Good evening,

Thank you for giving me the opportunity to reply to the Cabinet Secretary for Health and Social Care's response to Petition P-06-1550 - Place the drug Xonvea on to the formulary for the management of nausea and vomiting in pregnancy. Please see the following attached:
1) My main response entitled 'Senedd Petition Response'
2) A compilation of stories emailed to me in the last week from women who wanted their experience of hyperemesis gravidarum shared. I would be grateful if you could take the time to read through some of these as they show you the damaging impact of the condition on the sufferer and potentially fatal impact on the baby
3) Correspondence I've had with doctors who have contacted me about doxylamine with pyridoxine 'Xonvea' and their experience of hyperemesis gravidarum care
4) A paper written by the charity Pregnancy Sickness Support examining the efficacy of Xonvea and a brief overview of a cost benefit analysis.

I volunteer for the charity Pregnancy Sickness Support as a 'HG Advocate'. The charity have informed me that they would be happy to communicate with you directly to discuss this in greater detail. I am happy to put you in contact with them.

I sincerely hope that you give this petition the due consideration it deserves and do not reject it simply on the basis of a decision about cost that you have already made.
Regardless of your decision on Xonvea I hope you take the time to recognise that the care of pregnant women suffering with pregnancy sickness in Wales is in need of serious reform.

I look forward to hearing your response,

Yours sincerely,

Sarah

Sarah Spooner (Butterworth) BSc (hons) PGDip MCOptom Prof Cert Glauc Prof Cert Med Ret

Thank you for the opportunity to respond to Mr Jeremy Mile's response to Petition P-06-1550 - Place the drug Xonvea on to the formulary for the management of nausea and vomiting in pregnancy. Having read through his response there are a number of points I wish to raise.

As a brief introduction, pregnancy sickness affects around 70% of all pregnancies. Around 4% of women will suffer with a condition known as hyperemesis gravidarum (HG) (although the exact figure is likely higher than this as women struggle to get a diagnosis) which causes severe nausea and vomiting in pregnancy. HG is defined as severe nausea and/or vomiting with symptoms starting before 16 weeks of pregnancy, it is an inability to eat or drink normally and strongly limits daily activities[1]. HG is associated with several risks for both mother and baby. The physical impacts for the mother include dehydration requiring rehydration, ketoacidosis, increased risk of thrombus and increased risk of Wernicke's encephalopathy.[2] The mental health risks include a significantly higher incidence of psychosis, postnatal depression, post-traumatic stress disorder, OCD and eating disorders.[3] There is an increased risk to the baby of pre-term birth and low birth weight and developmental delay in HG babies and 4.9% of HG sufferers terminate their wanted pregnancy.[2]

Xonvea is the only medication licensed for use for the management of nausea and vomiting in pregnancy in the UK. It has an effective safety profile and does not have teratogenic effects. It is recommended for use by both the RCOG[4] and NICE[5].

In Mr Mile's response he mentioned that the AWMSG appraisal of Xonvea in 2019 remains the most up-to-date evaluation of the drug. In a response to an article by Sky News in July 2025[6] the Senedd wrote that Xonvea is not available as it has not been approved by NICE. However, this information is incorrect as it was approved by NICE in April 2025. In the response from Mr Miles on the 5th November 2025 he has acknowledged that NICE has approved its use but has shifted the goalpost by requesting it undertake a cost effectiveness analysis.

I understand the Senedd's concerns that Xonvea is more expensive than other first line antiemetics. In response to this I would like to suggest that this is a myopic approach to healthcare and that it fails to consider the significant cost attached to poorly treated hyperemesis gravidarum. A 2019 study found that nausea and vomiting in pregnancy costs the NHS up to £64 million a year. The same study, based on 2016 prices, found that it cost £45 for a GP appointment, £238 for an ambulance call out and £850 for a 2-night impatient admission with rehydration and antiemetics.[7] The cost of a box of Xonvea to the NHS is £28.50. This pales into insignificance when you consider the cost of an emergency C-section, a NICU stay or the number of perinatal mental health appointments a HG sufferer may require due to inadequate treatment of the condition.

I have attached in a separate document a survey by the charity Pregnancy Sickness Support from April 2025 which establishes the cost and impact of Xonvea for the management of Nausea and Vomiting in Pregnancy. From this survey of 749 women, 492 have been offered Xonvea. Of those 83% of women reported finding it effective. On average 53% of women were offered a second line antiemetic and 43% were offered a steroid before trying Xonvea. Second line antiemetics and steroids both come with increased side effects to the pregnant woman and ondansetron, one second line

antiemetic, has a small increased risk of cleft palate in the developing foetus. 83% of women in the study found it more effective than other medication they tried. The average cost of 3 antiemetic medications at one week's supply, along with 3 GP appointments is £180.80 per sufferer. The average cost of a three-week supply of Xonvea, with 1 GP appointment is £138.65. While Xonvea may appear more expensive than some other medications used to treat nausea and vomiting in pregnancy, this comparison ignores the broader picture. When factoring in real-world outcomes and the overall patient journey, the value of Xonvea becomes much clearer.[8]

Cyclizine, Promethazine and Prochlorperazine (5mg) 3 GP appointments Total = £175.14	Cyclizine, Promethazine and Ondansetron (4mg) 3 GP appointments Total = £184.18	Promethazine, Prochlorperazine (5mg) and Ondansetron (4mg) 3 GP appointments Total = £184.80	Cyclizine, Prochlorperazine (buccal) and Ondansetron (4mg) 3 GP appointments Total = £187.67	Cyclizine, Metoclopramide and Ondansetron (4mg) 3 GP appointments Total = £179.82
Cyclizine, Promethazine and Metoclopramide 3 GP appointments Total = £174.46	Cyclizine, Prochlorperazine (5mg) and Ondansetron (4mg) 3 GP appointments Total = £179.76	Promethazine, Prochlorperazine (buccal) and Ondansetron (4mg) 3 GP appointments Total = £191.97	Cyclizine, Prochlorperazine (buccal) and Ondansetron (8mg) 3 GP appointments Total = £183.14	Promethazine, Prochlorperazine (5mg) and Ondansetron (8mg) 3 GP appointments Total = £180.27
Cyclizine, Prochlorperazine (5mg) and Metoclopramide 3 GP appointments Total = £170.78	Promethazine and Prochlorperazine (5mg) and Metoclopramide 3 GP appointments Total = £174.40	Cyclizine, Prochlorperazine (5mg) and Ondansetron (8mg) 3 GP appointments Total = 175.97	Cyclizine, Promethazine and Ondansetron (8mg) 3 GP appointments Total = £184.18	Promethazine, Prochlorperazine (buccal) and Ondansetron (8mg) 3 GP appointments Total = £187.44
Cyclizine, Prochlorperazine (buccal) and Metoclopramide 3 GP appointments Total = £177.95	Promethazine and Prochlorperazine (buccal) and Metoclopramide 3 GP appointments Total = £182.25	Cyclizine, Promethazine and Prochlorperazine (buccal) 3 GP appointments Total = £182.31	Cyclizine, Metoclopramide and Ondansetron (8mg) 3 GP appointments Total = £175.29	Promethazine, Ondansetron (4mg) and Metoclopramide 3 GP appointments Total = £184.12

Fig 1. Taken from Establishing the Cost and Impact of Xonvea for NVP. A Summary of Findings by Pregnancy Sickness Support. Fareham: Pregnancy Sickness Support.[8]

