ALGORITHM FOR TREATMENT OF NVP

(HELP <20)
1. B6/Pyridoxine with or without doxylamine: (Select ONE)
   - Pyridoxine 10–25 mg PO (with or without Doxylamine 12.5 mg PO), 3 or 4 times per day.
   - Pyridoxine + Doxylamine 10 mg, two tablets PO at bedtime, add one tablet in AM & afternoon prn.
   - Pyridoxine + Doxylamine 20 mg PO, one tablet PO at bedtime, add AM tablet prn.
2. Thiamin/Vitamin B1 50-100 mg PO 1-4 times per day.
3. Continue prenatal vitamin with iron and thiamin until not tolerated → Switch to folic acid.
4. Add gastric/esophageal protection. (See shaded box below.)

(HELP <32)

Add up to 1 from each class:
1. Antihistamine (discontinue doxylamine before adding)
   - Dimenhydrinate 25-50 mg q 4-6 hours PO or PR (limit to 200 mg per day if taking doxylamine)
   - Diphenhydramine 25-50 mg PO q 4-6 hours
   - Meclizine 25 mg PO q 6 hours
2. Dopamine Antagonist
   - Metoclopramide 5-10 mg q 6-8 hours PO
   - Promethazine 12.5-25 mg q 4-6 hours PO or PR
   - Prochlorperazine 5-10 mg q 6-8 hours PO or 25 mg twice daily PR

Select IV Fluids:
1. Banana Bag + Vit B6 + Vit B1
2. Myer's Cocktail + 1 ampule MVI
3. D5NS or D5LR + 1 ampule MVI + Vit B6 + Vit B1
   - Add prn: KCl, Na, Vit K, Vit D, Zn, Se, Fe, Mg & Ca.
   - Always give thiamin with glucose to prevent WE.
   - Correct electrolytes slowly to prevent CPM.
   - Restrict PO intake for 24-48 hours for gut rest.
   - Consider midline or central line for frequent IVs.

If not responding to or tolerating PO meds, change to:

1. Thiamin 100 mg 1-5 times daily IV
   AND ONE OF THE FOLLOWING
2. Dimenhydrinate 50 mg (in 50 mL saline, over 20 min) q 4–6 hours IV
3. Ondansetron**:
   - IV: 8 mg over 15 minutes q 12 hours or 4 mg q 6 hours IV or continuous infusion
   - SubQ continuous infusion: 8 mg starting dose, then 12-40 mg/day; wean slowly to PO.
4. Granisetron** 1mg q 12 hours IV
5. Metoclopramide:
   - IV: 5–10 mg q 8 hours
   - SubQ continuous infusion: 5-10 mg starting dose, then 20-40 mg/day; wean slowly to PO.

**Daily Bowel Regimen required (see adjacent box)

GERD or gastric/esophageal protection:
1. Calcium Antacid (avoid Bismuth or Bicarbonate) AND/OR
2. H2 antagonist BID: ranitidine 150 mg PO OR famotidine 20-40 mg OR
3. PPI q 24 hours
   - esomeprazole 30-40 mg PO or IV
   - lansoprazole 15-30 mg PO
   - pantoprazole 40 mg PO or IV

Consider NUTRITION (see below) and one of the following:
1. Mirtazapine 15 mg q 8 hours PO or ODT (Dose not established for HG. Discontinue other serotonin antagonists.)
2. Methylprednisolone (if 10+ weeks) 16 mg q 8 hours PO or IV for 3 days. Taper over 2 weeks to lowest effective dose. Avoid duration exceeding 6 weeks.
3. Prochlorperazine 5-10 mg PO q 6-8 hours
4. Chlorpromazine 25-50 mg IV or 10–25 mg PO q 4-6 hours

NUTRITION - If weight loss ≥10% and/or persistent HG, consult with GI & Nutrition & IV Therapy:
1. Enteral therapy: gradual infusion with or without additional parenteral/enteral fluids (Jejunal placement preferred)
2. Intravenous fluids and/or parenteral nutrition
   - Consider midline or central line.
   - Continue until gaining weight on PO intake.
   - Prevent Refeeding Syndrome: Slowly restart nutrition & monitor weight, phosphorus & electrolytes.

NOTES:
1. If symptoms persist, follow the arrows to the next level of care.
2. Most of these medications can cause QT prolongation, consider EKG or cardiac monitoring for high risk patients, high doses, multiple medications, or electrolyte abnormalities.
3. IM not recommended due to muscle loss and pain sensitivity.
4. Avoid using multiple dopamine antagonists simultaneously.
5. CPM = Central Pontine Myelinolysis; WE = Wernicke’s encephalopathy
6. HELP = HyperEmesis Level Prediction Score, www.hyperemesis.org/tools

Disclaimer: This is not medical advice. Do not make any changes to your diet or lifestyle without consultation from your medical provider.
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SELECTED REFERENCES:


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