

Case Report: Midwifery Care for Second-Trimester Emesis Gravidarum with Evening-Predominant Symptoms

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ABSTRACT

Emesis gravidarum is common in early pregnancy, typically manifesting as morning sickness and subsiding by 12–16 weeks of gestation. However, persistent symptoms, particularly with evening predominance, may present clinical challenges. This case describes an atypical presentation of emesis gravidarum in the second trimester. This descriptive case report was conducted from January 29 to March 8, 2026, at the Independent Midwife Practice of Mrs. E, Bendo District, Magetan Regency, Indonesia. The subject was a second-trimester pregnant woman experiencing evening-predominant emesis gravidarum. Assessment and documentation used the SOAP approach, supported by structured assessment formats. Informed consent was obtained from the participant. At 20 weeks of gestation, the patient experienced nausea and vomiting 4–5 times daily, accompanied by reduced appetite and mild dehydration. Following four midwifery care visits, nausea decreased and occurred occasionally when exposed to strong odors, while vomiting ceased. Appetite was restored, maternal weight increased, vital signs remained stable, no signs of dehydration were observed, and fetal condition remained within normal limits. The case demonstrates an atypical evening-predominant pattern of emesis gravidarum in the second trimester. Hormonal changes, environmental triggers, and maternal fatigue may contribute to symptom patterns. Combined pharmacological and non-pharmacological interventions supported symptom improvement. Individualized and holistic midwifery care with continuous monitoring and tailored interventions can support maternal and fetal well-being in atypical emesis gravidarum.

Keywords: Pregnancy, Emesis gravidarum, Case report

INTRODUCTION

Nausea and vomiting of pregnancy, commonly referred to as emesis gravidarum, are among the most common complaints experienced by pregnant women, particularly during early pregnancy. These symptoms may cause considerable discomfort and interfere with daily activities, nutritional intake, and maternal well-being. Emesis gravidarum generally occurs during the first trimester and is associated with physiological changes in pregnancy, particularly increases in human chorionic gonadotropin (hCG), estrogen, and progesterone levels. Symptoms commonly decrease with advancing gestational age and generally improve by 12–16 weeks of pregnancy.^(1,2) In Indonesia, nausea and vomiting are reported to affect approximately 50–70% of pregnant women during the first 16 weeks of gestation, indicating that emesis gravidarum remains a common concern in antenatal care.⁽²⁾

Although emesis gravidarum is predominantly associated with the first trimester, symptoms may persist beyond this period in some pregnant women. Persistent nausea and vomiting require appropriate attention because inadequate food and fluid intake may result in dehydration, nutritional disturbances, fatigue, and electrolyte imbalance. In more severe conditions, persistent vomiting may progress to hyperemesis gravidarum, which is characterized by frequent vomiting and may be accompanied by dehydration, weight loss, and metabolic disturbances.^(2,3) Therefore, pregnant women with persistent symptoms require continuous assessment of vomiting frequency, nutritional and fluid intake, maternal condition, and fetal well-being.

The timing of nausea and vomiting may also vary among pregnant women. Although the term morning sickness is commonly used, symptoms are not necessarily restricted to the morning and may occur at different times of the day, including the afternoon and evening.⁽⁴⁾ Hormonal changes are recognized as important physiological factors in the development of emesis gravidarum, while individual responses to environmental stimuli and daily conditions may contribute to variations in symptom patterns. Previous findings have indicated that hCG may stimulate estrogen production, which may contribute to the occurrence of nausea and vomiting during pregnancy.⁽⁵⁾

This variation in symptom timing is particularly relevant to the present case. Mrs. T, a G1P0A0 pregnant woman, experienced nausea and vomiting beginning in the first trimester and continuing into the second trimester. At approximately 20–21 weeks of gestation, the symptoms demonstrated a distinctive pattern because they occurred predominantly during the late afternoon and evening, particularly between 17:00 and 20:00 WIB. In contrast, the client reported no nausea or vomiting during the morning to afternoon period and remained able to perform her usual daily activities. The pregnancy was planned and supported by her husband and family. The client also had no history of chronic, infectious, hereditary, or gastrointestinal disease that could aggravate the symptoms.