I also want to draw your attention to some key policies underpinning healthcare in Wales. The first of these is your keystone policy 'A Healthier Wales' which discusses the need to transition away from a heavy reliance on hospital-based care and treatment to a focus on health, wellbeing and prevention alongside community-based care.[9] I know from personal experience and speaking to many other women that sufferers often have to contact their hospital for a prescription of Xonvea. By allowing women to access this medication from their GP and local pharmacy there would be a reduction on the burden of hospitals. By making Xonvea more readily available for women you would likely reduce inpatient appointments for rehydration treatment and other HG complications

allowing for a better focus on prevention and wellbeing. In your policy 'Maternity Care in Wales: A Five-Year Vision of the Future (2019-2024)' your aim is for pregnancy and childbirth to be a safe and positive experience, and for parents to be supported to give their child the best start in life. By denying women access to treatment that is available to women in England you are failing to deliver on this aim.[10] I also have concerns that the difficulty in accessing Xonvea creates a socioeconomic disparity. I was fortunate enough for my husband to drive me to various locations in the Aneurin Bevan University Health Board to collect medication and it was still immensely difficult, on occasion having to travel to an abortion clinic in Bargoed to receive medication. For many women who may not have access to a vehicle accessing rural locations in the Valleys for a week or two's worth of medication is simply not feasible.

Finally, Once for Wales is a fundamental policy underpinning Welsh Health and Social Care. Mr Miles mentions that individual health boards can approve Xonvea on their own formularies and I am immensely grateful that this has happened in two Welsh health boards. However, the Once for Wales strategy aims to ensure equitable care across Wales without a postcode lottery. Unfortunately, this is not currently the case and many women do face a postcode lottery for adequate care.

If you would be amenable, I can put you in contact with the charity Pregnancy Sick ness Support who can discuss in greater detail with you the implications of inequity i n HG care pathways in the UK. I would also be happy to share with you my lived experie nce of the condition.

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Communication with Doctors

Copy of email sent by Dr Georgina Forbes to the Senedd:

Dear Minister,

I am writing to ask you to consider supporting the cause of allowing Xonvea to be prescribed to the women of Wales for the management of hyperemesis (severe nausea and vomiting in pregnancy).

The drug is recommended as the first line treatment by the RCOG in the greentop guideline and is the only licensed medication for hyperemesis in the UK.

The cost is just £28 for a 10 day supply. Far less than the cost of admission for rehydration or the cost of missed days of work/education.

I have unfortunately had to facilitate the termination of pregnancy for two women in ABUHB in the last week alone. Both pregnancies were very much planned and wanted. Both women had multiple admissions and were on multiple other medical treatments which were not giving adequate relief. For the sake of their physical and mental health they felt their only option was to terminate their much wanted pregnancies. Inevitably having a further impact on their wellbeing. These cases are very distressing for the patient and staff involved as Xonvea may well be the medication that provides symptomatic relief but departments are not allowed to prescribe it.

I urge you to consider addressing this on a national level so that women in Wales are not left behind compared to other UK nations and that ultimately there is no inequality between healthboards.

Dr Georgina Forbes
Specialist Doctor in Sexual and Reproductive Healthcare
Wales Committee Chair, College of Sexual and Reproductive Healthcare

Information sent to me by Dr Stephanie Hemmings

I don't know if my experience of women with HG in hospital will help, but you can have it just in case:

As a medical specialist I have been called to see women with HG on obstetric wards in hospital because obstetricians and gynaecologists (trainees mainly) are very inexperienced with managing HG and the complications it can cause (abnormal electrolytes, seizures due to not being able to tolerate medications) are seen as a medical problem. This is partly due to the main number of admissions from it come in

the early weeks when a pregnant patient is seen as a medical patient prior to 16 weeks. The patient I saw was having problems with her electrolytes and blood sugar, mainly due to her nausea and vomiting being inappropriately managed by medication. As medical specialists, we are in the wrong specialty to prescribe Xonvea off formulary (as it is seen as an obs and gynae specialist medication) and are restricted with other medications as we do not want to risk the growing baby.
If Xonvea was on the formulary it would open up the treatment options available for these patients and potentially prevent unnecessary hospital admissions. Additionally maternal medicine needs to be expanded as a specialty in Wales as it is a growing specialty in many places in England.

Information sent to me by Dr Heather Kosick

Hey Sarah my name is Heather Kosick and I'm a gastroenterologist from Canada. I just read the article about you in the BBC. I was honestly horrified that this happened to you! Here in Canada Xonvea, also called Diclectin, is readily available to all pregnant women. In fact, it is considered the first line agent for nausea and vomiting in pregnancy due to its extensive safety data. The approach here for patients is really to do anything possible for the mother to get her comfortable, even if there may be some risk to the fetus, as the risk of malnutrition and electrolyte abnormalities from HG far outweighs this.

Establishing the Cost and Impact of Xonvea for NVP. A Summary of Findings by Pregnancy Sickness Support

This survey was conducted in April 2025 and advertised via our social media platforms and email list.

1. Survey Design and Participation

This survey was conducted by Pregnancy Sickness Support in April 2025. It was open to anyone who had experienced NVP since 2018, when Xonvea became available in the UK. We received 749 responses within 10 days. Participants were asked about access to Xonvea, medication history, perceived effectiveness, and experiences of healthcare support. The survey was designed to understand real-world usage, outcomes, and barriers.

This was a self-selected survey, meaning participants chose to take part rather than being randomly selected. Aside from postcode and country data, no demographic information such as age, ethnicity, or sexuality was collected.

2. The History of Xonvea in the UK

The medication Xonvea (Doxylamine/Pyridoxine) was first licensed for use in the UK in 2018[1].

Xonvea is a medication that has been specifically designed for treating nausea and vomiting in pregnancy (NVP) and is the only licensed option for those being treated within the UK. Xonvea has been prescribed globally for decades and used to treat an estimated 30,000,000+ women worldwide.

[1] MHRA July 2018 (Medicines and Healthcare products Regulatory Agency)

Despite being formally added to the RCOG Greentop Guideline[2] for treating NVP as a first line treatment option in February 2024, it remains a postcode lottery drug (i.e. inconsistent availability based on local formulary decisions).

The **Pregnancy Sickness Support - Xonvea Feedback** survey was conducted via Pregnancy Sickness Support in April 2025 to gather feedback from service users who have suffered with NVP since Xonvea was introduced to the UK in 2018.

