

Hyperemesis Gravidarum

Information for women who have hyperemesis gravidarum during pregnancy or breastfeeding

The information provided below is for readers based in the United States of America. Readers outside of the United States of America should seek the information from local sources.

What is hyperemesis gravidarum?

Hyperemesis gravidarum (HG) is a complication of pregnancy featuring severe [nausea and vomiting](#), weight loss, and disruption of electrolytes, often with dehydration.

How common is HG?

HG develops in approximately 0.3 - 3% of pregnant women worldwide, although incidence reports are based on varying criteria used for the diagnosis in different countries. The rate of occurrence of HG differs among ethnic groups and national populations with an incidence as high as 10 percent reported for some populations of Asian and Middle Eastern women. Incidence is also fairly high among young, non-Caucasian women in their first pregnancy. Smoking seems to decrease the risk for HG, but this does not mean that you should smoke because smoking has negative consequences for both you and your baby.

How is HG diagnosed?

You would be diagnosed with HG if you are vomiting persistently with no other apparent cause, show evidence of severe short term starvation (such as the presence of molecules called ketones in your urine and weight loss of 5 percent or more of your pre-pregnancy weight), and have problems with electrolytes and acid-base balance.

Does HG cause problems during pregnancy?

Yes. Women suffering from HG can develop deficiencies of nutrients such as vitamin B1 (thiamine). This, in turn, can lead to a severe brain condition called Wernicke encephalopathy, featuring tiredness and confusion, dampened reflexes, problems with movement, including movement of the eyes. In very extreme cases, Wernicke encephalopathy can be fatal. If recognized early, thiamine deficiency is easily

curable. HG also can lead to deficiencies of fat-soluble vitamins, such as vitamin K, which is important for blood clotting, so deficiency can lead to bleeding during pregnancy and severe bleeding during labor and delivery. The vomiting may lead to a particular type of acid-base disturbance called metabolic alkalosis, which causes a particular electrolyte disturbance called hypokalemia, or low potassium. This can lead to muscle damage, kidney problems, and problems with the rhythm of the heart, which also can be fatal. Excessive vomiting and wretching can damage the esophagus badly enough to cause bleeding and entry of air into the tissues of and behind the chest.

Does HG cause problems for the baby?

HG is associated with increased rates of preterm birth and low birth weight, both of which can lead to physical and mental problems for the baby. Although a subject of debate, many researchers also think that HG can lead to problems with the placenta, which can lead to placental abruption (the placenta detaches from the uterus, often killing the baby). Infants born to mothers with HG also may be prone to psychiatric conditions.

What to consider about taking medications when you are pregnant or breastfeeding:

- The risks to yourself and your baby if you do not treat the HG
- The risks and benefits of each medication you use when you are pregnant
- The risks and benefits of each medication you use when you are breastfeeding

What should I know about using medication to treat HG?

The first medication that often is given is a combination of two drugs called [doxylamine succinate](#) (an antihistamine) and pyridoxine HCl (vitamin B6), which together are known as [diclegis](#). The treatment is safe for the baby, although its main use is not for HG but for nausea and vomiting of pregnancy, where it is reported effective in 70-80 percent of cases. First-line drugs specifically for HG include [ondansetron](#) and metoclopramide, while second choice drugs offered to patients who do not improve with one of the other drugs include promethazine, [clonidine](#), and mirtazapine. [Corticosteroid](#) medications also have been used in patients with HG, but there is disagreement over whether or not they are effective.

Who should NOT stop taking medication for HG?

If any of the drugs work for you, there are few reasons to stop taking them. However, in a small number of cases, ondansetron can cause a change in heart rhythm seen on electrocardiography called QT prolongation, in which case you might have to switch to a different drug.

What should I know about choosing a medication for my HG?

It is important to stay in communication with your health care provider as the release of new studies over time can change the outlook on the role of specific medications during pregnancy.

You may find Pregistrys expert reports about the medications to treat this condition [here](#). Additional information can also be found in the sources listed below.

What should I know about taking a medication for HG when I am breastfeeding?

Generally, HG resolves by the midpoint of pregnancy, so you will not need anti-HG medications by the time that you are breastfeeding.

What alternative therapies besides medications can I use to treat my HG?

Important components of HG treatment include rehydration with fluids and administration of electrolytes. Additionally, thiamine is given to prevent Wernicke encephalopathy. In some cases, patients may need to be fed intravenously.

What can I do for myself and my baby when I have HG?

It is very important to follow the instructions of your physician regarding medications and nutritional intervention.

Resources for HG in pregnancy:

For more information about hyperemesis gravidarum during and after pregnancy, contact <http://www.womenshealth.gov/> (800-994-9662 [TDD: 888-220-5446]) or contact the following organizations:

- Cleveland Clinic: [Hyperemesis Gravidarum](#)
- Baby Center UK: [Hyperemesis Gravidarum](#)

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General information

It is very common for women to worry about having a miscarriage or giving birth to a child with a birth defect while they are pregnant. Many decisions that women make about their health during pregnancy are made with these concerns in mind.

For many women these concerns are very real. As many as 1 in 5 pregnancies end in a miscarriage, and 1 in 33 babies are born with a birth defect. These rates are considered the background population risk, which means they do not take into consideration anything about the health of the mom, the medications she is taking, or the family history of the mom or the baby's dad. A number of different things can increase these risks, including taking certain medications during pregnancy.

It is known that most medications, including over-the-counter medications, taken during pregnancy do get passed on to the baby. Fortunately, most medicines are not harmful to the baby and can be safely taken during pregnancy. But there are some that are known to be harmful to a baby's normal development and growth, especially when they are taken during certain times of the pregnancy. Because of this, it is important to talk with your doctor or midwife about any medications you are taking, ideally before you even try to get pregnant.

If a doctor other than the one caring for your pregnancy recommends that you start a new medicine while you are pregnant, it is important that you let them know you are pregnant.

If you do need to take a new medication while pregnant, it is important to discuss the possible risks the medicine may pose on your pregnancy with your doctor or midwife. They can help you understand the benefits and the risks of taking the medicine.

Ultimately, the decision to start, stop, or change medications during pregnancy is up to you to make, along with input from your doctor or midwife. If you do take medications during pregnancy, be sure to keep track of all the medications you are taking.