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Antenatal care

Hyperemesis gravidarum

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The birth plan

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MIDWIFE

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* Due to unforeseen circumstances The babyfriendly page was omitted from the June issue. Apologies for the error.

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Hyperemesis gravidarum: how midwives can help

Research has shown that early, aggressive intervention is important if severe nausea and vomiting during pregnancy is to be controlled, says Natalie Farrell

The term nausea and vomiting during pregnancy (NVP) is used to describe a continuum of mild morning sickness to severe illness that is hyperemesis gravidarum (HG). This is defined as a 'debilitating and potentially life-threatening pregnancy disease marked by rapid weight loss, malnutrition, and dehydration due to unrelenting nausea and/or vomiting with potential adverse consequences for the newborn(s)' (MacGibbon 2006).

Research has shown that it is a complex and multifaceted physiological disease and is not, as many have been taught, a psychological illness (Simpson et al 2001, Munch 2002). It affects anywhere between 0.3-2 per cent of pregnancies and has no known cause. There are, however, numerous theories regarding the aetiology of HG – eg, hormone levels (Murphy Goodwin 2000) and genetics (Fejzo et al 2006), to name but two. The likelihood is that it is caused by multiple factors rather than one single factor.

The criteria used to diagnose HG and its severity varies among health professionals and researchers, which results in the term 'Hyperemesis' being applied to a wide spectrum of nausea and vomiting. The symptoms of HG typically involve unrelenting, excessive nausea and/or vomiting which prevents adequate intake of food and fluids (MacGibbon 2006). It almost always begins in the first trimester between weeks four and six, involving many vomiting episodes throughout the day with few, if any, symptom-free periods. This leads to rapid and significant weight loss, dehydration, electrolyte disturbances and nutritional deficiencies – often requiring hospitalisation.

Typically, symptoms peak between nine to 13 weeks' gestation, with improvement by the 14th-20th week of gestation irrespective of severity (Moran and Taylor 2002), although some women have frequent relapses throughout pregnancy. Some women will find that nausea and vomiting requires some degree of management until the birth, but is usually less severe than in the first trimester. Although rare, a very small number of women suffer from HG starting in the second trimester.

HG is not regular NVP or morning sickness, both of which refer to mild nausea and vomiting during pregnancy. Research shows that, unlike morning sickness, HG has a high rate of recurrence (Koren and Maltepe 2004).

Comparisons between mild NVP/morning sickness and HG are shown in Table 1.

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How can midwives help?

There are many ways in which midwives can help. The first thing to remember is that research has shown that early intervention with aggressive management is important for a number of reasons: decreasing severity of symptoms, preventing the continued cycle of vomiting and dehydration, preventing life-threatening complications and promoting quicker recovery (Koren and Maltepe 2004). Second, do not underestimate how great the impact of HG is on sufferers, their families and friends. If midwives are quick to identify the signs and symptoms of HG and refer the woman to the appropriate medical practitioner, it will benefit her physiologically and psychologically.

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Simple measures could include:

- Reduce stimuli and triggers as far as possible – eg, lighting and noise levels, odours, motion and interruptions to rest.
- Listen: loneliness and isolation may well have featured heavily during the course of the illness.
- Watch for signs of psychological illness and refer for assessment as appropriate.
- If possible, refer to a physiotherapist to minimise the effects of atrophy.
- Ask for permission to discuss food and before mentioning food names.
- Ascertain the level of sickness by asking what foods and drinks have been tried, what has helped/what has not.
- Be careful if recommending morning sickness cures to an HG sufferer; she will have been told innumerable times to try crackers and ginger. It may undermine confidence in the healthcare professional.
- Do not challenge what she is or is not eating/drinking; anything is better than nothing.
- Refer to HER (Hyperemesis Education & Research) or Blooming Awful (details in 'Further resources') for a list of foods,

TABLE 1 Comparisons between mild NVP/morning sickness and hyperemesis gravidarum

Morning sickness	Hyperemesis gravidarum
Lose little if any weight.	Lose 5% (or more) of pre-pregnancy weight.
Nausea and vomiting does not interfere with ability to eat/drink enough each day.	Nausea and vomiting causes very little, if anything, to be eaten/drunk; dehydration common if not treated.
Vomit infrequently; nausea is episodic but not severe. It may cause discomfort and misery.	Vomit often; may vomit bile or blood if not treated. Nausea is usually severe and constant.
Dietary and/or lifestyle changes are enough to improve symptoms most of the time.	Will probably require medications to stop the vomiting, and intravenous hydration. In severe cases supplemental nutrition may be required.
Typically, will improve gradually after the first trimester; may be a little queasy at times during the remainder of pregnancy.	Usually feel somewhat better by mid-pregnancy; may continue to be nauseous and/or vomit until the birth.
May lose an average of 0-3 weeks of employment and/or use sick time. Job performance may be reduced.	Often is unable to work for months and, in some cases, for the remainder of the pregnancy.
Can perform most household responsibilities, including caring for the family at some point during the day or week when symptoms are less intense.	May be unable to perform even simple household chores. May need to be cared for.
Fatigue is mild to moderate and decreases workload; recumbent rest is needed to alleviate symptoms.	Fatigue may be severe for weeks or months; bed rest is often a necessity. Prolonged fatigue is very common.
Relationships may be stressed but social functioning, if curtailed, is temporary.	Relationships are often greatly strained and family relationships may dissolve; isolation is common and may lead to depression.
Psychological stress is mild and is unlikely to result in depression.	Psychological stress is typically moderate to severe; increased risk of antenatal anxiety and depression and postnatal depression and Post Traumatic Stress Disorder.
Postnatal recovery is typical and usually takes a few months.	Postnatal recovery is prolonged, averaging 6 months – 2 years.

