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MIDWIFERY CARE FOR A PRIMIGRAVIDA WITH HYPEREMESIS GRAVIDARUM AND PICKY EATING TENDENCIES USING MENU VARIATIONS AND WARM GINGER

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ABSTRACT

Hyperemesis gravidarum (HEG) is a serious pregnancy-related issue marked by severe nausea and vomiting, which can cause dehydration from not drinking enough fluids. If not handled appropriately, HEG can lead to problems such as intrauterine growth restriction (IUGR), liver issues, and vomiting of blood. This report focuses on cases involving pregnant individuals with HEG who experienced improvements and a decrease in selective eating habits. This case report was created by gathering data and observing patients at the Ngrambe Ngawi Community Health Center in Ngawi Regency, during the period from February to March 2026. The procedure encompassed stages of assessment, management, and evaluation. An evaluation of Mrs. K, a 34-year-old woman in her first pregnancy (G1P0A0) during the first trimester, revealed that she had been experiencing nausea and vomiting more than three times a day since the sixth week. She showed a reduced appetite and selective food preferences. A check-up indicated that she had lost weight. The management plan adhered to standard protocols for pregnant individuals with HEG, which included nutritional advice, warm ginger tea, and vitamin B6 supplements. The mother's health showed improvement, as evidenced by less nausea and vomiting, weight gain from 42. 5 kg to 43. 5 kg, an increase in mid-upper arm circumference (MUAC) from 22. 5 cm to 23. 5 cm, an enhanced appetite, and a broader range of food choices. Midwifery support for expectant mothers dealing with hyperemesis gravidarum and selective eating habits was successful in alleviating nausea and vomiting, boosting appetite and food variety, and improving nutritional health, evident through weight gain and increased MUAC measurements. Timely identification, nutritional support, and consistent monitoring of dietary well-being are crucial for pregnant women facing HEG and selective eating to avoid complications.

Keywords: keyword hyperemesis gravidarum, picky eater, warm ginger, nutritional management

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INTRODUCTION

Pregnancy involves various physiological adjustments marked by changes in hormones, metabolism, and psychological states that can impact both the mother and fetus(1). A common issue faced in the early stages of pregnancy is nausea and vomiting; however, for some women, these symptoms escalate to hyperemesis gravidarum (HEG), a serious condition that necessitates specialized care. HEG is defined by intense and ongoing nausea and vomiting that disrupt fluid balance, electrolyte levels, and the mother's nutritional health(2).

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Women experiencing their first pregnancy (primigravida) are at a greater risk for developing HEG compared to those who have been pregnant before (multigravida), as the hormonal and physiological adjustments in a first pregnancy are often not fully optimized. Symptoms generally manifest between 6 and 12 weeks of pregnancy and can continue into the second trimester in certain instances[3]. This condition impacts not only the mother's comfort but can also lead to severe complications such as dehydration, liver issues, kidney problems, internal bleeding from prolonged vomiting, and restricted fetal growth[4].

Worldwide, the occurrence of HEG is reported to be between 0. 3% and 2% of all pregnancies, translating to about 3 to 20 cases per 1,000 pregnancies[5]. In Indonesia, studies indicate that HEG occurs in 1% to 3% of pregnancies (Arisdiani and Hastuti, 2020). Data from East Java indicated that HEG comprised around 10% to 15% of cases among 183,645 pregnant women documented in 2016[4]. In Ngrambe District, Ngawi Regency, the rate of HEG was noted to be approximately 10% to 15% of all pregnancies between 2024 and 2025[6]. Findings from a standalone midwifery clinic in Wakah Village revealed that out of 60 pregnant women in 2025, nearly 8. 3% reported experiencing HEG. These statistics highlight that HEG continues to be a significant concern for maternal health within primary healthcare frameworks.

