

key points

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For obese women the risks of adverse outcomes

during pregnancy, for both the mother and her child, are significantly higher than the general population. In 2016, 21% of all women attending antenatal services in the UK were reported to have a BMI ≥ 30 kg/m². In 2003-5, 27% of all maternal deaths occurred in women with a BMI ≥ 30 kg/m². Obesity increases the risk of developing pregnancy related problems such as gestational diabetes, pre-eclampsia, hypertension and venous thromboembolism. There is an increased likelihood of induction of labour, instrumental delivery and postpartum haemorrhage.

The greatest effect on risk reduction is weight loss

prior to conception, hence putting primary care in a key position to help these women early on. It is worthwhile finding out what weight management services are available locally and also how your local obstetric service manages these patients. Some women may benefit from being signposted to online NHS resources. Referral to a specialist weight management service for women with a high BMI may be of great benefit. Many obstetric services offer pre-pregnancy counseling for high-risk women, so it is worth finding out if this is available for your patient if you feel she needs more detailed explanations and assessments.

Around 20% of women with a BMI ≥ 35 kg/m² have

macrosomic babies, double the rate of women with a lower BMI. The stillbirth rate increases with BMI. For women with a BMI 35-39.9 kg/m² the stillbirth rate is 7.9 per 1,000 deliveries this figure rises to 15.8 per 1,000 deliveries for those with a BMI ≥ 50 kg/m². These respective rates are double and quadruple the rate for the general population. There is accumulating evidence that babies born to obese women have considerable lifelong health risks, in particular an excess cardiovascular risk.

Obese women have been shown frequently to have

poor nutrient uptake in their diet. There is an increased risk of neural tube defects and the RCOG advises 5 mg folic acid daily for all women with a BMI ≥ 30 kg/m² starting at least one month prior to conception and continuing during the first trimester. The obstetric team will refer all obese women to a dietitian in the first trimester.

Low-risk patients with a BMI 30-34.9 kg/m² can be

managed in a midwife-led service, but patients with a higher BMI or additional risks should be managed by a consultant-led service. The risk of gestational diabetes in obese women is increased three fold. All women with a BMI ≥ 30 kg/m² should be screened for gestational diabetes in accordance with NICE or SIGN guidance. In addition, given the much higher risks of congenital abnormality in type 2 diabetes, it may be prudent to test HbA_{1c} at booking.