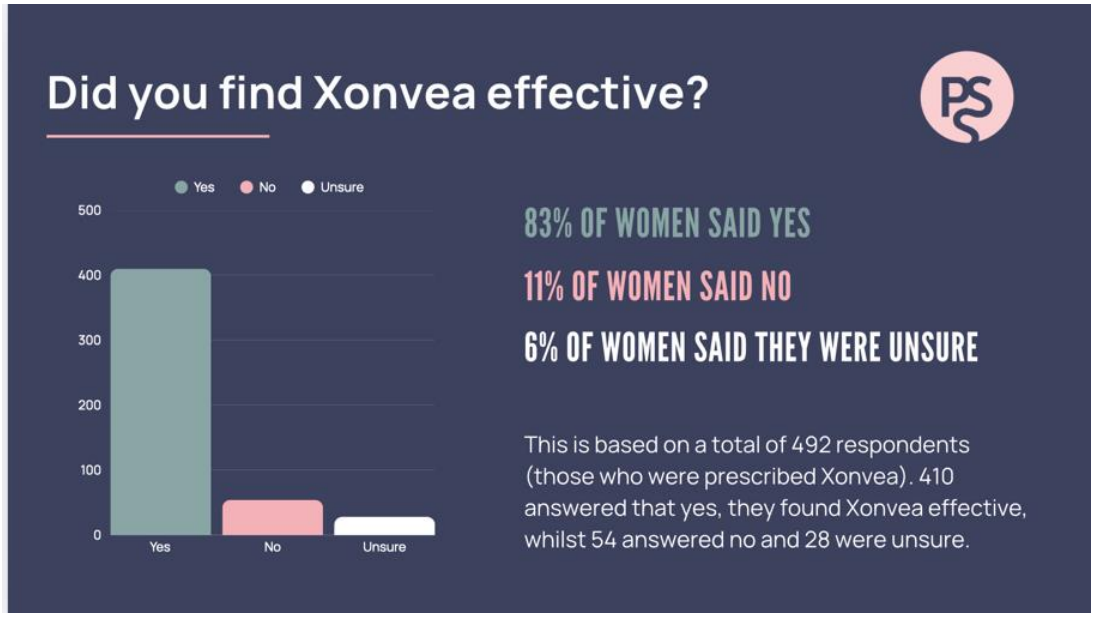
3. Survey questions and analysis

3.1 Were you given an opportunity to try Xonvea during your pregnancy?

Of the 749 respondents, 492 had been offered Xonvea and 257 had not. To strengthen the reliability of the findings and avoid a satisfaction bias, we actively encouraged participation from those who had not been offered the medication.

3.2 Did you find Xonvea effective

Chart 1.



[2] https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/the-management-of-nausea-and-vomiting-of-pregnancy-and-hyperemesis-gravidarum-green-top-guideline-no-69/

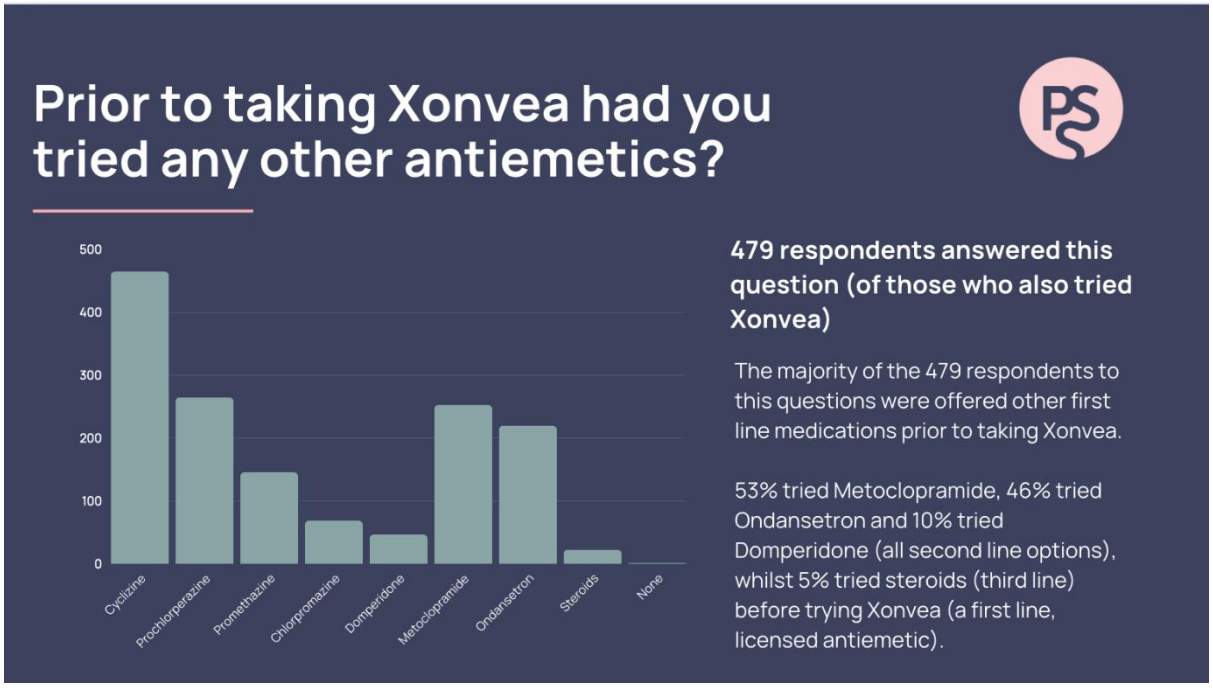
High perceived effectiveness: 83% effectiveness and supports an argument for earlier or more consistent access.

Only 11% found it ineffective: Relatively small proportion, suggesting the medication has a strong performance profile where used.

6% who were unsure: Further research needed. Where there mitigating factors—e.g. were they taking multiple medications at once or stopped too early?

3.3 Prior to taking Xonvea had you tried any other antiemetics?

Chart 2.



Xonvea is a first-line treatment, yet many respondents were prescribed **second- or even third-line drugs first**.

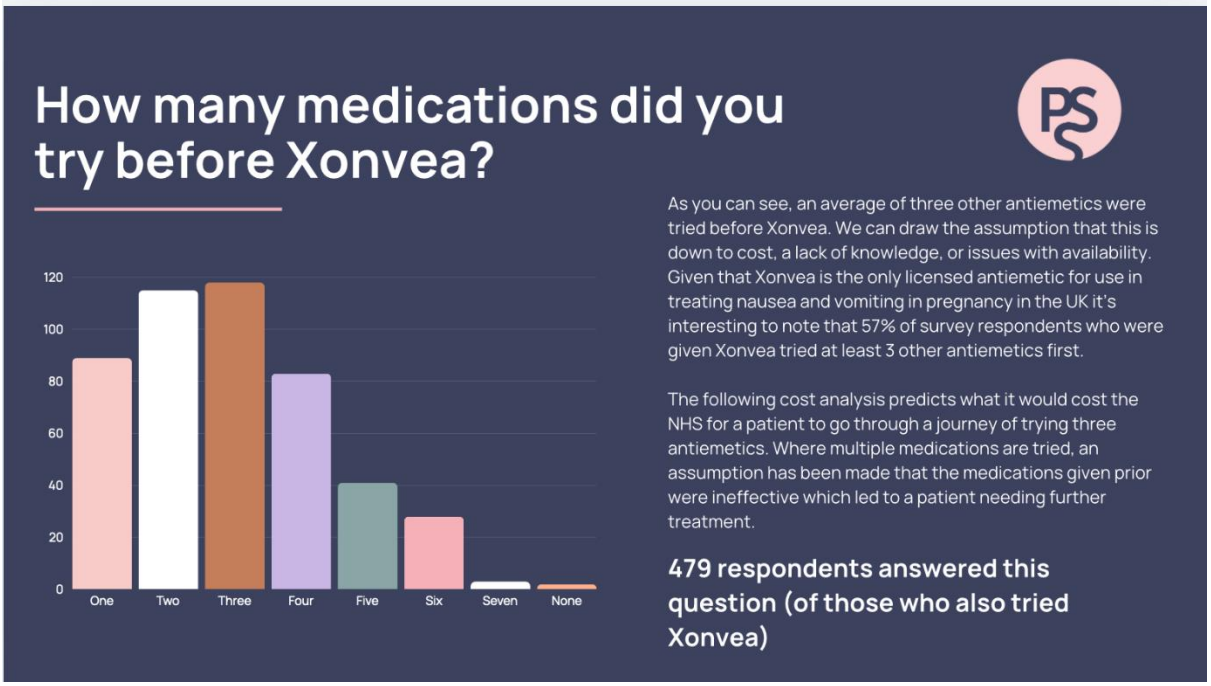
Over half (53%) were given Metoclopramide (a second line), just under **half (46% tried Ondansetron)** and **5% were prescribed steroids (third line)** *before* trying Xonvea.