Beyond medical issues, HEG is often associated with drastic shifts in dietary preferences. Pregnant individuals may find they have strong dislikes for many usual foods and can only manage a small range of acceptable options. Clinically, this resembles fussy eating habits, defined by a marked selectivity regarding food and a tendency to reject most food options[7]. These dietary limitations can compound energy and nutrient shortages during pregnancy.

Earlier research has indicated that HEG is linked to maternal nutritional health, the number of pregnancies (parity), weeks of gestation, and poor dietary habits, suggesting a need for heightened focus during prenatal care[8]. Other investigations have revealed that inadequate food intake while pregnant raises the likelihood of nutritional deficiencies and complications during pregnancy[9]. However, most Indonesian research has concentrated on picky eating patterns in children, which are found to affect approximately 33. 6% to 60%, whereas studies examining picky eating issues in pregnant individuals are still very scarce[10]. This gap reveals a significant research need, particularly in documenting midwifery care tailored for pregnant women experiencing HEG along with picky eating tendencies.

HEG, along with a tendency to be a picky eater, presents a notably intricate situation as dietary limitations may have been in place prior to pregnancy. The mix of ongoing vomiting caused by HEG and limited food consumption can result in malnutrition, weight reduction, deficiencies in essential nutrients, and challenges in following typical dietary interventions. If these issues are not handled properly, they could raise the chances of premature birth, low birth weight, and negative effects on fetal health[11]. Thus, prompt identification, nutritional advice, and consistent monitoring of nutrition are crucial aspects of midwifery care for pregnancies that are considered high risk.

Considering these points, this research seeks to detail midwifery care provided to a 34 year old first-time expectant mother experiencing hyperemesis gravidarum along with a tendency for selective eating at the Ngrambe Public Health Center in Ngawi. This case report aims to offer a thorough depiction of the assessment, management, and evaluation processes involved in midwifery care under such circumstances. The unique aspect of this study is its emphasis on HEG in conjunction with picky eating tendencies in a first-time mother, a subject that has not been extensively covered in Indonesian midwifery research. The results are anticipated to enhance evidence-based practices in midwifery and reinforce the significance of midwives in averting complications for mothers and newborns in pregnancies classified as high risk.

Background

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Hyperemesis gravidarum (HEG) is a severe form of nausea and vomiting in pregnancy that can cause decreased oral intake, weight loss, dehydration, and impaired nutritional status during the first trimester. The condition may become more difficult to manage when it occurs in pregnant women with a tendency toward picky eating, because selective food acceptance can further limit dietary diversity and increase the risk of inadequate nutrient intake.

This case involved a 34 year old primigravida at the Ngrambe Primary Health Center, Ngawi Regency, who experienced persistent nausea and vomiting accompanied by selective eating behavior since early pregnancy. The combination of HEG and picky eating resulted in reduced food intake, weight loss, and a decline in mid-upper arm circumference, indicating early nutritional compromise. This case was selected because it represents a clinically important condition in primary maternal care and illustrates the need for individualized nutritional counseling and comprehensive midwifery management to improve maternal nutritional status and support fetal well-being during pregnancy.

Goal

This case report focused on detailing the clinical signs, dietary issues, midwifery care, and maternal results of a 34-year-old first-time mother dealing with hyperemesis gravidarum and having a preference for selective eating, who received prenatal care at the Ngrambe Primary Health Center in Ngawi Regency. Additionally, the report sought to demonstrate how personalized nutritional advice and thorough midwifery support can enhance the nutritional health of the mother and aid her well-being throughout pregnancy.

METHODS

This research utilized a case report methodology, which seeks to thoroughly illustrate the clinical situation, treatment, and outcomes within an actual healthcare environment. The case report method was deemed fitting as it offers an extensive account of a distinctive and clinically noteworthy instance that could aid in enhancing evidence-based midwifery practices[8]. The case took place at Ngrambe Primary Health Center in the Ngrambe District of Ngawi Regency, East Java, Indonesia, spanning from February to March 2026. The first evaluation was conducted on January 28, 2026, while the care process commenced on March 6, 2026, and persisted until the completion of the evaluation phase.

