

Royal Hospital for Women (RHW)
BUSINESS RULE
COVER SHEET



Health
 South Eastern Sydney
 Local Health District

NAME OF DOCUMENT	HYPEREMESIS GRAVIDARUM (HG) AND NAUSEA AND VOMITING IN PREGNANCY (NVP) - MANAGEMENT
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SUMMARY	Assessment, Management, treatment and support for Nausea and Vomiting of Pregnancy, and Severe Nausea and Vomiting of Pregnancy – Hyperemesis Gravidarum.

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1. BACKGROUND

1.1 Definitions

- **NVP - Nausea and vomiting of pregnancy:** nausea, vomiting and/or dry retching, commencing in early pregnancy, without another cause and is not classified as HG
- **HG - Hyperemesis Gravidarum:** Characterised by severe nausea and/or vomiting with symptoms commencing in early pregnancy, before a gestational age of 16 weeks, leading to inability to eat and/or drink normally, strongly limiting daily activities with or without dehydration and/or electrolyte abnormalities²

Nausea and vomiting in pregnancy is estimated to occur in 69 per cent of pregnancies⁸. HG is a severe form of nausea and vomiting in pregnancy that affects approximately 1.1 per cent of pregnancies and is the main cause of hospitalisation in the first half of pregnancy⁸. HG can cause significant emotional, psychological, physical and financial distress for a woman and her family.

Appropriate assessment and management of a woman with nausea and vomiting in pregnancy, or HG is an integral part of providing holistic pregnancy care

2. RESPONSIBILITIES

2.1 Medical staff:

- Assess, prescribe medication/fluids, review physical and psychosocial wellbeing and refer to necessary services

2.2 Midwifery and nursing staff:

- Assess, administer medication/fluids, review physical and psychosocial wellbeing and escalate when needed

2.3 Dietician:

- Provide appropriate nutritional management

2.4 Social Worker:

- Support and assess needs of woman for community/non clinical supports

2.5 Perinatal mental health team:

- Provide psychological support, referral and treatment as appropriate

3. PROCEDURE

3.1 Clinical Practice

This CBR is to be used in the following settings:

- General practice (GP)
- Emergency department (ED)
- Early pregnancy assessment service (EPAS)

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- Maternity outpatient/antenatal clinic
- Pregnancy Day Stay Unit (PDSU)

3.1.1 Assessment

- Take a detailed obstetric and medical history
- Confirm details of current pregnancy including:
 - gestational age
 - investigations and ultrasounds to date
- Complete medical and obstetric history including:
 - onset and pattern of nausea and vomiting
 - fluid and dietary intake
 - exacerbating factors e.g. multivitamin use
 - current NVP/HG management (if any)
 - weight loss
- Use the 'Motherisk' Pregnancy-Unique Quantification of Emesis and Nausea (PUQE-24) scoring table (Table 1) to correctly classify the degree of nausea and vomiting:
 - Mild: PUQE-24: 4-6
 - Moderate: PUQE-24: 7-12
 - Severe: PUQE-24: ≥13

Table 1: Motherisk PUQE-24 scoring system²

1. In the last 24 hours, for how long have you felt nauseated or sick to your stomach?				
Not at all (1)	1 hour or less (2)	2-3 hours (3)	4 to 6 hours (4)	More than 6 hours (5)
2. In the last 24 hours, have you vomited or thrown up?				
I did not throw up (1)	1 to 2 (2)	3 to 4 (3)	5 to 6 (4)	7 or more times (5)
3. In the last 24 hours, how many times have you had retching or dry heaves without throwing up?				
None (1)	1 to 2 (2)	3 to 4 (3)	5 to 6 (4)	7 or more times (5)

3.1.2 Clinical Examination

- Perform an A-I assessment including measuring weight and assessing postural drop in blood pressure
- Assess hydration status and fluid deficit including decreased skin turgor, dry mucous membranes, decreased urine output and concentrated urine. The physical examination should be directed towards identification of alternate diagnoses (see appendix 1)