This suggests a widespread lack of awareness, adherence, or access related to current RCOG guidelines and Xonvea's status as the *only licensed antiemetic* for pregnancy in the UK.

This builds a strong case for better GP education, clearer formulary guidance, and potentially a patient-facing resource so sufferers can advocate for appropriate treatment sooner.

3.4 How many medications did you try before Xonvea?

Chart 3.



57% tried *three or more* antiemetics before accessing Xonvea, which is meant to be a first-line treatment.
→ This reinforces the inefficiency of current prescribing practices.

The average of three other medications being tried *before* Xonvea paints a clear picture of:

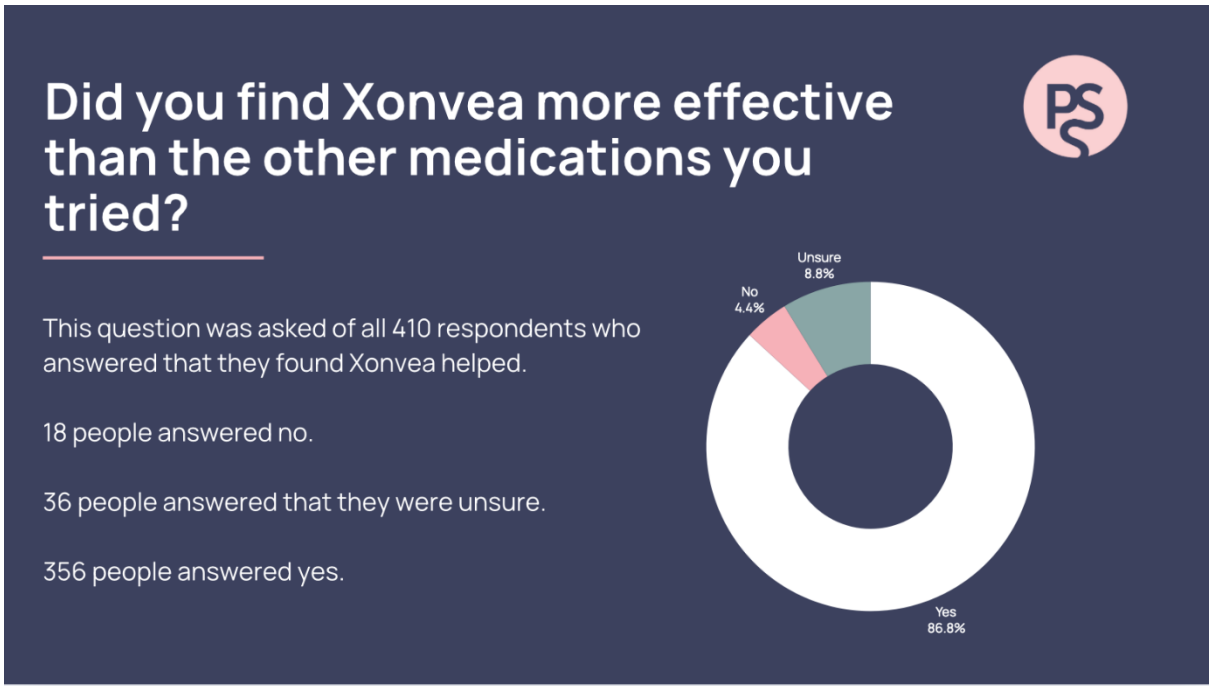
- Clinical uncertainty or lack of confidence in prescribing Xonvea.
- Possible cost-avoidance behaviour, which is short-sighted.
- Access issues (formulary, local policy, or stock).

Cost assumption is logical: If a patient is moving through multiple medications, it stands to reason the previous ones were ineffective leading to repeat consultations, prolonged illness, and potentially hospital care.

This directly supports the economic argument for prescribing Xonvea earlier—especially when paired with the high effectiveness already outlined.

3.5 Did you find Xonvea more effective than the other medications you tried?

Chart 4.



87% (356/410) of those who found Xonvea effective said it was *more* effective than other medications they had tried. That's a powerful message in favour of considering Xonvea earlier in treatment plans.

The small number who said **"no" or "unsure"** still suggests a favourable comparison to other antiemetics.

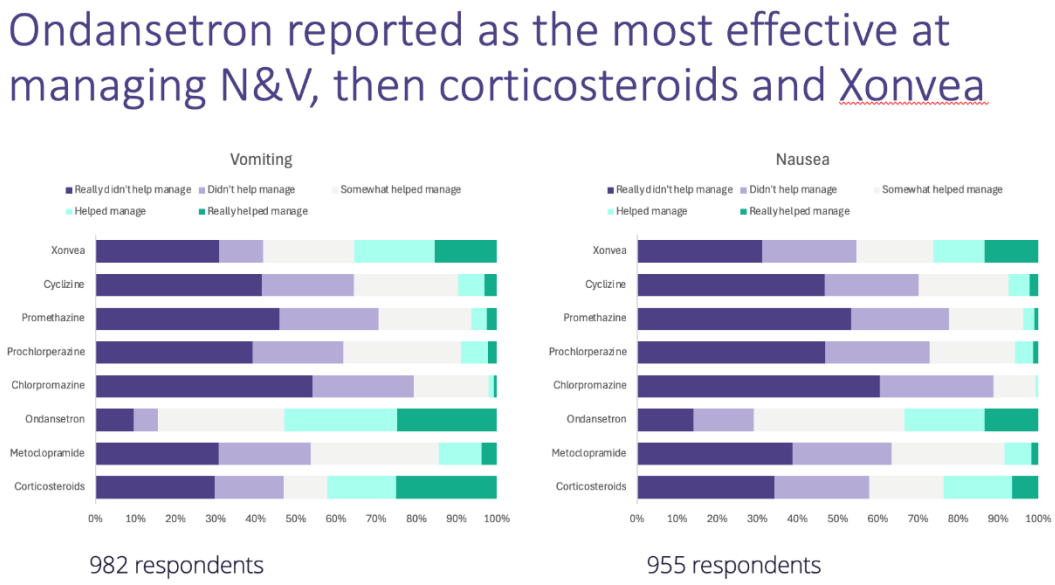
3.6 Efficacy of other medications – an analysis

In 2024 Pregnancy Sickness Support launched their survey "Insights on the treatment and care of Hyperemesis Gravidarum (HG) in the UK - A Survey conducted by Pregnancy Sickness Support".

It consisted of 45 questions and was advertised via a link to complete on SurveyMonkey and distributed via email list to subscribers and on main social media platforms: Instagram, Facebook, LinkedIn and Twitter.

1370 people responded.

Chart 6.



Respondents were asked:

In this pregnancy, please rank the following medications based on their effectiveness in managing your VOMITING.

In this pregnancy, please rank the following medications based on their effectiveness in managing your NAUSEA.

We submit this data to demonstrate efficacy rates amongst all current medications prescribed for Hyperemesis Gravidarum (HG) and Nausea and Vomiting in Pregnancy (NVP).

As seen above the second-line medication, Ondansetron, was ranked the most effective across both symptoms, then third-line medications corticosteroids and then Xonvea, the only first-line antiemetic.

This corresponds with the 83% efficacy rate established from the **Pregnancy Sickness Support - Xonvea Feedback** survey.