The persistence of emesis gravidarum into the second trimester, accompanied by a consistent evening-predominant pattern, makes this case clinically relevant to document. Persistent vomiting may compromise maternal nutritional and fluid intake and potentially affect maternal and fetal well-being if not appropriately managed. Consequently, management should be individualized and comprehensive, incorporating dietary modification, adequate fluid intake, avoidance of identified triggers, sufficient rest, counseling, and pharmacological treatment when clinically indicated. These interventions aim not only to reduce the frequency and severity of nausea and vomiting but also to maintain adequate maternal nutrition and hydration and support fetal well-being.

Based on these considerations, this case report aims to describe the midwifery care provided to a G1P0A0 pregnant woman at approximately 20 weeks of gestation with emesis gravidarum predominantly occurring in the evening. The report focuses on the assessment, management, and clinical progression of symptoms and provides a practical description of individualized midwifery care for an atypical presentation of emesis gravidarum.

METHODS

Study Design

This study employed a descriptive case report design to provide a comprehensive description of the midwifery care provided to a pregnant woman with emesis gravidarum occurring predominantly in the afternoon and evening. The case report focused on the assessment, management, monitoring, and clinical response of the client during the period of midwifery care. The care process was documented using the Subjective, Objective, Assessment, and Plan (SOAP) approach.

Population and Case Subject

The case subject was one G1P0A0 pregnant woman in the second trimester who experienced emesis gravidarum predominantly in the late afternoon and evening. The client was selected because the symptoms persisted into the second trimester and demonstrated a specific temporal pattern. At the initial assessment, the client was approximately 20 weeks pregnant and reported nausea accompanied by vomiting, particularly in the late afternoon.

Study Setting and Period

The case was managed at the Independent Midwife Practice (PMB) of Midwife “E”, located in Bulugeldeg Village, Bendo District, Magetan Regency, Indonesia. The initial assessment was conducted on January 29, 2026, at the midwife's practice, followed by continued midwifery care and monitoring during subsequent visits. The case documentation covered the period from January to March 2026. The practice provides antenatal and other maternal and child health services.

Data Collection

Data were collected through subjective and objective assessments during the midwifery care visits. Subjective data included the client's identity, gestational age, obstetric history, chief complaint, onset and timing of nausea and vomiting, frequency of vomiting, appetite, dietary intake, fluid intake, daily activities, and relevant health history. At the initial assessment, the client reported nausea and vomiting 4–5 times per day, predominantly between 17:00 and 20:00 WIB, while no nausea or vomiting occurred from morning to afternoon.

Objective data were obtained through assessment of the general condition, vital signs, physical examination, and evaluation of signs of dehydration. Obstetric assessment was also performed to monitor maternal and fetal well-being. The management process included dietary counseling, advice to consume small and frequent meals,

avoidance of foods or odors that triggered nausea, adequate fluid intake, sufficient rest, and non-pharmacological measures such as warm ginger consumption according to the client's tolerance. The client's response to the interventions was monitored throughout the care process.

Study Variables

The variables assessed in this case included the frequency and timing of nausea and vomiting, appetite and oral intake, maternal condition, signs of dehydration, maternal weight, vital signs, and fetal condition. The clinical response to midwifery care was assessed based on changes in the frequency and intensity of nausea and vomiting, improvement in appetite and daily activities, maintenance of maternal hydration and nutritional status, and the condition of the fetus during follow-up.

Data Analysis

The data were analyzed descriptively by comparing the subjective and objective findings obtained during each midwifery care visit. Changes in the client's symptoms, maternal condition, and response to interventions were described chronologically using the SOAP documentation approach. Because this study involved a single case, no inferential statistical analysis was performed.