3.1.3 Management

- Assess woman using PUQE-24 score at every point of contact (GP, ED, outpatient clinic) from 4-16 weeks gestation. After 16 weeks gestation a woman should be assessed as per clinician judgment
- Aim to manage the woman with PUQE-24 score ≤12 in the community by referring to [Nausea and Vomiting in Pregnancy and Hyperemesis Gravidarum \(nsw.gov.au\)](https://www.nsw.gov.au/nausea-and-vomiting-in-pregnancy-and-hyperemesis-gravidarum) for non-pharmacological and oral pharmacological treatments (Appendix 3.2 'Prescribing Summary' of Guideline)
- Refer woman scoring PUQE-24 ≥13 to PDSU and for Obstetric review by calling 9382 6417 in hours to book (if out of hours refer to ED depending on clinical condition):
 - If arriving from the GP, ED or private obstetrician woman should have a referral letter. Woman may self-refer to PDSU if this is a subsequent visit (in the current pregnancy) and they have been given a referral letter previously

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- Woman booked under a private obstetrician may attend PDSU for HG management. In each instance the private obstetrician should be contacted and a collaborative management plan made
- Advise inpatient care for a woman who is unable to tolerate oral fluids/medications
- Investigate a woman with a PUQE-24 ≥ 13 as per table 2
- Manage woman with IV fluid therapy as per table 3 below and medication management as per [Nausea and Vomiting in Pregnancy and Hyperemesis Gravidarum \(nsw.gov.au\)](https://www.nsw.gov.au/health-and-care-services/publications/nausea-and-vomiting-in-pregnancy-and-hyperemesis-gravidarum) (Appendix 3.2 'prescribing summary', 3.3 'antiemetics and corticosteroids' and 3.4 'acid suppression medication' of Guideline)
- Refer to *ED RHW* flowchart (appendix 2) for a woman attending from ED
- Provide woman with Hyperemesis gravidarum NSW Health factsheet [hyperemesis-gravidarum.pdf \(nsw.gov.au\)](https://www.nsw.gov.au/health-and-care-services/publications/hyperemesis-gravidarum)
- Document an ongoing management plan for the woman using the NSW Health NVP & HG Care Plan (see appendix 3)
- Consider dietetic involvement for nutritional advice and commencement of enteral and parenteral feeding if needed
- Consider the most appropriate setting to deliver fluid resuscitation and antiemetic therapy including:
 - ED
 - PDSU (9382 6417 Mon-Fri 0830-1630)
 - Inpatient (Antenatal Ward)
- Consider inpatient management for a woman with:
 - A PUQE-24 score of ≥ 13 and/or
 - Abnormal blood results
 - Concurrent co-morbidity (e.g. T1DM, Epilepsy, Transplant patient/user of essential medications)
 - Inability to tolerate oral fluids/ medications
 - Any other condition where clinician recommends admission
- Arrange early 'booking-in' appointment for a woman diagnosed with HG

3.1.4 Investigations

- Avoid investigations on the woman with a PUQE-24 ≤ 12 and where symptoms are not suspicious for HG or another diagnosis
- Perform investigations as per Table 2 for the woman with severe NVP (PUQE-24 ≥ 13) or suspected HG at first presentation only
- Daily monitoring (or more frequently if needed) of electrolytes is required for a woman with diabetes or other significant underlying conditions
- Arrange fetal growth surveillance in the third trimester of pregnancy for any woman with HG that continues past 16 weeks gestation

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Table 2: Investigations for severe nausea and vomiting

Indication	Investigations	Notes
Severe nausea and vomiting (PUQE score ≥ 13 or suspected hyperemesis gravidarum)	Pathology <ul style="list-style-type: none"> EUC (sodium, potassium, chloride, bicarbonate, urea, creatinine) CMP (calcium, magnesium, phosphate) LFTs (bilirubin, alanine transaminase [ALT], aspartate aminotransferase [AST], albumin) 	If requiring IV fluids for more than 24 hours – repeat electrolytes daily
	Obstetric ultrasound	Women with multiple pregnancy or gestational trophoblastic disease have an increased incidence of HG
Nausea and vomiting unresponsive to treatment	Thyroid-stimulating hormone (TSH)	TSH < 0.25 mIU/L is suggestive of thyrotoxicosis
Signs and/or symptoms of thyrotoxicosis (heat intolerance, palpitations, new anxiety, tremor, weight loss or lid lag)		
Signs or symptoms of urinary tract infection	Midstream urine - microscopy and culture, including white cell count	White cell count is raised in pregnancy; up to $12.0 \times 10^9/L$ is normal
<i>Beta human chorionic gonadotrophin (hCG) measurement is of no practical value for diagnosing or managing HG</i>		
<i>Ketonuria is not reliably associated with either the diagnosis or severity of HG</i>		