Other efficacy resources:

1. Ondansetron

- **Efficacy:** A systematic review and meta-analysis indicated that ondansetron had higher efficacy in terminating nausea and vomiting than metoclopramide (89.6% vs. 77.4%, respectively; p=0.013). [3]

2. Metoclopramide [4]

- **Efficacy:** Metoclopramide is considered safe and effective for NVP but is generally recommended as a second-line therapy due to the risk of extrapyramidal side effects.

3. Other First line antiemetics

- **Efficacy:** The NICE guideline NG201 (August 2021)[5] provides a comprehensive comparison of pharmacological treatments for nausea and vomiting in pregnancy (NVP). Notably, it highlights that several commonly prescribed first-line medications lack robust evidence supporting their efficacy:

Cyclizine: No randomized controlled trial (RCT) evidence exists for its use in NVP. Older, low-quality studies have assessed a combination of cyclizine with pyridoxine, but this combination is not available in the UK.

Prochlorperazine: There is no RCT evidence supporting its efficacy in treating NVP.

[3] https://pmc.ncbi.nlm.nih.gov/articles/PMC9249360

[4] https://pmc.ncbi.nlm.nih.gov/articles/PMC7037589/#:~:text=Also%2C%20metoclopramide%20with%20pyridoxine%20was,2007).

[5] https://www.nice.org.uk/guidance/ng201/resources/table-1-advantages-and-disadvantages-of-different-pharmacological-treatments-for-nausea-and-vomiting-in-pregnancy-pdf-9204302125

Chlorpromazine: Similarly, no RCT evidence is available for its use in NVP.

Promethazine: Limited, moderate-quality evidence suggests benefits on vomiting frequency when combined with pyridoxine, a combination not available in the UK.

In contrast, **doxylamine/pyridoxine** (Xonvea) is the only medication specifically licensed in the UK for NVP. While the evidence in this guideline is of low to very low quality, it does show symptom relief compared with placebo and this guideline was produced before the findings from Pregnancy Sickness Support from both surveys detailed in this report.

This discrepancy is particularly noteworthy given that some Integrated Care Boards (ICBs) express reservations about prescribing Xonvea due to perceived insufficient efficacy data yet continue to prescribe other medications with even less supporting evidence.

For a detailed comparison, refer to footnote 5.

3.7 ICB Data –Were you given an opportunity to try Xonvea during your pregnancy?

Post code data collected from the Survey corresponding to ICB's and respondents' location.

NB: Respondents were asked to provide their current county and postcode, but the survey did not specify that this should relate to where they lived during the pregnancy or pregnancies they were reflecting on. As a result, some location data may reflect where respondents live now, rather than where they were living at the time of their experience. While this may affect the geographical accuracy of some responses, it does not impact the overall findings or themes of the survey.

Chart 6.

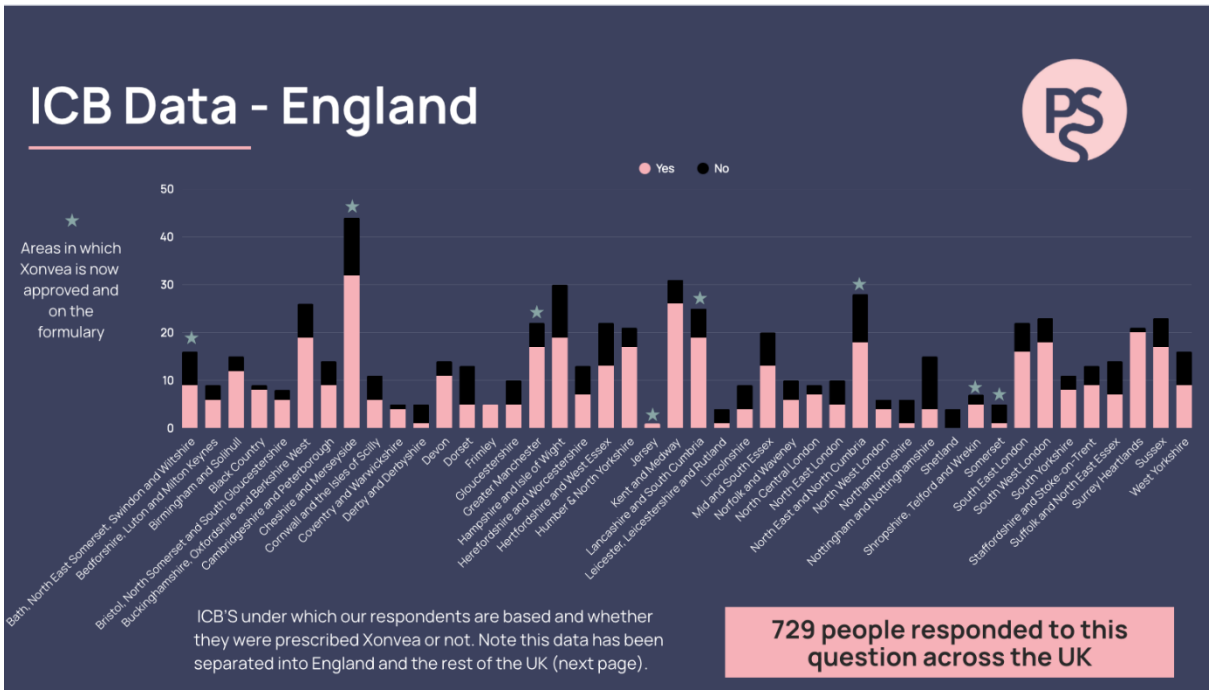
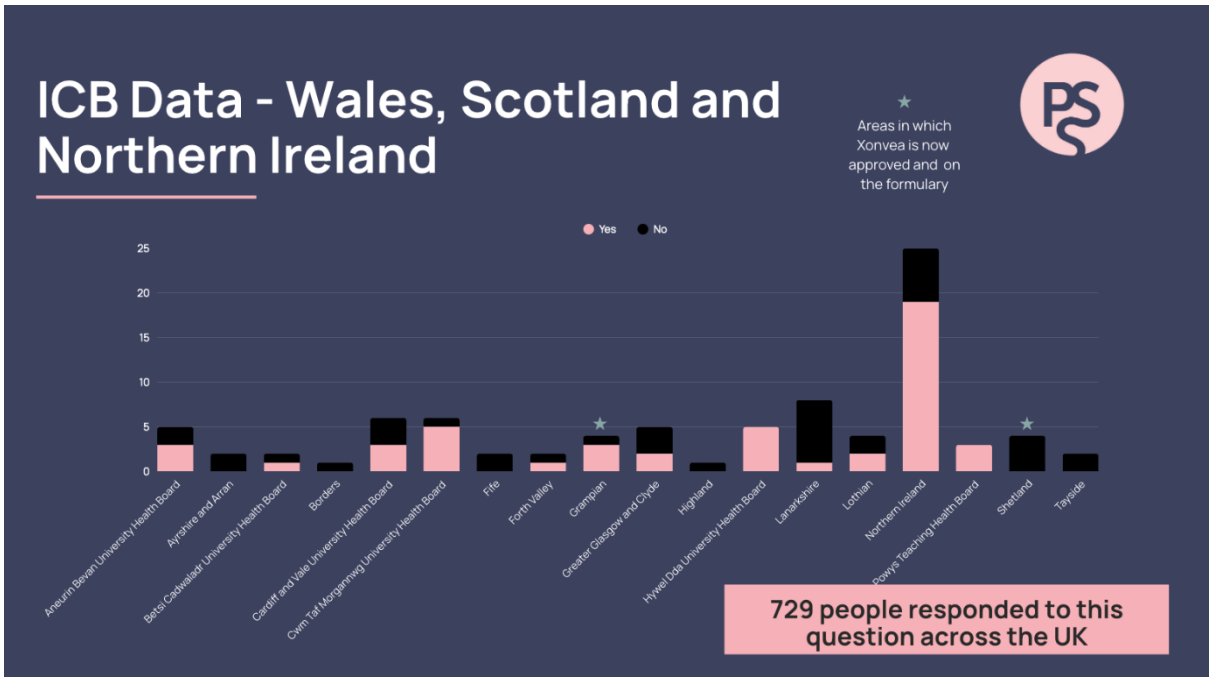


Chart 7.