The focus of this report is a single patient, Mrs. K, a 34 year old first-time pregnant woman who received prenatal care at Ngrambe Primary Health Center. The selection of this patient was intentional due to her rare clinical condition of hyperemesis gravidarum combined with a preference for selective eating, a situation that is infrequently documented in Indonesian midwifery sources[12]. The established diagnosis was G1P0A0 corresponding to a first-trimester pregnancy complicated by hyperemesis gravidarum and a tendency toward selective eating[13]. Information was gathered via interviews, clinical assessments, physical examinations, obstetric checks, anthropometric evaluations, and analysis of medical records as per the national Midwifery care guidelines[14]. The care process incorporated monitoring of nausea and vomiting frequency, dietary intake, food likes and dislikes, weight fluctuations, dehydration signs, and the mother's nutritional status. The interventions included nutritional guidance, advice on consuming smaller, more frequent meals, recommending warm ginger water, overseeing nausea and vomiting, tracking body weight and nutrition, and cooperation in administering vitamin B6 following the maternal health service protocol[15].

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Periodic evaluations were conducted to measure clinical progress, which included a decrease in nausea and vomiting, enhancement of appetite, diversification in food choices, weight gain, and improvements in nutritional indicators, including mid-upper arm circumference (MUAC). The narrative account of the mother's condition pre- and post-intervention was provided to depict the reaction to the midwifery care received[16]. Throughout the case report process, ethical standards were upheld. Written informed consent was secured from the patient prior to data gathering and care delivery. The patient was informed about the objectives of the case report, the processes involved, anticipated benefits, and her entitlement to decline participation at any point. Confidentiality was preserved by anonymizing all personal details, and all data collected were exclusively used for scientific objectives, adhering to health research ethics and professional midwifery protocols (Ministry of Health of the Republic of Indonesia, 2020).

RESULTS

Subjective

The case was recognized on January 28, 2026, at the Ngrambe Primary Health Center's Maternal and Child Health Clinic in Ngawi Regency. The patient was a 34-year-old first-time pregnant woman who reported ongoing nausea and vomiting in the early stages of her pregnancy. Her last menstrual period occurred on November 19, 2025, which suggested that she was around 7 to 8 weeks pregnant. This was her initial pregnancy, following nearly five years of marriage. She mentioned that her nausea and vomiting began in the sixth week of the pregnancy, happening 4 to 5 times a day, often continuing throughout the day. These symptoms significantly disrupted her daily life, led to a decrease in food consumption, and resulted in noticeable weight loss over a relatively brief time.

The subjective evaluation indicated a clear inclination towards selective eating habits. The patient managed to eat only small amounts of rice paired with basic side dishes like tempeh, tofu, eggs, and chicken, while most vegetables and certain meats caused her to feel nauseous. Her fruit consumption was limited to a few favored options, including bananas, watermelon, and melon. Although she made efforts to eat three meals a day, her portions were very small and often left unfinished because she would feel nauseous either before or during her meals. These observations suggest that her nutritional issues were not solely due to frequent vomiting but were also worsened by a long-standing preference for certain foods, increasing the likelihood of insufficient energy and nutrient intake during her pregnancy.

Objective

The physical examination indicated that the patient was generally stable, fully alert, and hemodynamically sound. Her blood pressure was recorded at 110/66 mmHg, pulse rate at 79 beats per minute, respiratory rate at 20 breaths per minute, and body temperature at 36. 1°C. Although her vital signs were stable, early indicators of nutritional deficiency were apparent, such as slightly dry and chapped lips. Her weight before pregnancy was 45 kg, and at the initial examination, it was 42 kg, indicating a loss of 3 kg, which is over 5% of her pre-pregnancy weight. The measurement of mid-upper arm circumference (MUAC) was 22. 5 cm, implying that her nutritional status was nearing a level that poses a risk for chronic energy deficiency.