*adapted from NSW nausea and vomiting in pregnancy and hyperemesis gravidarum GL2022_009

3.1.5 Treatments

Non-pharmacological Treatments

- Recommend modification of working patterns, exercise, daytime sleeps and earlier bedtime
- Advise woman to eat whatever and whenever they can to maintain nutrition and hydration
- Consider acupressure bands
- Encourage oral ginger
- Avoid iron-containing preparations

Pharmacological Treatments refer to appendix 3 of [NSW Health Guideline Nausea and Vomiting in Pregnancy and Hyperemesis Gravidarum](#) 'Medication Management'

- **Antiemetic therapy**
 - Individualise the antiemetic according to the woman's symptoms, previous response to treatment and potential side effects
- **Acid suppression therapy**
 - Treat all women with NVP or HG with antacids
 - Treat women with severe NVP or HG with histamine 2 (h2) antagonists or proton-pump inhibitors (PPI)
- **Constipation management**
 - Prescribe laxatives to every woman with constipation or at risk of constipation

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- **Intravenous Fluid and Electrolyte Replacement**
 - Treat the woman with dehydration or uncontrolled vomiting with IV fluids, prior to the development of electrolyte deficiency (see Table 3)
 - Administer a dose of 100mg IV thiamine if dextrose-based solutions are used or if there is evidence of significant undernutrition to avoid Wernicke's encephalopathy
 - Review electrolytes and treat hypokalaemia, hyponatraemia, and hypomagnesaemia if present
 - Arrange ongoing IV fluid and antiemetic's for a woman with poor oral intake and/or continued nausea and vomiting despite antiemetic therapy as:
 - outpatient management in PDSU, or
 - inpatient management in ANW
 - Advise Obstetric Medicine review for a woman who has attended PDSU:
 - ≥ 3 times in 1 week or
 - 4 times in 2 consecutive weeks
 - Contact private obstetrician for any woman booked under private obstetric care to make follow up plan

Table 3: Recommendations for IV fluids and electrolyte replacement

Type of fluid	Quantity/Rate	Comments
0.9% sodium chloride (NaCl) or Hartmann's	1-2 L Initial rate up to 1L/hour	Further IV fluids should be given at a rate of 500ml – 1000ml/hour or slower to correct dehydration and electrolytes. Add IV thiamine (100 mg/day) if poor oral intake or administering intravenous glucose(see below)
4% dextrose and 0.18% sodium chloride or 5% dextrose	1 L Initial rate up to 1L/2 hours.	Consider this option if minimal oral intake, starvation, or uncontrolled nausea and only after correction of thiamine deficiency and exclusion of hyponatremia Add IV thiamine (100 mg/day) if poor oral intake or administering intravenous glucose
Add electrolytes as required		
Potassium chloride (KCl)	30mmol/L Maximum infusion rate 10mmol over 1 hour	Preferred product is premixed 30mmol KCl in 1 L bags of 0.9% NaCl. Administer as per local guidelines. For RHW see Potassium – Administration of Oral and Intravenous Infusion CBR . Administer with caution.
Magnesium sulphate (MgSO₄)	10-20 mmol/day over 20-40 minutes	Administer as per local guidelines. For RHW see Magnesium Sulphate Intravenous Administration for Electrolyte Disturbance CBR

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3.1.6 Psychological/Community support

- Screen woman for mental distress and depression at first presentation
- Complete Edinburgh Postnatal Depression Scale (EPDS) (see appendix 4)
- Individualised assessment of the woman's psychosocial state is recommended. Repeat EPDS screening as necessary. For scores ≥ 13 consider perinatal mental health referral (appendix 6)
- Contact Social Work department (9382 6670) for a review if required. Social worker may attend to Nausea and Vomiting in Pregnancy Quality of Life form (NVP QoL, see appendix 6)
- Contact Perinatal Mental Health clinical midwife consultant (CMC) if there are significant concerns about the woman's mental health (ext.26337 or 0457 733 554)
- Utilise available community supports, including [ComPacks](#) packages. These can be organised via Social Work. Eligibility criteria:
 - *Primary threshold*
Evidence of HG as assessed by:
 - Clinical judgement – severe nausea and/or vomiting; symptoms start in early pregnancy (before 16 weeks gestation); inability to eat and/or drink normally; strongly limited daily activities; for some women – signs of dehydration and/or electrolyte abnormalities
 - PUQE-24 score (between 13-15)
 - Need for IV fluids
 - NVP QoL (specific questions)
 - Need for non-clinical support which is not available via alternate means (such as family)
 - *Secondary threshold*
Women with PUQE-24 score of ~ 11 and other factors such as:
 - Women with co-morbidities (physical and mental health)
 - Women who live alone
 - Other social situations as identified by Social Worker
 - Significant risk of admission or re-admission

