

# Antenatal Management of Obesity

Purpose: To assist OB providers managing women who are obese with respect to antenatal surveillance, management, timing of delivery and postpartum management.

Definition: Class I obesity BMI $\geq$ 30-34.9 kg/m<sup>2</sup>, Class II obesity BMI $\geq$ 35-39.9 kg/m<sup>2</sup>, Class III obesity BMI $\geq$ 40 kg/m<sup>2</sup>. NB: all BMI calculations are pre-pregnancy.

Recommendations:

Recommendation	Class I/II	Class III	BMI>60
ASA 162mg	X	X	X
Early anatomy at 16 weeks with MFM (TVUS)	X	X	X
Early ultrasound for accurate dating	X	X	X
Consider nutrition consult	X	X	X
Early screening for GDM, baseline preeclampsia labs and HgbA1c should be done at first prenatal visit	X	X	X
Maternal Echocardiogram	<b>X (with risk factors: cHTN/GDM)</b>	<b>X (with risk factors: cHTN/GDM)</b>	X
Detailed anatomy ultrasound at 18-24 weeks to screen for congenital anomalies. Use of msAFP can be used as an adjunct to screen for NTDs especially if ultrasound visualization is poor.	X	X	X
Pediatric Cardiology/MFM fetal echocardiography should be considered if detailed anatomy scan <i>cannot</i> adequately visualize: 4CH, RVOT/LVOT, 3VV and tracheal view.	X	X	X
Consider sleep apnea screening (STOPBANG questionnaire: <a href="https://www.mdcalc.com/stop-bang-score-obstructive-sleep-apnea">https://www.mdcalc.com/stop-bang-score-obstructive-sleep-apnea</a> )	X	X	X

SHMG Maternal Fetal Medicine has developed these guidelines as a reference tool to assist referring physicians. Obstetric medical needs are complex and these guidelines may not apply in every case. Treating clinicians should exercise their own professional medical judgment with regard to the appropriate treatment and management of their patients. Treating clinicians are solely responsible for confirming the accuracy, timelines, completeness, appropriateness and helpfulness of this material in making all medical, diagnostic, or prescription decisions.

Fetal growth assessment at 28 and 34 weeks	<b>X</b>	<b>X</b>	<b>X</b>
Start once weekly NSTs once a week at 36 weeks.		<b>X</b>	<b>X</b>
Anesthesia consult			<b>X</b>
Perioperative Antibiotics: Azithro + Ancef (3g if >120kg)	<b>X</b>	<b>X</b>	<b>X</b>
Delivery timing	<b>40w (39w with risk factors: LGA,GDM,poly)</b>	<b>39-40w</b>	<b>39-40w</b>
Consider wound vac placement postop		<b>X (with risk factors such as DM/chorio)</b>	<b>X</b>
Postop prophylactic Lovenox while inpatient	<b>X (with risk factors)</b>	<b>X</b>	<b>X</b>

**References:**

American College of Obstetricians and Gynecologists. Practice Advisory on low-dose aspirin and prevention of preeclampsia: Updated recommendations. <http://www.acog.org>.

Wax et al. Consensus report on the detailed fetal anatomic ultrasound examination: indications, components and qualifications. J Ultrasound Med 2014;33:189-95.

Donofrio et al. Diagnosis and treatment of fetal cardiac disease: a scientific statement from the American Heart Association. Circulation 2014;129:2183.

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