Policy Extract

Obesity in Pregnancy

The objective is to review the evidence and provide recommendations for the counselling and management of obese parturient.

It is critical that women be informed prior to pregnancy about the need to be as healthy as possible before becoming pregnant, which includes having a normal BMI, eating a balanced diet, and participating in regular exercise. It is also critical that provincial and federal authorities recognize the impact on future populations and health care costs of pregnancies complicated by obesity. A long-term national information campaign is required to exploit women’s interest in having as healthy a pregnancy as possible by giving them the information they need to become fit and have a normal BMI before they consider pregnancy. Only a national strategy can change the complacency about pre-pregnancy weight and inform women about the significant increase in risks for themselves and their children.

Recommendations

1. Periodic health examinations and other appointments for gynaecologic care prior to pregnancy offer ideal opportunities to raise the issue of weight loss before conception. Women should be encouraged to enter pregnancy with a BMI <30 kg/m², and ideally <25 kg/m².
2. BMI should be calculated from pre-pregnancy height and weight. Those with a pre-pregnancy BMI >30 kg/m² are considered obese. This information can be helpful in counselling women about pregnancy risks associated with obesity.
3. Obese pregnant women should receive counselling about weight gain, nutrition, and food choices.
4. Obese women should be advised that they are at risk for medical complications such as cardiac disease, pulmonary disease, gestational hypertension, gestational diabetes, and obstructive sleep apnea. Regular exercise during pregnancy may help to reduce some of these risks.
5. Obese women should be advised that their fetus is at an increased risk of congenital abnormalities, and appropriate screening should be done.
6. Obstetric care providers should take BMI into consideration when arranging for fetal anatomic assessment in the second trimester. Anatomic assessment at 20 to 22 weeks may be a better choice for the obese pregnant patient.
7. Obese pregnant women have an increased risk of Caesarean section, and the success of vaginal birth after Caesarean section is decreased.
8. Antenatal consultation with an anaesthesiologist should be considered to review analgesic options and to ensure a plan is in place should a regional anaesthetic be chosen.
9. The risk of venous thromboembolism for each obese woman should be evaluated. In some clinical situations, consideration for thromboprophylaxis should be individualised.