Ethical Consideration

Ethical principles were applied throughout the case report. Before the midwifery care was provided, the client received a clear explanation regarding the purpose and procedures of the case, including assessment, physical examination, monitoring of nausea and vomiting, assessment of dehydration, and the planned management. The client voluntarily agreed to participate and to undergo monitoring throughout the care process after receiving adequate information. Informed consent was obtained without coercion, respecting the client's autonomy and rights as the subject of the case report.

RESULTS

Clinical Progress and Initial Assessment

At the first visit on January 29, 2026, Mrs. T, a 33-year-old primigravida (G1P00000) at 19–20 weeks of gestation (19 weeks 3 days), presented with nausea accompanied by vomiting approximately 4–5 times per day. The symptoms occurred predominantly in the late afternoon and evening, specifically between 17:00 and 20:00 WIB, whereas no nausea or vomiting was reported from morning until early afternoon. Despite these symptoms, the patient maintained her ability to perform routine daily activities.

Objective evaluation revealed that Mrs. T was in good general condition, with stable vital signs and no clinical evidence of dehydration. Fetal growth was appropriate for gestational age, and the fetal heart rate remained within normal limits. Based on the subjective reports and objective findings, Mrs. T was diagnosed with emesis gravidarum with a predominant afternoon onset, accompanied by favorable maternal and fetal status.

The afternoon diurnal pattern observed in this case is noteworthy because nausea and vomiting in pregnancy are conventionally associated with morning onset (morning sickness), although symptom presentation may vary across different times of the day. Similar findings regarding the manifestation and clinical management of emesis gravidarum have been documented in previous literature.

Initial midwifery care comprised patient education regarding emesis gravidarum, dietary recommendations emphasizing small and frequent meals, gradual increase of fluid intake, avoidance of greasy, spicy, and strongly scented foods, snack consumption prior to expected symptom onset, adequate rest, and reduction of strenuous physical exertion. Mrs. T was also prescribed Multiple Micronutrient Supplements (MMS) and vitamin B6 in accordance with institutional healthcare guidelines. Education regarding maternal warning signs and instructions to seek immediate care upon symptom exacerbation was also provided.

Symptom Progression During Follow-up

At the second visit on February 23, 2026 (23 weeks 0 days of gestation), Mrs. T continued to report persistent afternoon nausea, particularly between 17:00 and 20:00 WIB. However, the frequency of vomiting had decreased from a daily occurrence to approximately 2–3 episodes per week. The patient noted that while the nausea remained

troublesome, its severity had diminished relative to baseline. Appetite had begun to improve, enabling the intake of small, frequent nutritional portions. Her general condition remained optimal, vital signs were stable, and no clinical signs of dehydration were observed.

The reduction in emetic frequency and improved oral intake occurred while Mrs. T adhered to the recommended dietary and fluid management protocols. This outcome aligns with established non-pharmacological interventions for emesis gravidarum involving dietary adjustments, adequate hydration, patient education, and lifestyle modification. Existing literature similarly suggests that non-pharmacological approaches significantly contribute to alleviating pregnancy-related nausea and vomiting.

Table 1. Clinical progress of Mrs. T across four midwifery care visits

Visit	Date	Gestational Age	Symptoms	Appetite	Maternal/Fetal Status	Primary Intervention	Clinical Outcome
1	Jan 29, 2026	19–20 weeks	Nausea and vomiting 4–5 times/day (predominantly 17:00–20:00 WIB)	Decreased	Good general condition; no dehydration; fetal status reassured	Small frequent meals, adequate hydration, trigger avoidance, scheduled snacks, rest, MMS, and vitamin B6	Initial management initiated
2	Feb 23, 2026	23 weeks	Afternoon nausea (17:00–20:00 WIB); non-daily vomiting (2–3 times/week)	Improving	Good general condition; no dehydration; stable fetal status	Continuation of dietary/fluid management, trigger avoidance, and rest	Reduced vomiting frequency
3	Mar 1, 2026	23 weeks 6 days	Nausea markedly reduced (occasional post-odor exposure); diminished vomiting	Normal (3–4 meals/day)	Good general condition; FHR 140 bpm; weight 68.9 kg; no dehydration	Continued dietary modification, fluid maintenance, rest, and trigger avoidance	Enhanced physical comfort and normalized appetite
4	Mar 8, 2026	24 weeks 6 days	Vomiting resolved; nausea clinically insignificant	Good	Good general condition; active fetal movement; FHR normal; no dehydration	Ongoing clinical monitoring, nutritional counseling, rest, and trigger avoidance	Complete resolution of vomiting; sustained maternal/fetal well-being