In many of the ICB's mentioned in the charts 6&7, we know that Xonvea is not available on the formulary - therefore we can conclude that Xonvea is being prescribed 'off-formulary'. Whilst this is positive, it can also be difficult for NVP sufferers who are perhaps prescribed it by one healthcare professional, only to then have it withdrawn by another. This is an incredibly common situation that we hear about on the helpline at PSS.

Equally there are areas, such as Greater Manchester, in which we know that Xonvea is on the formulary, but not all sufferers were given the opportunity to try it. Further analysis is needed to understand why they didn't try it (e.g. it may have been available if they asked for it - but it just wasn't offered)

NB: This survey did not ask respondents in what year they were pregnant. Further research will need to be conducted to ascertain when they were pregnant to compare with the introduction of Xonvea into the RCOG Greentop Guidelines on Nausea & Vomiting in Pregnancy (NVP) and Hyperemesis Gravidarum (HG) No.69. This data would also enable us to compare with when Xonvea was added to specific ICB's formulary.

The areas in which we know Xonvea to be readily available are as follows: Bath and Northeast Somerset, Cheshire and Merseyside, Greater Manchester, Lancashire and South Cumbria, Northeast and North Cumbria, Shropshire, Telford and Wrekin, Somerset, Shetland, Grampian and Jersey - so further analysis could be done with these locations.

Quick Analysis - Inconsistency of access and prescribing:

- Even in areas *with* formulary approval, Xonvea isn't always offered.
- In areas *without* formulary approval, it's sometimes prescribed off-formulary—but not consistently or sustainably (e.g. it's later withdrawn).

Real-world impact on patients:

- The issue of it being prescribed and then withdrawn is emotionally and physically damaging.

Potential area for further research:

- Encouraging more location-specific, time-specific research could be a recommendation going forward.

3.8 Cost analysis

Based on drug cost information[6], estimations regarding NHS costs are detailed in the next two tables.

The average number of medications that sufferers were asked to try was three, and therefore combination scenarios have been created based on three of the most prescribed first line medications **(Cyclizine, Promethazine and Prochlorperazine)** along with two of the most prescribed second line medications **(Metoclopramide and Ondansetron).**

Figures are based on one week's supply of each medication at the maximum dose. For Xonvea the cost is related to its suggested dose as documented in the BNF.

An estimation is made that for each new prescription a GP appointment would be needed (these medications need to be prescribed by a doctor), and the cost for that has been taken from the Kings Fund.[7]

Further costs for consideration are A&E/UTC or EPU visits, hospital admissions and the cost of calling out an ambulance - all of which are scenarios we hear of regularly via the helpline at Pregnancy Sickness Support.

[6] https://www.nhsbsa.nhs.uk/nhs-prescription-services

[7] https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/key-facts-figures-nhs

Table 1.

Medication	Cost of one box of medication to the NHS	Cost of 1 week's supply (on max suggested dosage)
Cyclizine	£3.91	£0.74
Promethazine	£13.44	£5.04
Prochlorperazine 5mg	£1.81	£1.36
Prochlorperazine Buccal	£23.33	£8.53
Metoclopramide	£0.91	£0.68
Ondansetron (4mg)	£4.95	£10.40
Ondansetron (8mg)	£4.19	£5.87
Xonvea	£28.50	£31.35

Data from The Kings Fund

GP Visit - £56 per appointment

Lowest level of investigation and treatment (I&T) at an Urgent Treatment Centre - £91 per I&T

A&E department with more complex I&T - £137 - £445.

3.9 Cost Analysis – Medication scenarios

Table 2.

Cyclizine, Promethazine and Prochlorperazine (5mg) 3 GP appointments Total = £175.14	Cyclizine, Promethazine and Ondansetron (4mg) 3 GP appointments Total = £184.18	Promethazine, Prochlorperazine (5mg) and Ondansetron (4mg) 3 GP appointments Total = £184.80	Cyclizine, Prochlorperazine (buccal) and Ondansetron (4mg) 3 GP appointments Total = £187.67	Cyclizine, Metoclopramide and Ondansetron (4mg) 3 GP appointments Total = £179.82
Cyclizine, Promethazine and Metoclopramide 3 GP appointments Total = £174.46	Cyclizine, Prochlorperazine (5mg) and Ondansetron (4mg) 3 GP appointments Total = £179.76	Promethazine, Prochlorperazine (buccal) and Ondansetron (4mg) 3 GP appointments Total = £191.97	Cyclizine, Prochlorperazine (buccal) and Ondansetron (8mg) 3 GP appointments Total = £183.14	Promethazine, Prochlorperazine (5mg) and Ondansetron (8mg) 3 GP appointments Total = £180.27
Cyclizine, Prochlorperazine (5mg) and Metoclopramide 3 GP appointments Total = £170.78	Promethazine and Prochlorperazine (5mg) and Metoclopramide 3 GP appointments Total = £174.40	Cyclizine, Prochlorperazine (5mg) and Ondansetron (8mg) 3 GP appointments Total = 175.97	Cyclizine, Promethazine and Ondansetron (8mg) 3 GP appointments Total = £184.18	Promethazine, Prochlorperazine (buccal) and Ondansetron (8mg) 3 GP appointments Total = £187.44
Cyclizine, Prochlorperazine (buccal) and Metoclopramide 3 GP appointments Total = £177.95	Promethazine and Prochlorperazine (buccal) and Metoclopramide 3 GP appointments Total = £182.25	Cyclizine, Promethazine and Prochlorperazine (buccal) 3 GP appointments Total = £182.31	Cyclizine, Metoclopramide and Ondansetron (8mg) 3 GP appointments Total = £175.29	Promethazine, Ondansetron (4mg) and Metoclopramide 3 GP appointments Total = £184.12

NB: This is not an exhaustive list of all options, but illustrates a cost of usual and potential combinations

The average cost of 3 antiemetic medications at one week's supply, along with 3 GP appointments is £180.80 per sufferer.

NB: This figure does not factor in A&E visits, possible hospital admissions, IV fluid treatment and mental health support.

Average cost of a three-week supply of Xonvea, with 1 GP appointment is £138.65.

NB: Based on the recommended dose as found in the BNF[8] of a starting dose of 2 tablets at night for the first 2 days, then an extra tablet in the morning for 2 days and an extra tablet in the afternoon for 2 days. Continuing with the maximum dose of 4 tablets a day.

Analysis - While Xonvea may appear more expensive than some other medications used to treat nausea and vomiting in pregnancy, this comparison ignores the broader picture. When factoring in real-world outcomes and the overall patient journey, the value of Xonvea becomes much clearer.

For example, one respondent shared:
"It stopped the vomiting, although not the nausea, and kept me out of hospital. I didn't have Xonvea for my 2015 pregnancy and was hospitalised 7 times with dehydration."
Seven hospital admissions for fluids far outweigh the cost of a few months of Xonvea.