3.2 Documentation

- Medical record
- NSW health sickness in Pregnancy Plan

3.3 Educational Notes

- In a recent Australian observational study 72% of women reported NVP of which 42% had mild symptoms, 55% moderate and 1% severe³
- Both NVP and HG typically have their onset between the 4th and the 10th week of gestation, with the majority experiencing resolution by 20 weeks gestation. In a global meta-analysis, 24% of women described NVP even in late pregnancy and in approximately 10% of HG patients, symptoms persisted throughout pregnancy⁴. In another prospective recent study, only 50% of women reported relief of their symptoms by 14 weeks' although 90% had relief by week 20⁵
- The aetiology of NVP and HG remains unclear but is likely to be multifactorial. Conditions with higher hCG levels, such as trophoblastic disease and multiple pregnancy, have been associated with increased severity of NVP. In a recent meta-analysis, Helicobacter Pylori (H. Pylori) infection was associated with an increased likelihood of HG during pregnancy. Other associations including deficiency of trace elements, excess thyroid hormones, gravidity, multiple pregnancy, fetal female sex, psychiatric and dietary factors have all been suggested as part of the aetiology. Methodology to support these hypotheses have been criticised²
- In women with HG or severe NVP, studies have suggested a higher incidence amongst first degree relatives^{6, 7} and therefore the condition may be linked to a genetic origin⁸.
- Many women with vomiting in pregnancy experience symptoms of gastroesophageal reflux and the presence of such symptoms is associated with more severe NVP².

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- IV fluids have been shown to reduce vomiting and are therefore valuable for both outpatient and inpatient management of the symptoms of HG and severe NVP as well as associated dehydration and electrolyte disorders
- When selecting pharmacotherapy for NVP and HG, the prescriber needs to make a rational assessment of maternal and fetal benefit versus risk. The woman must be appropriately counselled prior to the commencement of therapy. Any potential increase in the risk of congenital malformation needs to be compared with the background rate of congenital malformations²
- There is inconsistent evidence regarding the risk of congenital malformation with the use of ondansetron and corticosteroids in the first trimester²:
 - Ondansetron is therefore recommended for second line use
 - Corticosteroids have generally been used after other antiemetic therapies have failed or are inappropriate and should be reserved for more severe NVP or HG
- In severe cases, if antiemetic and steroid therapy has failed, nutritional support via enteral or parenteral routes may be required. Enteral nutrition would preferentially be recommended over total parenteral nutrition (TPN). Women commencing enteral or parenteral nutrition are at high risk of refeeding syndrome and need to be monitored closely, with a slow introduction of supplementation⁹
- Women with HG were found to have high rates of post-traumatic stress disorder, with several associated negative outcomes including inability to breastfeed, marital problems, financial problems, and inability to self-care². Social isolation is a major risk factor; social work review and support should be assessed in each case and whether responsibilities can be delegated to another member of the family²
- Women who are diagnosed with HG have higher chance of being diagnosed with preeclampsia, deep vein thrombosis or anaemia¹⁰. HG has also been associated with an increased risk of preterm birth and an increased risk of small for gestational age (SGA) neonates¹¹
- 10% of women with a pregnancy complicated by HG will choose to terminate the pregnancy. These women would not have otherwise chosen this outcome if they did not have HG¹²

3.4 **Implementation, communication and education plan**

The revised CBR will be distributed to all medical, nursing and midwifery staff via @health email. The CBR will be discussed at ward meetings, education and patient quality and safety meetings. Education will occur through in-services, open forum and local ward implementation strategies to address changes to practice. The staff are asked to respond to an email or sign an audit sheet in their clinical area to acknowledge they have read and understood the revised CBR. The CBR will be uploaded to the CBR tab on the intranet and staff are informed how to access