drinks and vitamins that may work.

- Watch for signs of dehydration; refer for medical assessment as appropriate.
- Alleviate any guilt and reassure the mother if she has been unable to take prenatal vitamins.
- Remind her to take the pregnancy a day at a time and that the HG will end.
- Remember that pregnancy sickness is not always a 'good sign'. There are many cases of women whose HG has continued despite later discovering that the fetus died weeks earlier. Unpublished evidence has shown that women with HG are more likely to suffer fetal demise (see www.hyperemesis.org/HER-Research).
- Encourage appropriate medication.
- Those with prolonged illness and inadequate medical care – eg, those with greater than 10 per cent loss of pre-pregnancy body weight or those who fail to gain weight for two consecutive trimesters – are at increased risk of serious complications such as pre-eclampsia and pre-term labour. A referral should be made to an obstetrician or assessment unit to check for signs of Intra Uterine Growth Retardation.
- Remember that recovering from HG takes time and that there may be a long-term impact on both mother and baby.

Medications

There is always a risk with any medication taken during pregnancy. Medications prescribed during pregnancy typically present less risk to the mother and child than chronic dehydration/lack of nutrition (Dodds et al 2006). Research has been carried out on the teratology of some medications used during pregnancy (Kallen 1987, Berkovitch et al 2002, Einarson et al 2004, Seto et al 1997). Doctors will often treat HG with medications deemed 'safe' to use in pregnancy due to their long history of being used for pregnancy nausea and vomiting.

To treat a sufferer of HG, typically a combination of several medications is most effective (Levichek et al 2002, Einarson et al 2007). It is important to remember that a certain combination of medications may help one sufferer but not the next. Combinations can include standard anti-emetics, antihistamines, antacid medications, complementary or alternative medicines and nutritional therapies. Thiamine and multivitamin supplementation are critical for a mother who has vomited excessively for more than a few weeks to prevent life-threatening complications. Psychotherapy may be effective for secondary psychological complications.

Termination

An article about HG would be incomplete without discussing therapeutic termination. If requested by the sufferer, it is often a cry of desperation for help and for better management. For HG sufferers, therapeutic termination rates are approximately 25 per cent. A significant proportion cite lack of understanding by their healthcare professional as a factor (Poursharif et al ►

2007, Mazzota et al 1997). Termination in most cases of HG is avoidable with aggressive use of the available treatment options, and should always be a last resort. The long-term consequences of termination of a usually much wanted child cannot be overlooked or underestimated (Mazzota et al 1997). **TPM**

Natalie Farrell is a moderator for the Hyperemesis Education & Research Foundation and two-times HG survivor.

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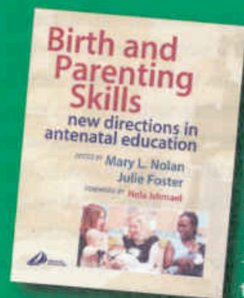
FURTHER RESOURCES

- The Hyperemesis Education & Research Foundation (HER) (www.hyperemesis.org) is a non-profit organisation that has a website containing comprehensive information for health professionals, sufferers and survivors of HG with busy discussion forums. A volunteer system is in place.
- Blooming Awful (www.hyperemesis.org.uk), the HG awareness group in the UK, is run by midwife Johanne Jakeway. Helpline: 01656 863883.
- Beyond Morning Sickness (BMS) (www.beyondmorningsickness.com) is a website and forum for HG sufferers and survivors based on the first comprehensive book on HG, *Beyond Morning Sickness: Battling Hyperemesis Gravidarum* by Ashli Foshee McCall. BMS is not for profit, and all monies raised go directly to helping those suffering from HG.

Book of the month



This month we are giving away a copy of ***Birth and Parenting Skills: New Directions in Antenatal Education*** by Mary Nolan and Julie Foster (2005, Churchill Livingstone, £23.99, pbk).

This is a research-based, up-to-the minute account of the current status of antenatal education, focusing on the key challenges it faces in the future, offering suggestions for how these challenges might best be met. It describes some innovative approaches to accessing vulnerable groups of parents and how collaboration between the statutory and voluntary sectors might result in a better educational service for pregnant women and their families. Narratives from parents are analysed and commented upon, and underpinning the book is an account of how the principles and practices of adult education should inform antenatal education.

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