Another wrote:
"I was able to function effectively throughout my pregnancy—unlike my first pregnancy, where I was off work for 10 weeks and unable to function at all."
Ten weeks of absence, distress, and impaired daily life carries both societal and personal costs—financially, emotionally, and in terms of mental health.

And another:
"In my first pregnancy, I didn't have Xonvea. I was being sick up to 50 times a day, off work, in and out of hospital for fluids. I had no quality of life. Second pregnancy, I've had

[8] https://bnf.nice.org.uk/drugs/doxylamine-with-pyridoxine/

Xonvea—I'm still nauseous and struggling, but no hospital admissions and it's so much better."

These comments are not isolated. They reflect the kind of feedback we hear daily at Pregnancy Sickness Support. When prescribed appropriately, we believe Xonvea has the potential not only to improve patient outcomes but to save the NHS money—by reducing hospital admissions, repeat appointments, and prolonged suffering.

Further health economics research would be hugely beneficial to complete the picture of the cost to society.

In total **we had 354 positive responses of how Xonvea** helped respondents and 53 responses from respondents who did not find Xonvea effective.

For balance here are three comments from those who did not find Xonvea effective.

"HG was too severe".

"It was only effective when combined with metoclopramide and ondansetron and then steroids. Last pregnancy it was effective on its own. This one had other ideas!"

"Only worked for a small window then felt and was sick again".

4.0 How did they request Xonvea?

Chart 8.

Over 40% of respondents had to advocate for themselves to access Xonvea. That's a major indicator of:

- Gaps in healthcare professional awareness or confidence in prescribing it.
- A system where access is skewed towards those who are informed, assertive, and able to self-advocate—raising **equity concerns**.

Most people are being prescribed Xonvea by a GP or hospital doctor, which shows that it is being accessed *within both primary and secondary care*—but not necessarily in a timely or preventive way.

If prescribed by a hospital doctor, it likely followed a crisis point—**hospital admission**—rather than proactive management.

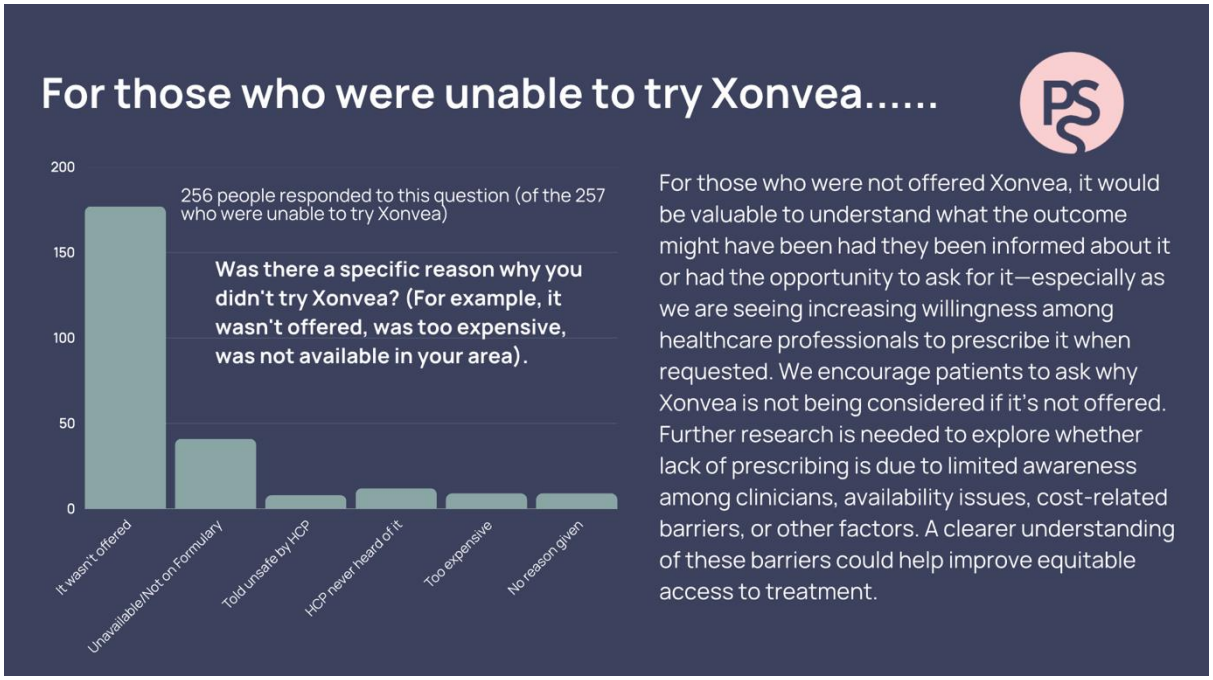
This strongly supports a call for:

- **Improved clinician education** on the RCOG guidelines and Xonvea's status.

- **Clearer prescribing guidance** across regions
- Possibly **patient-facing materials** to help sufferers know what to ask for if they're not being offered licensed, first-line treatment.
- **Earlier intervention in primary care** could prevent escalation to hospital care.
- **Standardising GP knowledge and prescribing confidence** is critical—especially as they're often the first point of contact.

4.1 Those who responded 'No' to being offered Xonvea

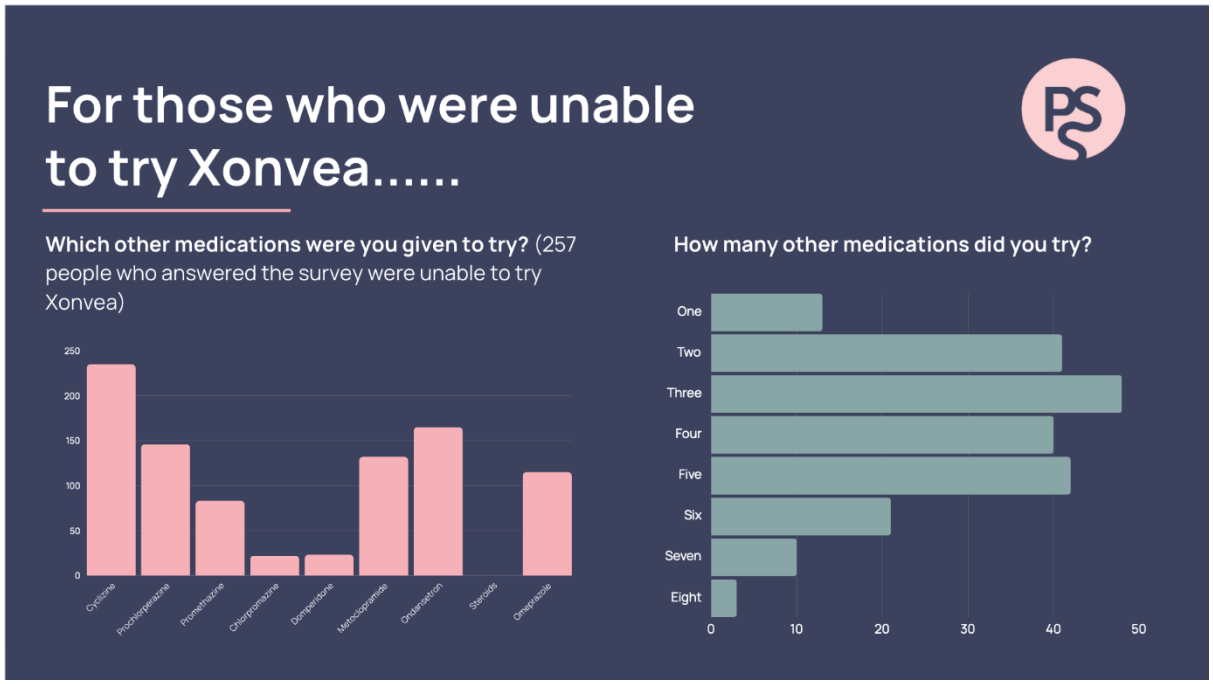
Chart 9.