Laboratory tests showed a hemoglobin level of 12. 8 g/dL with no protein in the urine. Obstetric ultrasound confirmed the presence of a single viable intrauterine fetus with a heartbeat and a crown-rump length of 37. 99 mm. These results suggest that the main clinical issue was maternal hyperemesis gravidarum linked to a decline in nutritional status, while the fetus appeared to be in normal condition at the time of evaluation.

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Assessment

After considering both subjective and objective data, the midwifery diagnosis was determined as G1P00000, with a gestational age of 7-8 weeks, a single live intrauterine fetus, and a low-risk pregnancy alongside grade 1 hyperemesis gravidarum accompanied by a tendency for picky eating. The assessment highlighted two interconnected issues: severe nausea and vomiting that diminished food intake and an existing tendency towards selective eating that further limited dietary options. Therefore, the main areas of focus in care included managing the nausea and vomiting, preventing dehydration, enhancing nutritional intake, gradually diversifying the diet, and closely monitoring both maternal and fetal health.

Plan

Initial management involved extensive guidance related to hyperemesis gravidarum and clarification of the distinction between normal nausea during the first trimester and pathological vomiting that needs intervention. The patient was encouraged to eat smaller, more frequent meals, recognize tolerable foods, steer clear of triggers that caused nausea, drink more fluids, and try warm ginger water as part of supportive care. The counseling also included information on pregnancy warning signs, the necessity of sufficient rest, maintaining personal hygiene, and the importance of sticking to the treatment plan. Medication included a daily dose of Multiple Micronutrient Supplement (MMS), iron supplement every day, and a twice-daily intake of vitamin B6 based on maternal health service guidelines. Family members assisted in ensuring dietary compliance and keeping track of symptoms at home.

During the second follow-up appointment on March 6, 2026, the gestational age was roughly 15–16 weeks, and there were noticeable clinical improvements, even though symptoms had not fully disappeared. The frequency of nausea and vomiting had decreased to around three episodes daily, as assessed directly and via WhatsApp updates. The patient was managing household tasks but noted that she was getting tired more quickly. Vital signs recorded were blood pressure 113/83 mmHg, pulse 76 beats per minute, respiratory rate 22 breaths per minute, and temperature 36. 2°C. Her body weight had risen slightly to 42. 5 kg, indicating a 0. 5 kg increase since the first visit, and the fetal heart rate measured 156 beats per minute. Further counseling emphasized the gradual addition of vegetables, planning meals, and maintaining sufficient hydration, and it was decided to involve a physician and nutritionist due to previous weight loss issues.

The third follow-up appointment took place on March 13, 2026, when the patient was about 16–17 weeks pregnant, showing the most significant improvement. She noted that nausea happened only sporadically when exposed to strong smells, and she had stopped experiencing daily vomiting. Her appetite had greatly improved, allowing her to finish small meals with rice, tempeh, green beans, and chicken. Notably, she started incorporating small amounts of vegetables, signaling better food acceptance. A physical exam revealed her to be in good overall condition with moist lips, non-sunken eyes, and normal skin elasticity. Her vital signs included a blood pressure of 110/80 mmHg, a pulse of 80 beats per minute, a respiratory rate of 20 breaths per minute, and a temperature of 36. 5°C. Body weight increased to 43. 5 kg, a total gain of 1. 5 kg since the initial visit and 1. 0 kg since the last checkup, while the mid-upper arm circumference (MUAC) improved from 22. 5 cm to 23. 5 cm, indicating a positive change in maternal nutritional health.

In summary, thorough midwifery care centered on managing hyperemesis gravidarum and adjusting nutrition resulted in notable clinical advancements. Nausea and vomiting reduced from 4–5 times a day to only rare nausea triggered by smells, body weight rose from 42 kg to 43. 5 kg, MUAC increased from 22. 5 cm to 23. 5 cm, appetite was restored, and dietary variety

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expanded to include vegetables. There were no indications of dehydration or fetal distress during follow-up. These outcomes show that personalized nutritional guidance, supportive measures, continuous monitoring, and family involvement effectively enhanced maternal health and avoided further nutritional decline in a pregnant individual facing hyperemesis gravidarum and selective eating issues.

