Pregnancy in people living with obesity

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■ Cite as: *CMAJ* 2023 May 29;195:E747. doi: 10.1503/cmaj.221343

1 Obesity affects 8%–12% of pregnancies[1]

A pre-pregnancy body mass index (BMI) of 30 kg/m^2 or greater is linked with an increased risk of adverse outcomes in pregnancy.[1] The risk of preeclampsia doubles with each 5–7 kg/m^2 increase in pre-pregnancy BMI.[1] In anticipation of pregnancy, weight management options may include lifestyle changes, pharmacotherapy and bariatric surgery, where appropriate. Pre-pregnancy screening may include assessment of liver, cardiac, respiratory and thyroid function, in addition to a lipid profile.[2] If the person presents after conceiving, screening may be modified depending on history. Early screening for type 2 diabetes mellitus with glycosylated hemoglobin is encouraged.[1]

2 Controlled weight gain and daily acetylsalicylic acid (ASA) during pregnancy are evidence-based strategies to prevent preeclampsia[2]

With a pre-pregnancy or first-trimester BMI of 30 kg/m^2 or greater, a total gestational weight gain of 5–9 kg is recommended.[2] Low-dose ASA (75–150 mg) can reduce the risk of preeclampsia by 62%, and should be started before 16 weeks' gestation and taken until 36 weeks' gestation.[3]

3 Obesity is associated with increased risk of cesarean delivery[4]

A higher incidence of dystocia in the first stage of labour accounts for this increased risk. The odds of ineffective uterine contractility increase in a dose-dependent fashion with class of obesity (odds ratio 2.14, 2.72 and 3.98 in people with class I, II and III obesity, respectively).[4] Pregnant people with obesity are more likely to require induction of labour with increased failure rates. However, studies show that planned induction at term may decrease rates of cesarean delivery, macrosomia and neonatal morbidity.[4]

4 Breastfeeding should be recommended

People with obesity are less likely than people who are not obese to start breastfeeding, and tend to breastfeed for a shorter duration.[4] Lactation education should emphasize the benefits of breastfeeding — including protection against sudden infant death syndrome, childhood obesity and maternal cardiovascular risk[4,5] — and also provide information on challenges and management options.[4]

5 Weight bias is common, and people with obesity often experience shaming by health care providers[6]

Stigmatizing language erodes the therapeutic alliance and deters patients from seeking care. People-first language should be used (e.g., "person with obesity" rather than "obese person").[4]

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Competing interests: None declared.

This article has been peer reviewed.

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