This reinforces our earlier call for:

- **Further research into prescribing behaviour and system-level barriers**
- **Consistent messaging to patients** so they can advocate for themselves if necessary
- **Clear accountability in commissioning decisions** around formularies.

4.2 What and how many other medications where you offered?



This data reflects that of the 257 people who weren't given Xonvea (a first line, licensed antiemetic) to try, 165 were given Ondansetron, 132 Metoclopramide and 23 Domperidone (all second line antiemetics).

It also shows that 64% of respondents in this category were given three or more antiemetics to try - we can conclude from this that the medications they tried were ineffective. This is likely to have resulted in multiple trips to their GP, possible hospital admissions, and long periods of suffering - all of which is detrimental to the physical and mental health of the sufferer, and of cost implication to the NHS.

64% of patients denied Xonvea tried three or more other medications

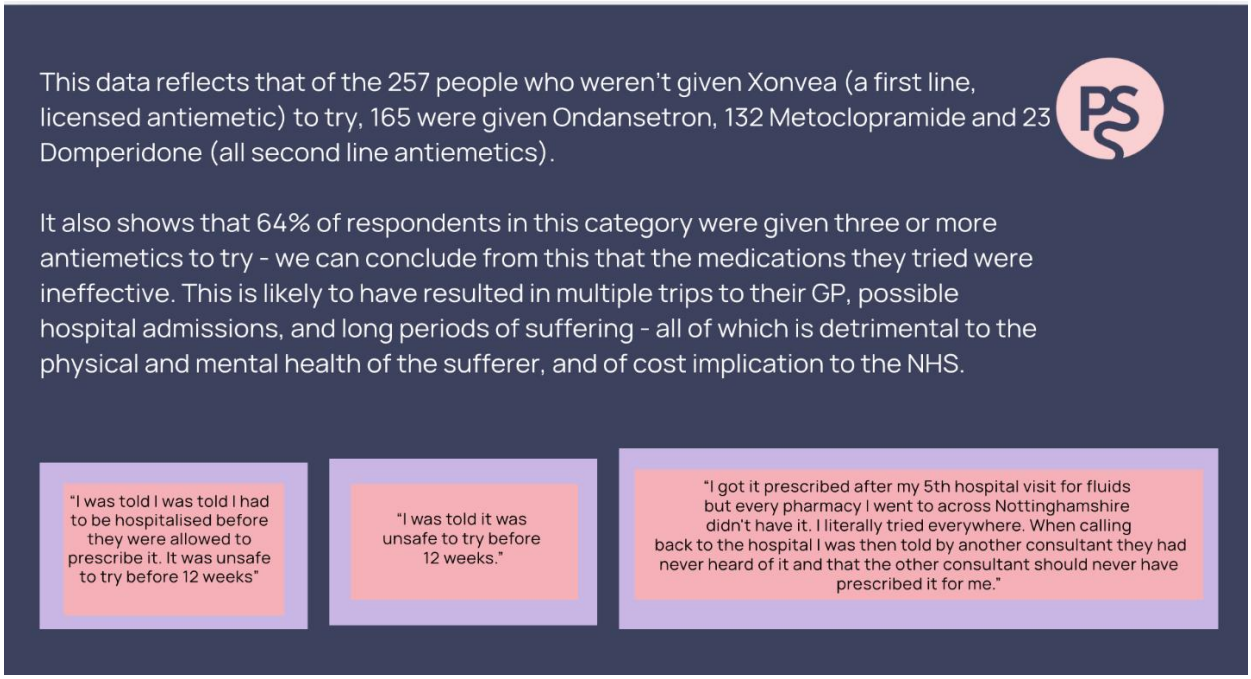
→ These were primarily *second-line* drugs, indicating a disregard for Xonvea's first-line, licensed status. This makes a strong case that **many patients are going through ineffective treatment cycles** while a recommended option is withheld.

Implied suffering and NHS cost

→ The logical consequence of these ineffective treatment cycles:

- Multiple GP visits
- Emergency care and admissions
- Increased risk of physical and mental health deterioration
- **Inefficient use of NHS resources**

Crucially, these were preventable: These individuals *never even had the chance* to try the one medication designed specifically for NVP.



5. Conclusions

Most respondents (84%) who were able to try Xonvea reported that it was effective in treating their symptoms. Of those, 83% said it was more effective than other antiemetics they had previously tried. This suggests that, where appropriate, Xonvea can be a highly effective treatment option.

From a cost perspective, prescribing Xonvea earlier may offer better value for the NHS than cycling through multiple less effective medications. The knock-on effects of delayed treatment—such as repeat GP appointments, emergency care, and hospital admissions—represent not only increased costs but also avoidable suffering. While Xonvea is not effective for everyone, the financial risk of trialling it is low: a single box costs £28.50 and can be stopped quickly if ineffective.

Despite being the only medication licensed in the UK specifically for NVP and formally listed in the 2024 RCOG guidelines as a first-line treatment, 57% of respondents who accessed Xonvea had already tried at least three other medications first. Many were even prescribed second- or third-line drugs such as Ondansetron, Metoclopramide, and steroids before being offered Xonvea. These findings raise questions about whether cost concerns, lack of clinician awareness, or formulary restrictions are driving inappropriate sequencing of treatment.

Notably, 33% of respondents who accessed Xonvea did so only after seeing a hospital doctor—suggesting that some had to reach a point of hospital admission before being offered the drug. This reactive approach increases the burden on both patients and NHS services.

Xonvea is also being prescribed in some areas where it is not included on local formularies, demonstrating that some clinicians are willing to prescribe it off-formulary when necessary. However, this leads to inconsistent access and reports of prescriptions being withdrawn once reviewed by another healthcare professional. These inconsistencies cause confusion and distress for sufferers, many of whom turn to the Pregnancy Sickness Support helpline for advice after being told they can no longer access a treatment that helped them.

6. What Pregnancy Sickness Support are calling for

1. **Equitable access to Xonvea across all UK regions**
Every Integrated Care Board (ICB) should add Xonvea to its formulary. Women should not be denied access to the only licensed antiemetic for NVP based on postcode.

2. **Earlier prescribing of Xonvea in line with national guidelines**
Xonvea should be considered as a first-line treatment, as outlined in the 2024 RCOG Green-top Guideline. Prescribing it only after other medications have failed contradicts best practice and causes avoidable harm.

3. **Improved GP and hospital clinician awareness and confidence**
Over 40% of those who accessed Xonvea had to request it themselves. Clinicians need support and training to prescribe appropriately, understand the dosing, and know when it is indicated.

4. **Clearer local prescribing protocols and formulary alignment**

Patients should not face the distress of being prescribed a medication, finding it effective, then having it withdrawn. Trust in care is undermined when policies are inconsistent.

5. **Further research into prescribing barriers and inequalities**

There is a need to understand why women are not being offered Xonvea—is it cost? Lack of awareness? Commissioning restrictions? Data is needed to close this gap once on all formularies.

Recognition of the wider cost of untreated NVP and HG

Decisions about prescribing must account for the physical, mental, social, and financial costs of delayed or ineffective treatment—not just the price of a single box of medication.

7. Contacts

For more information and to receive the charts and slides used in this report, please contact:

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