modern conditions"**.

Since nausea and vomiting are very common in pregnancy (NVP), many remedies have been proposed for preventive therapy. The non-pharmacological and low-pharmacological strategy in NVP first of all can been used prevention for high-risk pregnancy complicartions (early pregnancy loss, placental problems, FGR, preeclampsia, gestational diabetes). Psychological support should be offered to all patients with hyperemesis gravidarum as well as information on patient' associations involved in supporting these women and their families.

Rest

The first trimester of pregnancy is frequently associated with fatigue, at a time when pregnancy has often not been declared in public. Interventions to improve nausea and fatigue include modification of working patterns, exercise, day time sleeps and an earlier bedtime, however the data around the efficacy of these interventions is weak [LOE-III].

Diet

An ecological study across 21 countries reported higher rates of nausea and vomiting with higher intake of meat, milk and eggs, and low intake of cereal and pulses. Prior to pregnancy, a diet with a higher daily intake of saturated fat increased rates of hospitalisation for hyperemesis. Vitamin use, smoking and alcohol consumption have all been linked to a reduced risk of NVP, the latter two remedies would of course be inadvisable in pregnancy)) Women will tend to alter their diets to minimise their symptoms and they should be encouraged to eat whatever and whenever they can to maintain nutrition and hydration.

Acupuncture/Acupressure

Stimulation of the P6 (Nei guan) point on the wrist has been used for thousands of years by acupuncturists to treat nausea and vomiting from a variety of causes. Acupressure wrist bands are commonly used by women experiencing nausea in early pregnancy. The specialists emphasised the importance of wearing the acupressure band for a minimum of 12 hours per day.

Hypnosis

A review of 45 studies of the use of hypnosis for NVP found no good quality clinical evidence for its' efficacy [LOE-I].

Aromatherapy

It is suggested that aromatherapy not be used in the management of patients with uncomplicated nausea and vomiting of pregnancy due to the potential risks associated with essential oils and the lack of demonstrated efficacy.

Ginger

Improvement in gastrointestinal motility: weak effect on cholinergic M3 receptors and serotonergic 5-HT3 and 5-HT4 receptors in the gut. Use standardised products rather than foods: up to 1200 mg/day split doses eg 250 mg QID. Theoretical but unproven risk of bleeding risk by decreasing platelet-aggregation. May inhibit growth of Helicobacter Pylori.

Vitamin B6 (Pyridoxine)

Water soluble vitamin, inhibits H1 receptor, acts indirectly on vestibular system, some inhibition of muscarinic receptors to decrease stimulation of vomiting centre. 10 to 25 mg PO 3-4x/day Up to 200 mg/day or 37.5 mg combined with ginger 600 mg up to 2x/day. More effective when used in combination eg with doxylamine or dicyclomine (equivalent to metoclopramide).

CONCLUSIONS

Psychological support should be offered to all patients with NVP and HG. Women should be counselled to eat whatever pregnancy-safe food appeals to them and lifestyle changes should be liberally encouraged.
There are safety and efficacy data for first line antiemetics such as pyridoxine and ginger and they should be prescribed initially when required for NVP and HG. Ginger may be beneficial in ameliorating the symptoms of NVP.
Acupressure may help some women in the management of nausea and vomiting of pregnancy.

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