At the third visit on March 1, 2026 (23 weeks 6 days of gestation), Mrs. T reported a marked reduction in nausea, which occurred only sporadically following exposure to pungent odors in the late afternoon. Emetic episodes had further subsided over the preceding four days. Her appetite had returned to baseline, permitting 3–4 daily meals of moderate volume. The patient expressed increased physical comfort and full capability in performing daily afternoon routine activities.

Physical examination demonstrated good general health, blood pressure of 110/70 mmHg, pulse rate of 82 beats/minute, respiratory rate of 18 breaths/minute, body temperature of 36.5°C, and a fetal heart rate of 140 beats/minute. Her body weight was recorded at 68.9 kg, reflecting a 0.2 kg gain from the prior visit. Oral mucosa

was moist, skin turgor was prompt, capillary refill time was under 2 seconds, and no dehydration signs were present.

The observed clinical improvement corresponds with the structured application of dietary modifications and supportive care strategies in managing emesis gravidarum. Complementary and non-pharmacological modalities are widely cited as effective measures for mitigating gestational nausea and vomiting.

Response to Midwifery Interventions

Mrs. T demonstrated a favorable therapeutic response to the midwifery care interventions administered throughout the follow-up period. She consistently implemented recommendations concerning dietary fractionalization, fluid maintenance, trigger avoidance (odors and specific foods), and rest optimization. This positive response was evidenced clinically by a progressive decrease in vomiting frequency, diminished nausea intensity, appetite restoration, and improved functional tolerance during daily living.

Longitudinal monitoring confirmed that Mrs. T sustained a stable overall physical status without developing dehydration. These outcomes underscore the necessity of continuous clinical surveillance in pregnant women presenting with gestational complaints to preserve maternal nutritional status and overall health.

Final Clinical Outcome

At the fourth visit on March 8, 2026 (24 weeks 6 days of gestation), Mrs. T exhibited complete resolution of key symptoms. The final clinical evaluation documented a good general condition, normal vital signs, and no evidence of dehydration. Obstetric assessment confirmed a single live intrauterine fetus with active movements and a fetal heart rate within normal parameters.

By the final follow-up, emesis had completely resolved, and nausea was no longer reported as a clinically significant complaint. Mrs. T's nutritional intake had normalized, body weight increased over the care trajectory, and daily activities were fully resumed. Overall, the four-visit longitudinal care from January 29 to March 8, 2026, demonstrated progressive resolution of nausea and vomiting, improved appetite, progressive weight gain, and optimal maintenance of both maternal and fetal well-being.

DISCUSSION

This section addresses the relationships, convergences, and discrepancies between theoretical literature and the clinical outcomes of midwifery care provided to Mrs. T, a 33-year-old primigravida (G1P0A0) between 20 and 24 weeks of gestation, who presented with emesis gravidarum characterized by a distinct pattern of symptoms predominantly occurring in the late afternoon to evening (17:00–20:00 WIB).^(6,7) Based on the subjective assessment during the initial visit on January 29, 2026, Mrs. T reported experiencing nausea and vomiting with a frequency of 4 to 5 episodes per day at 20 weeks of gestation.⁽⁸⁾ Generally, emesis gravidarum is most frequently encountered during the first trimester of pregnancy—specifically between 4 and 16 weeks of gestation—triggered by peak surges in Human Chorionic Gonadotropin (hCG), estrogen, and progesterone levels.⁽⁹⁾ The majority of literature states that symptoms peak in the morning (morning sickness) and gradually subside after 12 to 16 weeks of gestation.⁽¹⁰⁾ However, clinical findings in Mrs. T demonstrate a unique variation, as her symptoms persisted into the second trimester and manifested specifically in the late afternoon.⁽⁴⁾ This finding aligns with other study which state that gestational nausea and vomiting patterns can exhibit diurnal variations, with approximately 10 to 12 percent of pregnant women experiencing symptoms extending into the second trimester due to circadian rhythm fluctuations, cumulative physical fatigue following daily activities, and delayed gastric emptying in the late afternoon.

