Obesity in Maternity - Summary Clinical Guideline

Reference No.: CL/02:23/B12

Measuring weight, height and BMI

Pregnant women should have their weight and height measured and their BMI calculated:

- For all women at the first ante natal contact (booking appointment in early pregnancy)
- For women with BMI ≥30 at booking: additionally at 28 week antenatal contact (27-30/40)
- For women with BMI ≥35 at 28 weeks: additionally around 34-37 week antenatal contact

Antenatal care for obese women

Recommendations for all pregnant women with a booking BMI of ≥30:

- Signpost to the patient information leaflet (Being overweight during pregnancy and birth) and/or supply a printed copy and point out:
    - Importance of increased dose of folic acid (5mg on GP prescription) in 1st trimester
    - Importance of supplementing with 10µg vit D during pregnancy and breast feeding (normal dose as found in Pregnacare)
    - Effect of diet and lifestyle intervention on improved birth outcomes and reduction of hypertension
    - All forms of screening for structural anomalies are more limited in obese pregnant women
- Screening for gestational diabetes (see diabetes guideline)
- Use appropriate size of cuff for blood pressure measurements
- Consider the use of TV ultrasound in women in whom it is difficult to obtain nuchal translucency measurements trans-abdominally
- In the absence of other obstetric or medical indications, obesity alone is not an indication for induction of labour
- Where macrosomia is suspected, induction of labour may be considered at 39 weeks
- Class 1 and 2 maternal obesity (BMI <40) when re-weighed, is not a reason in itself to be transferred to CLC if BMI was <35 at booking

Pregnant women with a gastric band regardless of BMI will need a consultant review.

Additional for women with BMI ≥35 at booking

- Serial assessment of fetal size using ultrasound
- Consultant led care

Additional for women with BMI ≥ 40 at any time <30 weeks

- Obstetric team to refer to Anaesthetic team

Pregnancy following bariatric surgery

Women with previous bariatric surgery:

- Should have consultant led antenatal care
- Should have nutritional surveillance and screening for deficiencies during pregnancy
- Should be referred to a dietician for advice with regard to their specialised nutritional needs

Labour planning during pregnancy

A birth discussion should be completed by 37 weeks gestational age.

In case of a BMI < 40 at 34-37 weeks

Birth planning should be done by the community midwife (in absence of other labour related risk factors e.g. previous LSCS, shoulder dystocia etc)

Discussion to include:

- A normal birth should be encouraged
- Recommendations for fetal monitoring: intermittent auscultation should be offered during labour in the absence of other comorbidities, or medical or obstetric complications
- Advise active management of the 3rd stage
- Class 1 and 2 maternal obesity (BMI <40) at 34-37 weeks is not a reason in itself for advising birth within a CLU. The additional intrapartum risks and the additional care that can be provided in a CLU should be discussed with the woman so that she can make an informed choice about planned place of birth
- Considerations for birth settings should be advised as follows:
    - If BMI at booking <35: all options may be offered including standalone MLC unit and home birth
    - If BMI at booking ≥35: may be offered planned birth in a midwife led unit with an adjacent CLC unit and a neonatal intensive care unit

In case of a BMI ≥ 40 at 34-37 weeks

An informed management plan for labour and delivery to be completed with the woman in Antenatal Clinic to include:

- A normal birth should be encouraged
- The option of induction of labour ≥ 39 weeks should be discussed on an individual basis
- Record weight and BMI at the time of the consultation
- Venous access established at the onset of labour, advise about the possible technical difficulties of iv access
- Discuss incision site if CS needed
- Difficulty of fetal monitoring and advise CTG monitoring during labour
- Active management of third stage with regard to choice of drug and route of administration

Additional discussion / assessment to be considered: consider need for senior medical involvement in case of c-section or instrumental delivery (obstetrics and/or anaesthetic); moving and handling risk assessment; health and safety and risk assessment of choices made especially

when against best practice i.e. home/water birth (not recommended); recommended doses for LMWH and antibiotics if required (see relevant clinical guidelines); wound care related to perineum and abdominal wound; airway and apnoea assessment; advisability of early epidural

Intrapartum care

The Clinical Risk assessment in Labour to include most recent BMI, tissue viability assessment; Plymouth score, fetal growth in pregnancy; signs of IUGR or macrosomia.

To be taken into consideration regarding the use of the birthing pool:

- Monitoring of fetal wellbeing is essential and should not be compromised by use of the birthing pool at any stage
- The woman should be able to get in and out of the birthing pool with minimal assistance
- Use of the birthing pool is not recommended if weight ≥100kg or BMI ≥40.

Additional for women with BMI ≥40 (any time during pregnancy or on admission):

- Inform the obstetric registrar and anaesthetist covering the labour ward of admission to labour ward
- Any requirement for specific equipment e.g. in case of extremely high BMI/weight
- Consideration of additional measures to prevent pressure sores
- have venous access established early in labour and consideration should be given to siting a second cannula

Caesarean section or instrumental delivery for women with BMI ≥40

When admitted to labour ward where c-section or operative intervention is anticipated:

- Update obstetric registrar and anaesthetist covering labour ward at the earliest opportunity
- Follow care plan and consider equipment to be used (i.e. large blood pressure cuffs, safe working loads of bed/operating table, slide sheets etc.)
- Consider using the Alexis O C-section retractor to maximise exposure and to maximise surgical efficiency by freeing up valuable hands of the first assistant. (Information and instructions for use (see Appendix C))

For women whose weight exceeds 120kg:

- Alert theatre staff including main theatre coordinator if a women is due to have an operative intervention in theatre

Postnatal care

Postnatal assessment of:

- VTE risk and Tissue viability
- Obese women should be reminded of and signposted to the patient information leaflet. Alternatively a printed copy may be provided.