3.5 **Related Policies/procedures**

- [Estimated Due Date \(EDD\)](#)
- [Early Pregnancy - EPAS – Management of women with problems in early pregnancy](#)
- [Magnesium Sulphate Intravenous Administration for Electrolyte Disturbance](#)
- [Potassium – Administration of Oral and Intravenous Infusion](#)
- [Enteral \(Nasogastric Tube\) Feeding](#)
- [Parenteral Nutrition - Adult](#)
- [Diabetes - Management of Pre-Gestational Diabetes in Pregnancy Policy SESLHDPD/283](#)
- [Diabetes - Gestational Diabetes Mellitus \(GDM\) Screening and Management Policy SESLHDPD/282](#)

3.6 **References**

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4. CULTURAL SUPPORT

- When clinical risks are identified for an Aboriginal woman, she may require additional supports. This may include Aboriginal health professionals such as Aboriginal liaison officers, health workers or other culturally specific services.
- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service: NSW Ministry of Health Policy Directive PD2017_044-Interpreters Standard Procedures for Working with Health Care Interpreters.

5. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
Endorsed by Safety and Quality Committee June 2023 Reviewed and endorsed Maternity Services LOPs 6/8/20 Approved Quality & Patient Safety Committee 20/6/13 Maternity Services LOPs group 18/6/13		

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Appendix 1.

Differential diagnosis of nausea and vomiting in pregnancy (NVP)

<i>Differential diagnoses of nausea and vomiting in pregnancy</i>		
	More common	Less common
Gastrointestinal	<ul style="list-style-type: none"> • Infectious gastroenteritis • Gastro-oesophageal reflux disease • Helicobacter pylori 	<ul style="list-style-type: none"> • Infectious hepatitis • Pancreatitis • Biliary tract disease • Peptic ulcer disease • Bowel obstruction • Gastroparesis • Appendicitis • Peritonitis
Genitourinary	<ul style="list-style-type: none"> • Urinary tract infection, including pyelonephritis 	<ul style="list-style-type: none"> • Ovarian torsion • Nephrolithiasis
Metabolic/toxic	<ul style="list-style-type: none"> • Drugs, including pregnancy vitamins 	<ul style="list-style-type: none"> • Use and/or withdrawal of cannabinoids or other illicit drugs • Diabetic ketoacidosis • Addison's disease • Thyrotoxicosis • Non-infectious hepatitis • Hypercalcemia • Eating disorders
Central-nervous system disease	<ul style="list-style-type: none"> • Migraine 	<ul style="list-style-type: none"> • Infection • Tumours • Raised intracranial pressure • Vestibular system pathology: labyrinthitis, Meniere's

*adapted from NSW nausea and vomiting in pregnancy and hyperemesis gravidarum GL2022_009