The objective examination indicated that Mrs. T was in good general condition, fully conscious (compos mentis), and exhibited stable vital signs: blood pressure of 115/78 mmHg, pulse rate of 81 beats per minute, body temperature of 36.5°C, respiratory rate of 21 breaths per minute, elastic skin turgor, moist oral mucosa, a capillary refill time of less than 2 seconds, and no clinical signs of dehydration or ketonuria.⁽¹¹⁾ Maternal weight demonstrated a gradual increase from 68.7 kg at the initial consultation to 68.9 kg by the third visit, with a mid-upper arm circumference (MUAC/LILA) of 24 cm.⁽¹²⁾ These findings signify that the condition experienced by Mrs. T remains classified as mild-to-moderate emesis gravidarum and has not progressed to Hyperemesis Gravidarum (HG).⁽¹³⁾

The management of midwifery care delivered to Mrs. T focused on a holistic approach encompassing nutritional and dietary education. This included recommending small, frequent meals (small frequent meals), avoiding high-fat, spicy, or strongly odorous foods that provoke nausea, and providing bland crackers or toast

prior to the late afternoon onset.⁽¹⁰⁾ Furthermore, hydration management was implemented by recommending frequent, small sips of warm fluids (8–12 glasses per day), scheduling afternoon rest intervals, and providing pharmacological support in the form of vitamin B6 (pyridoxine) and Multiple Micronutrient Supplements (MMS) prescribed by healthcare practitioners. Through these interventions, a progressive improvement in clinical status was observed: the frequency of vomiting decreased from 4–5 times daily at the first visit (20 weeks of gestation), to 2–3 times daily at the second visit (23 weeks of gestation), until completely resolving (0 times) by the third visit (24 weeks of gestation), accompanied by a regular fetal heart rate of 135–140 beats per minute.⁽¹⁴⁾

The evening-predominant symptom timing observed in this case underscores the crucial role of midwives in performing meticulous, patient-centered history taking rather than relying solely on the conventional construct of morning sickness.⁽⁴⁾ Additionally, socio-cultural challenges emerged regarding dietary taboos, as the patient held beliefs restricting the intake of certain protein sources, such as eggs and fish, due to fear of exacerbating nausea. The midwife successfully delivered balanced nutritional counseling without confronting cultural beliefs disruptively by introducing alternative, odor-neutral protein sources.

CONCLUSION

This case report highlights the clinical presentation of emesis gravidarum occurring predominantly in the evening during the second trimester, which represents an atypical and rare symptom pattern compared to the common morning sickness observed in early pregnancy. The patient demonstrated significant improvement following four consecutive midwifery care visits, with nausea markedly reduced, vomiting resolved, appetite restored, and daily activities resumed normally. Objective findings confirmed stable maternal vital signs, weight gain, absence of dehydration, and normal fetal condition. These results emphasize that consistent and holistic midwifery interventions—combining pharmacological treatment with non-pharmacological strategies such as dietary modification, rest, and counseling—can effectively manage emesis gravidarum and prevent progression to hyperemesis gravidarum. From a theoretical perspective, hormonal changes remain the primary etiological factor, while clinical opinion suggests that environmental triggers and maternal fatigue may influence symptom timing. Overall, this case underscores the importance of individualized care and continuous monitoring in midwifery practice to safeguard maternal health and fetal outcomes.

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