



## Your Monthly Update

### Dear Colleague

Welcome to the April 2014 newsletter from Pure Bio Ltd.

### Did you know:

The latest NHS mammograph information leaflet warns that the technology is three times more likely to pick up a benign abnormality – which may, nonetheless, still trigger a course of chemotherapy or even mastectomy – than an actual life-threatening tumour. (*JRSocMed, 2013: 106:234-42*)

Be sure to check our homepage regularly on [www.purebio.co.uk](http://www.purebio.co.uk) as there are currently a number of reformulations occurring.

## Gestational Hypertension (Preeclampsia)

Protocol Summary

Ranking	Nutritional Supplements	Botanical Medicine
Primary	Calcium Magnesium	
Secondary		
Other	Zinc	

**Primary** – Reliable and relatively consistent scientific data showing a substantial health benefit.

**Secondary** – Contradictory, insufficient, or preliminary studies suggesting a health benefit or minimal health benefit.

**Other** – An herb is primarily supported by traditional use, or the herb or supplement has little scientific support and/or minimal health benefit.

## **The Facts**

Gestational hypertension (GH) is high blood pressure that develops after the twentieth week of pregnancy and returns to normal after delivery, in women with previously normal blood pressure.

GH may be an early sign of either preeclampsia or chronic hypertension. If these complications do not develop, or if chronic hypertension develops but remains mild, the outcome of pregnancy is usually good for both the mother and newborn. GH has been shown to occur more frequently in women who are obese or in those who are glucose-intolerant.

## **Symptoms**

Symptoms, which appear after the twentieth week of pregnancy, include swelling of the face and hands, visual disturbances, headache, high blood pressure, and a yellow discoloration of the skin and eyes.

## **Dietary and Lifestyle Modification**

In GH, regular checkups during pregnancy and after delivery are needed for the prevention and early detection of preeclampsia and chronic hypertension.

Job stress (lack of control over work pace and the timing and frequency of breaks) has been reported to be detrimental; therefore, reducing job stress may be beneficial in the prevention of GH. In a preliminary study, women exposed to high job stress were found to be at greater risk of developing GH than were women with low job stress.

The common practice of prescribing bed rest for women with GH has been questioned by some researchers. In the few studies examining this issue, results have been inconsistent. While one controlled study found that bed rest reduced progression of GH to severe hypertension, evidence is currently insufficient to determine whether bed rest reduces blood pressure in women with the condition.

Increased consumption of fish was associated with reduced risk of GH in one preliminary study. In this study, the incidence of hypertension during pregnancy was significantly higher in women from communities with lower consumption of fish and lower in women from communities with high fish consumption.

Unlike salt restriction in primary hypertension, a low-salt diet has not been shown to have a significant effect in reducing high blood pressure during pregnancy. As a result, salt restriction is not specifically recommended to women with GH.

## **Complimentary Therapies**

- A randomized study of yoga in high-risk pregnancy has shown that yoga can potentially be an effective therapy in reducing hypertensive related complications of pregnancy and improving foetal outcomes
- Mindfulness meditation interventions have recently shown benefits for reducing stress and the symptoms of stress in GH

## Nutritional Supplement Treatment Options

**Calcium** - *1,200 to 1,500 mg daily*. Calcium deficiency has been implicated as a possible cause of GH. In two preliminary studies, women who developed GH were found to have significantly lower dietary calcium intake than did pregnant women with normal blood pressure. Calcium supplementation has significantly reduced the incidence of GH in preliminary studies and in many, though not all, double-blind trials. Calcium supplements may be most effective in preventing GH in women who have low dietary intake of calcium. The National Institutes of Health (NIH) recommends an intake of 1,200 to 1,500 mg of calcium daily during normal pregnancy. In women at risk of GH, studies showing reduced incidence have typically used 2,000 mg of supplemental calcium per day, without any reported maternal or foetal side effects.

**Magnesium** - *300 mg daily*. Magnesium deficiency has also been implicated as a possible cause of GH. Dietary intake of magnesium is below recommended levels for many women during pregnancy. Magnesium supplementation has been reported to reduce the incidence of GH in preliminary and many double-blind trials. In addition to preventing GH, magnesium supplementation has also been reported to reduce the severity of established GH in one study. Amounts used in studies on GH range from 165 to 365 mg of supplemental magnesium per day.

**Zinc** – *up to 50mg per day*. Zinc supplementation (20 mg per day) was reported to reduce the incidence of GH in one double-blind trial studying a group of low-income Hispanic pregnant women who were not zinc deficient.

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