DISCUSSION

Subjective Findings

From the subjective analysis, the patient reported experiencing recurrent feelings of nausea and episodes of vomiting 4 to 5 times daily, especially in the morning and when exposed to food smells. She noted a reduced appetite, feelings of dizziness, and difficulties when trying to eat, and she confessed to having a distaste for vegetables and various protein foods even prior to her pregnancy. These observations suggest that the patient was suffering from hyperemesis gravidarum, as well as having a pre-existing inclination towards selective eating. This situation aligns with the findings by Fitriani in 2025 [(4)], who stated that women with slight hyperemesis gravidarum are likely to deal with ongoing nausea, vomiting, and a lack of appetite, although they can manage to eat small portions. The nausea triggered by certain odors in this case corroborates research by Hadya in 2024 [(17)], who found that women with hyperemesis gravidarum often have heightened sensitivity to smells during the first trimester. The patient's limited acceptance of food points to the possibility that her selective eating habits may have worsened the nutritional effects of hyperemesis gravidarum while pregnant.

The presence of both hyperemesis gravidarum and selective eating is of clinical significance as it greatly limits food variety during a time when nutritional needs are heightened. The World Health Organization[(18)] advises that maternal nutrition should aim for sufficient intake of vital nutrients, and foods that are avoided should be substituted with alternatives that hold similar nutritional benefits. Monica in 2026[(19)] further underlined that individuals who are picky eaters tend to better accept new foods if they are gradually introduced and share sensory traits with foods they already enjoy. In this instance, insisting the patient eat foods she found unappealing might have exacerbated her nausea and refusal to eat; thus, a gradual change in diet was deemed a more suitable strategy. These observations imply that the patient’s hyperemesis gravidarum was not just a natural reaction to pregnancy but was also worsened by her long-standing selective eating habits, thereby heightening her risk for nutritional deficiency.

Objective Findings

The objective evaluation revealed clear signs of nutritional decline. The patient's weight before pregnancy was recorded at 45 kg, which dropped to 42 kg, indicating a weight loss of roughly 6. 7%, surpassing the clinical threshold typically associated with hyperemesis gravidarum. This finding aligns with the description of HEG grade I provided by Ristiyana in2024[(20)], which details how ongoing nausea and vomiting can lead to fatigue, reduced food consumption, and notable weight loss. Additionally, the patient displayed symptoms indicative of early dehydration, such as slightly sunken eyes and dry lips. While severe dehydration was not evident, these signs suggest that repeated vomiting had started to disrupt fluid balance. Such alterations are clinically relevant, as untreated HEG can escalate into electrolyte imbalances, metabolic issues, and more serious complications for the mother.

Nutritional evaluation was additionally reinforced by physical measurement results. The patient’s mid-upper arm circumference (MUAC) dropped from 23. 5 cm to 22. 5 cm, suggesting a heightened risk of chronic energy deficiency. As noted by Wulandari in 2022 [(21)], extended periods of nausea and vomiting can significantly decrease food and fluid consumption, leading

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to observable reductions in both body weight and MUAC. Nevertheless, despite these dietary shifts, lab and ultrasound results remained encouraging, showing a hemoglobin level of 12. 8 g/dL, negative urine protein, and a single live fetus in utero with detectable cardiac activity. These findings imply that the nutritional issue had not escalated to significant anemia or fetal distress, underscoring the necessity of early identification and intervention to prevent the onset of more serious complications.

Assessment

Drawing from both subjective and objective observations, the patient was identified as G1P0A0, in the first trimester of pregnancy with grade I hyperemesis gravidarum and a propensity for selective eating. This determination aligns with the definition offered by Jansen in 2024[(22)], who characterized hyperemesis gravidarum as intense nausea and vomiting that disrupts everyday life and leads to insufficient caloric intake and substantial weight loss. The evaluation in this scenario was particularly crucial as it acknowledged two interrelated issues: pregnancy-associated hyperemesis and pre-existing picky eating habits. Ongoing vomiting diminished food intake, while selective eating further restricted the range of acceptable foods, thereby elevating the risk of nutritional deficiencies.

