The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

PRACTICE BULLETIN SUMMARY

CLINICAL MANAGEMENT GUIDELINES FOR OBSTETRICIAN–GYNECOLOGISTS

NUMBER 156, DECEMBER 2015

(Replaces Committee Opinion Number 549, January 2013)

For a comprehensive overview of obesity in pregnancy, the full-text version of this Practice Bulletin is available at http://dx.doi.org/10.1097/AOG.0000000000001211.

Scan this QR code with your smart phone to view the full-text version of this Practice Bulletin.

Committee on Practice Bulletins—Obstetrics. This Practice Bulletin was developed by the Committee on Practice Bulletins–Obstetrics with the assistance of Patrick M. Catalano, MD and Gayle Olson Koutrouvelis, MD. The information is designed to aid practitioners in making decisions about appropriate obstetric and gynecologic care. These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

Obesity in Pregnancy

Obstetrician–gynecologists are the leading experts in the health care of women, and obesity is the most common health care problem in women of reproductive age. Obesity in women is such a common problem that the implications relative to pregnancy often are unrecognized, overlooked, or ignored because of the lack of specific evidence-based treatment options. The management of obesity requires long-term approaches ranging from population-based public health and economic initiatives to individual nutritional, behavioral, or surgical interventions. Therefore, an understanding of the management of obesity during pregnancy is essential, and management should begin before conception and continue through the postpartum period. Although the care of the obese woman during pregnancy requires the involvement of the obstetrician or other obstetric care provider, additional health care professionals, such as nutritionists, can offer specific expertise related to management depending on the comfort level of the obstetric care provider. The purpose of this Practice Bulletin is to offer an integrated approach to the management of obesity in women of reproductive age who are planning a pregnancy.

Clinical Management Questions

- ***Are there interventions for the management of obesity before and during pregnancy?***
- ***What are the recommendations for weight gain in pregnancy for overweight and obese women?***
- ***How should antepartum care be altered for the obese patient?***
- ***How might intrapartum care be altered for the obese patient?***
- ***What are the operative and perioperative considerations in labor and delivery for the obese patient?***
- ***How should postpartum care be altered for the obese patient?***
- ***What are effective postpartum care and interconceptual strategies for weight loss before the next pregnancy?***

Recommendations and Conclusions

The following recommendations are based on good or consistent scientific evidence (Level A):

- Body mass index calculated at the first prenatal visit should be used to provide diet and exercise counseling guided by IOM recommendations for gestational weight gain during pregnancy.
- Subcutaneous drains increase the risk of postpartum cesarean wound complications and should not be used routinely.
- Behavioral interventions employing diet and exercise can improve postpartum weight reduction in contrast to exercise alone.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- Obese women who have even small weight reductions before pregnancy may have improved pregnancy outcomes.
- Allowing a longer first stage of labor before performing cesarean delivery for labor arrest should be considered in obese women.
- Mechanical thromboprophylaxis is recommended before cesarean delivery, if possible, as well as after cesarean delivery.
- Weight-based dosage for venous thromboembolism thromboprophylaxis may be more effective than BMI-stratified dosage strategies in class III obese women after cesarean delivery.
- Interpregnancy weight loss in obese women may decrease the risk of a large-for-gestational-age neonate in a subsequent pregnancy.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Obese women should be counseled about the limitations of ultrasound in identifying structural anomalies.
- Consultation with anesthesia service should be considered for obese pregnant women with OSA because they are at an increased risk of hypoxemia, hypercapnia, and sudden death.
- Early pregnancy screening for glucose intolerance (gestational diabetes or overt diabetes) should be based on risk factors, including maternal BMI of 30 or greater, known impaired glucose metabolism, or previous gestational diabetes.
- Even though stillbirth rates are higher in obese gravidas, there is no evidence showing a clear improvement in pregnancy outcomes with antepartum surveillance, and a recommendation cannot be made for or against routine antenatal fetal surveillance in obese pregnant women.

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force. Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A—Recommendations are based on good and consistent scientific evidence.

Level B—Recommendations are based on limited or inconsistent scientific evidence.

Level C—Recommendations are based primarily on consensus and expert opinion.

The American College of Obstetricians and Gynecologists
409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920

Official Citation
Obesity in pregnancy. Practice Bulletin No. 156. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;126:e112–26.