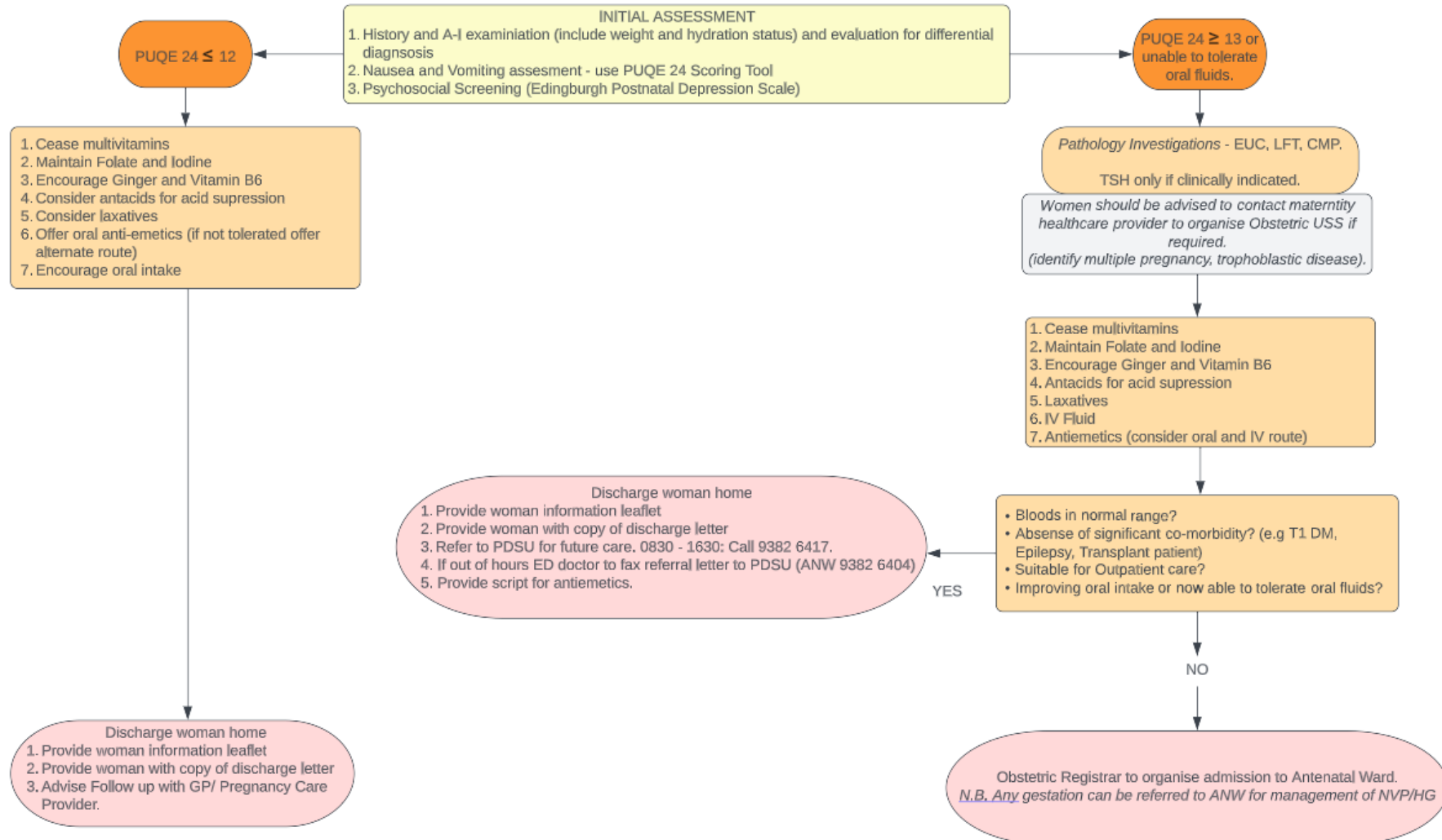
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Appendix 2

Management in POWH ED flowchart



Private Patients should have a review by their own private obstetrician

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Appendix 3

Care Plan

Nausea and vomiting in pregnancy and Hyperemesis gravidarum

Date:

My care providers (names/roles/contact numbers):

Patient label

Next clinical review:

My medications

Medication	Morning	Middle of day	Evening	Bedtime
For nausea, vomiting or retching				
For stomach acid (reflux)				
For constipation				
Others (including vitamins and minerals)				

If I feel worse, I could try:

If I feel better, I could try:

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Appendix 4:

Edinburgh Depression Scale - EDPS


For multi-language and English versions click -> [Edinburgh Postnatal Depression Scale \(EPDS\)](#)

Scoring


This 10 item questionnaire is designed to screen women for symptoms of emotional distress during pregnancy and the postnatal period.

QUESTIONS 1, 2, & 4 are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.



SMR060460

 NSW Health	FAMILY NAME		MRN	
	GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
	D.O.B. ____/____/____		M.O.	
	ADDRESS			
	LOCATION			

Facility:

THE EDINBURGH DEPRESSION SCALE (ANTENATAL)

As you are about to have a baby we would like to know how you are feeling. Please tick the box of the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today. Here is an example, already completed.:

I have felt happy

☐ Yes, all the time
☒ Yes, most of the time
☐ No, not very often
☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Complete the other questions in the same way.