The decrease in both body weight and MUAC supports the conclusion that the mother's nutritional reserves had started to wane. The standards for midwifery care in Indonesia highlight the importance of evaluation in identifying not just the main obstetric diagnosis but also any nutritional and psychosocial challenges that could impact both maternal and fetal health. In this instance, identifying picky eating as a relevant clinical issue was vital because it directly influenced nutritional management strategies. Thus, the assessment rightly highlighted the necessity for extensive nutritional intervention along with symptom management, providing a solid foundation for personalized midwifery care focused on enhancing dietary intake and averting further nutritional decline.

Management

The management strategy concentrated on alleviating hyperemesis symptoms while also enhancing nutritional intake. The patient was educated on the physiological aspects of hyperemesis gravidarum, received dietary counseling, followed medical recommendations for medication, and was subject to regular follow-up assessments. Dietary advice stressed the importance of consuming small, frequent meals, steering clear of foods that induced nausea, progressively introducing tolerated vegetables, ensuring proper hydration, and enjoying warm ginger beverages. These guidelines are corroborated by Ristiyana in 2024[(20),] who indicated that small, frequent meals and the elimination of greasy, spicy, and strongly flavored foods can mitigate nausea and vomiting in women experiencing HEG.

The patient also received vitamin B6, treatment for nausea, various micronutrient supplements, and iron supplements based on medical needs. During follow-up visits, a noticeable improvement in clinical condition was noted. By the third appointment, the patient only felt nausea with strong smells, vomiting significantly lessened, appetite was better, and the patient could eat a small amount of vegetables. Objective signs of recovery included a 1 kg weight increase and normal hydration indicators, such as moist lips and good skin elasticity. These observations show that the approach combining nutritional guidance, gradual changes in diet, symptom relief, and medication was successful in enhancing both clinical symptoms and nutritional health. The findings also imply that effective nutritional recovery can be accomplished through tailored and gradual changes in behavior, even in cases of ongoing selective eating habits.

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CONCLUSION

This case study illustrates that a 34-year-old first-time mother at the Ngrambe Primary Health Center encountered grade 1 hyperemesis gravidarum alongside a propensity for selective eating in her first trimester. The patient reported experiencing nausea and vomiting occurring more than three times daily since the sixth week of her pregnancy, along with a reduced appetite and limited acceptance of various foods. This led to a weight loss from 45 kg to 42 kg and a decrease in mid-upper arm circumference (MUAC) from 23. 5 cm to 22. 5 cm. While both maternal vital signs and the condition of the fetus were stable, the situation highlighted a heightened risk of nutritional deficiencies related to ongoing vomiting and selective eating habits. A thorough midwifery approach was applied, which included health education on hyperemesis gravidarum, tailored nutritional advice, suggestions for small and frequent meals, incorporation of warm ginger, adjustments in food choices to align with maternal likes, continuous tracking of weight and MUAC, and coordinated medication management with antiemetics, vitamin B6, and prenatal supplements. This was achieved through regular follow-up visits and at-home monitoring. After three appointments, the patient demonstrated significant clinical advancement, shown by a decrease in the severity of nausea and vomiting, enhanced oral intake, increased willingness to accept a wider range of foods, including vegetables, and better awareness of her nutritional requirements during pregnancy. The final assessment indicated a rise in body weight from 42. 5 kg to 43. 5 kg and an increase in MUAC from 22. 5 cm to 23. 5 cm, reflecting an improvement in maternal nutritional health. These results imply that ongoing, personalized midwifery support focusing on both hyperemesis gravidarum and picky eating habits can effectively enhance maternal nutritional health and promote fetal development during pregnancy.

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