Antenatal Management of obesity (Smart phrases .mtobesity12, .mtobesity3)

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≥30-34.9 kg/m^2, Class II obesity BMI≥35-39.9 kg/m^2, Class III obesity BMI≥40 kg/m^2.

NB: all BMI calculations are prepregnancy.

Recommendation	**Class I/II**	**Class III**	**BMI>60**
ASA 162mg	**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	**X(with risk factors: cHTN/GDM)**	**X(with risk factors: cHTN/GDM)**	**X**
Detailed anatomy scan 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**
Peds Cards/MFM fetal echocardiography should be considered if detailed anatomy scan *cannot* adequately visualize: 4CH, RVOT/LVOT, 3VV and tracheal view.	**X**	**X**	**X**
Consider sleep apnea screening (STOPBANG questionnaire: https://www.mdcalc.com/stop-bang-score-obstructive-sleep-apnea)	**X**	**X**	**X**
Fetal growth assessment at 30 and 36 weeks	**X**	**X**	**X**
Start once weekly NSTs at 34 weeks		**X**	**X**
Start once weekly NSTs at 36 weeks.	**X (class II only)**		
Anesthesia consult			**X**
Periop Abx: Azithro + Ancef (3g if >120kg)	**X**	**X**	**X**
Consider postop Abx: PO Keflex + Flagyl q8 x 48 hrs		**X**	**X**
Delivery timing	**40w (with risk factors: LGA,GDM,poly) 39w**	**39-40w**	**39-40w**
Consider wound vac placement postop		**X (with risk factors such as DM/chorio)**	**X**

Postop prophylactic Lovenox while inpatient	**X (with risk factors)**	**X**	**X**

Disclaimer: This information is designed to assist the provider in the clinical management of women who are in the late preterm period and as educational resource. The use of this information is voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care but instead represent guidelines for management. It is not intended to substitute for the independent professional judgement of treating clinician. Variations in practice may be warranted when, in the reasonable judgement of the treating clinician, such course of action in indicated by the condition of the patient, limitations of available resources, regional experience or advances in knowledge or technology.

References:

American College of Obsetetricians 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.

Schuster M et al. The effect of the MFM obesity protocol on cesarean delivery rates. Am J Obstet Gynecol 2016;215:492e1-6.