1. I have been able to laugh and see the funny side of things:

☐ As much as I always could
☐ Not quite so much now
☐ Definitely not so much now
☐ Not at all

2. I have looked forward with enjoyment to things:

☐ As much as I ever did
☐ Rather less than I used to
☐ Definitely less than I used to
☐ Hardly at all

3. I have blamed myself unnecessarily when things went wrong:

☐ Yes, most of the time
☐ Yes, some of the time
☐ Not very often
☐ No, never

4. I have been anxious or worried for no good reason:

☐ No, not at all
☐ Hardly ever
☐ Yes, sometimes
☐ Yes, very often

5. I have felt scared or panicky for no very good reason:

☐ Yes, quite a lot
☐ Yes, sometimes
☐ No, not much
☐ No, not at all

6. Things have been getting on top of me:

☐ Yes, most of the time I haven't been able to cope at all
☐ Yes, sometimes I haven't been coping as well as usual
☐ No, most of the time I have coped quite well
☐ No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping:

☐ Yes, most of the time
☐ Yes, sometimes
☐ Not very often
☐ No, not at all

8. I have felt sad or miserable:

☐ Yes, most of the time
☐ Yes, quite often
☐ Not very often
☐ No, not at all

9. I have been so unhappy that I have been crying:

☐ Yes, most of the time
☐ Yes, quite often
☐ Only occasionally
☐ No, never

10. The thought of harming myself has occurred to me:

☐ Yes, quite often
☐ Sometimes
☐ Hardly ever
☐ Never

Completed by _____ Date _____

(initials)

Total Score: ____ / 30 Total Score for Question 10: ____ / 3

© 1987 The Royal College of Psychiatrists. Cox, J.L., Holden, J.M., & Sagovsky, R. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry, 150, 782-786.

THE EDINBURGH DEPRESSION SCALE (ANTENATAL) SMR060460

Royal Hospital for Women (RHW) CLINICAL BUSINESS RULE

HYPEREMESIS GRAVIDARUM (HG) AND NAUSEA AND VOMITING IN PREGNANCY (NVP) - MANAGEMENT

Appendix 6

Perinatal Mental Health Referral



Health
South Eastern Sydney
Local Health District

RHW & KARITANE RANDWICK PERINATAL MENTAL HEALTH CLINIC REFERRAL FORM FAX to: (02) 9382 6421

Please Fill in all Details & Attach completed EPDS & ANRQ August 2020 version

Referral Date: _____

Name: _____ DOB: _____ MRN: _____

Address: _____ Mobile #: _____

ANTENATAL / POSTNATAL* (circle) Gestation: _____ EDB: _____

Infant age: _____ Infant DOB: _____ Baby born @ RHW YES/NO (circle)

Referrer Name/Role/Service _____ Email: _____

Reason for referral: _____

EPDS score: ____; Q10: ____ Date of EPDS: ____ Ever seen at RHW psychiatry Clinic? YES/NO (circle)

Past Mental Health History: _____

Current Mood Meds: (? recent changes)

Substance use & Key Medical/Obstetric history:

GP details* (Name, address): _____

Other health care providers: _____

Clinic Referral Criteria:

ANTENATAL: Any woman birthing at RHW

POSTNATAL: up to 12 months postnatal AND living in Northern sector SESLHD

Royal Hospital for Women (RHW)

CLINICAL BUSINESS RULE

HYPEREMESIS GRAVIDARUM (HG) AND NAUSEA AND VOMITING IN PREGNANCY (NVP) - MANAGEMENT

Appendix 7

Nausea and Vomiting in Pregnancy Quality of Life Questionnaire (to be attended by social work)

