Treatment of intractable vomiting in pregnancy: A clinical dilemma

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Objective:
Presentation of two unique cases with intractable vomiting in pregnancy managed by different pathways with good outcomes

DISCUSSION:
Nausea and emesis in pregnancy are very common, affecting around 80% of pregnant women to some degree[1]. Fortunately, the condition is most often self-limiting without long-term consequences for mother or child. If continues, it can result in significant morbidity in mother and increases the risks of preterm delivery, low birthweight (<2500 g) and growth restriction. It also results in significant morbidity in mothers. These two case reports Outlines the management of intractable vomiting in Pregnancy.

CASE 1:
The first case comprise of G1P0 with history of Type1 diabetes. The patient had her first hospital admission at ~12th week of gestation with Hyperemesis Gravidarum.
She then continued to have multiple admissions and, subsequently, diagnosed with starvation ketoacidosis on multiple occasions.
She was managed with steroids and continuous antiemetic infusion with limited success.
The patient was discussed in local MDT with input from tertiary care hospital. She was started on total parenteral nutrition around 30 weeks of gestation through peripherally inserted central line.
The patient delivered at 34weeks of gestation through C section with good recovery afterwards.

CASE 2:
The second case is about G1P0 with history of hepatoblastoma in childhood resulting in partial resection of liver and chemotherapy. She developed subcostal scar discomfort and severe dysphagia in first trimester which resulted in starvation ketoacidosis and significant weight loss.
No organic cause for her dysphagia was identified despite multiple investigations and it did not improve despite psychiatric input.
She had *gastrojejunal tube* insertion and enteral feeding started around 30 weeks of gestation. She delivered at 34+3 weeks of gestation with good recovery post natally.

Conclusion:
The management of these cases reiterates the fact that intractable vomiting can be managed in different ways. Careful selection of patient, MDT involvement and patient participation in decision making is essential for the best outcomes.
The management of second case shows that enteral feeding can be a feasible alternative in management of difficult cases of intractable vomiting in pregnancy not amenable to antiemetics and steroids. More research is needed to see if enteral feeding can be management in community to give more autonomy to pregnant women.

References:
[1]. Gadsby R, Barnie-Adshead AM, Jagger C. A prospective study of nausea and vomiting during pregnancy. *Brit J Gen Pract* 1993;**43**:245–8.