with standard care where the evidence showed benefits in relieving symptoms in women with moderate-to-severe nausea and vomiting in pregnancy, which was not shown for women with mild and moderate nausea and vomiting. Therefore, the committee recommended that acupressure could be considered for women with moderate-to-severe nausea and vomiting as an additional treatment.

No recommendation was made on the use of corticosteroids as a treatment for severe nausea and vomiting in pregnant women because, despite research in this area, no evidence was found to support its use. The committee discussed that although corticosteroids have well-known harms, the benefits can outweigh them so that some units use corticosteroids in severe cases of nausea and vomiting in pregnancy, and so a research recommendation on the effectiveness of corticosteroids for women with severe nausea and vomiting in pregnancy was made.

Some women with moderate-to-severe nausea and vomiting in pregnancy might need intravenous fluids. The evidence showed no difference in most outcomes between offering intravenous fluids in an inpatient or outpatient setting. Offering them to an outpatient is less expensive, reduces time spent in hospital and, in the committee's experience, is generally preferred by women. Inpatient care may be needed when severe nausea and vomiting persists despite treatment. Hyperemesis gravidarum can have serious harmful consequences, and treatment and care in hospital may be needed. It should be noted that this guideline only covers treatments to manage nausea and vomiting in pregnancy, and comprehensive management of hyperemesis gravidarum, which may include nutritional interventions, is not covered by this guideline on routine antenatal care.

How the recommendations might affect practice

The treatment options are all used in current practice but there may be a change in practice in encouraging shared decision making for different options. This may mean that those prescribing medicines may need to spend more time discussing the options with the woman.

An increase in giving intravenous fluids as an outpatient service instead of an inpatient service could bring cost savings.

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Heartburn

Recommendations 1.4.8 and 1.4.9

Why the committee made the recommendations

There was no evidence on whether giving lifestyle and diet information to pregnant women with heartburn is effective, but the committee agreed, based on their own knowledge and experience, that it may help. This is supported by guidance for the general adult population in the NICE guideline on gastro-oesophageal reflux disease and dyspepsia.

The committee recommended considering either antacid or alginate therapy for women with heartburn in pregnancy because there is evidence that they are equally effective. These medicines are available over the counter. Because the studies examined various antacid and alginate remedies, the committee agreed that they could not make a more specific recommendation.

The committee did not make any recommendations about acupuncture or proton pump inhibitors (PPIs) because, although there was some evidence that acupuncture is effective in alleviating heartburn and that PPI use in the first trimester is not harmful to the baby, it was of very low quality and not good enough to support recommending them to be used routinely. In addition, there was no evidence on H2 receptor antagonist (H2RA) therapy to treat heartburn in pregnancy.

How the recommendations might affect practice

The recommendations reflect current clinical practice.

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Symptomatic vaginal discharge

Recommendations 1.4.10 to 1.4.14

Why the committee made the recommendations

There was limited evidence on the effectiveness of treatments for symptomatic vaginal

discharge in pregnant women, so the committee used their knowledge and clinical experience to make the recommendations. The committee agreed that some women can find an increase in vaginal discharge distressing or uncomfortable, so it is important to reassure women that it is a normal feature of pregnancy. However, women should also be made aware of the symptoms and signs of infection that may need further action, because there is a small chance that some infections could lead to complications.

Candidiasis (thrush) is often an easily identifiable cause of symptomatic vaginal discharge and may not need a formal investigation. However, if there is doubt about the cause, a vaginal swab could be used. It is important that possible sexually transmitted infections are appropriately investigated so that they can be treated, because they could have an impact on the baby.

The evidence on antifungal treatment to treat symptomatic vaginal discharge because of vaginal candidiasis was very limited, imidazole being the only drug class being studied. However, imidazole (for example, clotrimazole or econazole) was consistently shown to be effective.

The evidence on the benefits and harms of antibiotics to treat symptomatic vaginal discharge due to bacterial vaginosis was also very limited. There was only evidence on oral amoxicillin (which is not commonly prescribed in current practice for this indication) and oral metronidazole. The committee were aware of evidence among asymptomatic populations that antibiotics are effective in treating the underlying infection, but the committee agreed that it cannot be assumed that they would be effective in relieving symptomatic vaginal discharge. The committee noted that it is common practice to prescribe vaginal rather than oral antibiotics for this indication – in particular, clindamycin or metronidazole. Combining this with their knowledge and experience, they recommended that either oral or vaginal antibiotics could be considered. The NICE guideline on antimicrobial stewardship gives guidance on good practice in prescribing antimicrobials.

No evidence was identified on the effectiveness of metronidazole to treat symptomatic vaginal discharge because of vaginal trichomoniasis, therefore no recommendations were made.

How the recommendations might affect practice

The committee agreed that the recommendations will reinforce current best practice and

standardise care.

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Pelvic girdle pain

Recommendation 1 4.15

Why the committee made the recommendation

There was evidence of varying quality from several randomised controlled trials that exercise advice from a physiotherapist may reduce pain intensity and pelvic-related functional disability. The committee recommended referral to physiotherapy services rather than to a physiotherapist because, in some cases, information and advice could be given over the telephone or in an email or letter rather than in a face-to-face appointment.

Moderate quality evidence from 1 randomised controlled trial showed that a non-rigid lumbopelvic belt together with general information about anatomy, body posture and ergonomic advice reduced pelvic girdle pain intensity, compared with exercise advice and information, and information only. However, it did not have an impact on functional status in daily activities. No evidence was identified about adverse effects of using a lumbopelvic belt. Providing a non-rigid lumbopelvic belt was also found to be cost effective based on an economic evaluation, but because the clinical evidence base was limited, the committee agreed not to make a strong recommendation.

The committee agreed that there was not enough evidence to show that manual therapy alone had any benefits for women with pelvic girdle pain, so did not make a recommendation. The committee agreed that the evidence for acupuncture to treat pelvic girdle pain was mixed, of poor quality and therefore not adequate enough to justify a recommendation that would have a substantial resource impact.

How the recommendation might affect practice

Current practice for pregnancy-related pelvic girdle pain is to offer analgesics (for example, paracetamol) and provide information about lifestyle and health changes. Some hospitals also have access to physiotherapy services. Providing a lumbopelvic belt is not current practice in all units, so the committee recognised that the recommendation may

have cost implications. However, health economic modelling showed that it is cost effective even if women are referred for physiotherapy. The recommendation may increase the number of pregnant women seeking referral to physiotherapy services.

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Unexplained vaginal bleeding after 13 weeks

Recommendations 1.4.16 to 1.4.21

Why the committee made the recommendations

There was very little evidence, so the committee used their knowledge and experience to make recommendations. They took into account the risks associated with a delay in assessing and treating unexplained vaginal bleeding in pregnancy, the possibility that anti-D injections may be needed for women who are rhesus D-negative, the need to exclude a low-lying placenta (placenta praevia) and that corticosteroids may be needed if there is a risk of preterm birth.

The committee agreed that a review in secondary care is needed when unexplained vaginal bleeding occurs after 13 weeks of pregnancy. Evidence on the effectiveness of hospitalisation was limited, with only 1 retrospective study that showed no difference in the number of fetal deaths whether women were admitted to hospital or discharged on the day they presented. Because of limited evidence, the committee made a research recommendation on the effectiveness of hospitalisation compared with outpatient management for pregnant women with unexplained vaginal bleeding.

The committee agreed that hospitalisation should be considered for monitoring, administering corticosteroids and neonatal unit care if the baby is born preterm. Discussion with the woman about the possibility of preterm birth may also be helpful.

How the recommendations might affect practice

The recommendations reflect current practice.

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