NVP QOL

Domains	30-Items	The following questions have been designed to find out how you have been feeling in <u>the past week</u> .	None of the time (1)	Hardly any of the time (2)	A little of the time (3)	Some of the time (4)	A good bit of the time (5)	Most of the time (6)	All of the time (7)
Physical symptoms and aggravating factors	Nausea	1. How often did you have nausea in <u>the past week</u> ?							
Physical symptoms and aggravating factors	Vomiting	2. How often did you have vomiting in <u>the past week</u> ?							
Physical symptoms and aggravating factors	<u>Dry-heaves</u>	3. How often did you have dry heaves in <u>the past week</u> ?							
Physical symptoms and aggravating factors	Sick to your stomach	4. How often did you experience sickness to your stomach in <u>the past week</u> ?							
Limitations	Took longer to get things done than usual	5. How often did it take you longer to get things done than usual <u>as a result of your nausea, vomiting in pregnancy in the past week</u> ?							
Limitations	Difficult or took extra effort to perform, and/or limited in types of work and other activities	6. How often in <u>the past week</u> have you had <u>difficulty</u> or you have been limited or it has taken you extra effort to perform work and other activities as a result of your nausea, vomiting in pregnancy?							
Emotions	Downhearted, blue, sad, unhappy, depressed, gloomy	7. How often have you felt downhearted or blue <u>as a result of your nausea, vomiting in pregnancy in the past week</u> ?							
Fatigue	Worn-out, lack of energy	8. How often in <u>the past week</u> did you feel worn out and had lack of energy <u>as a result of your nausea, vomiting in pregnancy in the past week</u> ?							
Physical symptoms and aggravating factors	Poor appetite	9. How often in <u>the past week</u> did you have poor appetite <u>as a result of your nausea, vomiting in pregnancy in the past week</u> ?							
Limitations	Difficulty maintaining your normal social activities with family, friends, neighbours, or social groups	10. How often in <u>the past week</u> have you had difficulty maintaining your normal social activities with family, friends, <u>neighbours</u> or social groups, as a result of your nausea, vomiting in pregnancy?							
Physical symptoms and aggravating factors	Symptoms worse in evening	11. How often in <u>the past week</u> did you experience nausea and vomiting in pregnancy in the evening?							
Emotions	Frustrated	12. How often have you felt frustrated <u>as a result of your nausea, vomiting of pregnancy in the past week</u> ?							
Fatigue	Exhausted	13. How often did you feel exhaustion <u>as a result of your nausea, vomiting of pregnancy in the past week</u> ?							
Limitations	Rely on your partner to do things that you would normally do for family	14. How often, <u>as a result of your nausea and vomiting in pregnancy, in the past week</u> have you had to rely on your partner to do things you would normally do for your family?							

Royal Hospital for Women (RHW)

CLINICAL BUSINESS RULE

HYPEREMESIS GRAVIDARUM (HG) AND NAUSEA AND VOMITING IN PREGNANCY (NVP) - MANAGEMENT

		partner to do things you would normally do for your family?							
Emotions	Fed up with being sick	15. How often in the past week have you felt fed up with being sick as a result of your nausea, vomiting in pregnancy?							
Limitations	Difficulty looking after home	16. How often in the past week have you had difficulty looking after your home as a result of your nausea, vomiting in pregnancy?							
Limitations	Difficulty shopping for food	17. How often have you had difficulty shopping for food in the past week as a result of your nausea, vomiting in pregnancy?							
Fatigue	Tired	18. How often did you feel tiredness as a result of your nausea, vomiting in pregnancy in the past week?							
Physical symptoms and aggravating factors	Not eaten for longer than you would like	19. How often in the past week did you not eat for longer than you would like as a result of your nausea, vomiting in pregnancy?							
Emotions (Scoring reversed)	Reassured that your symptoms are part of normal pregnancy	20. How often in the past week did you feel reassured that your symptoms are part of normal pregnancy?							
Emotions	Less interested in sex	21. How often did you feel less interested in sex in the past week as a result of your nausea, vomiting in pregnancy?							
Fatigue	Fatigue	22. How often did you feel fatigue, as a result of your nausea, vomiting in pregnancy in the past week?							
Emotions	Emotional	23. How often have you felt emotional, as a result of your nausea, vomiting in pregnancy in the past week?							
Limitations	Accomplished less than you would like	24. How often in the past week have you felt that you have accomplished less than you would like, as a result of your nausea, vomiting in pregnancy?							
Limitations	Cut down on amount of time you spent at work or other activities	25. How often have you cut down on the amount of time you spent at work or other activities in the past week as a result of your nausea, vomiting in pregnancy?							
Physical symptoms and aggravating factors	Worse when exposed to certain smells	26. How often in the past week did you experience nausea and vomiting from being exposed to certain smells?							
Limitations	Everything is an effort	27. How often in the past week have you felt that everything is an effort, as a result of your nausea, vomiting in pregnancy?							
Emotions	Can't enjoy your pregnancy	28. How often have you felt that you can't enjoy your pregnancy, as a result of your nausea, vomiting of pregnancy in the past week?							
Physical symptoms and aggravating factors	Worse when exposed to certain foods	29. How often in the past week did you experience nausea and vomiting from being exposed to certain foods?							
Limitations	Difficulty preparing or cooking meals	30. How often in the past week have you had difficulty preparing or cooking meals as a result of your nausea, vomiting in pregnancy?							