Belfast Health and Social Care Trust
caring supporting improving together

Reference No: SG 174/11

Title:	Guidelines for the management of Obesity in Pregnancy, during Labour and Postnatal			
Author(s)	Dr Janitha Costa, Consultant Obstetrician Dr.Agneiska Zawislak, Consultant Obstetrician and Gynaecologist			
Ownership:	Mr Aidan Dawson, Director, Specialist Hospitals Women's Health			
Approval by:	Standards and Guidelines Policy Committee Executive team Meeting		**Approval date:**	12/04/2017 07/06/2017 28/06/2017
Operational Date:	July 2017		**Next Review:**	July 2022
Version No.	V2	**Supercedes**	V1 – May 2011-2013	
Key words:	Obesity in pregnancy, antenatal care, intrapartum care, postnatal care, Weigh to Healthy Pregnancy clinic, BMI			
Links to other policies	http://intranet.belfasttrust.local/policies/Documents/Thromboprophylaxis%20during%20pregnancy,labour%20and%20delivery.pdf http://intranet.belfasttrust.local/policies/Documents/Early%20referral%20of%20patients%20to%20the%20Obstetric%20Anaesthetic%20Team.pdf http://intranet.belfasttrust.local/policies/Documents/Acute%20deep%20venous%20thrombosis%20and%20pulmonary%20embolus%20in%20pregnancy-Management%20of.pdf http://intranet.belfasttrust.local/policies/Documents/Hypertension%20in%20pregnancy.pdf http://intranet.belfasttrust.local/policies/Documents/Vaginal%20birth%20after%20previous%20caesarean%20section.pdf http://intranet.belfasttrust.local/Policies%20and%20Procedures/Antimicrobial%20prophylaxis%20in%20specific%20adult%20surgical%20procedures.pdf GAIN (2016) Guideline for admission to midwife-led units in Northern Ireland and Northern Ireland Normal labour and birth care pathway			

Date	Version	Author	Comments
19/03/2015		Dr J Costa	Clinical Director requests Dr Costa (Obesity Clinic Lead) update guideline
20/03/2015	1.1	Dr J Costa	Awaiting Clinical Audit outcomes from Dr C Beattie
25/08/2015		Dr J Costa	Author awaiting recommendations from audit
02/03/2016	1.1	Dr J Costa	Initial Draft (on old BHSCT template)
22/03/2016	1.2	Dr J Costa	Clinical Director offered input from Excellence and Governance Lead to progress guideline
22/03/2016	1.2	Dr J Costa	Author acknowledges initial draft to be formatted on current BHSCT policy template

12/04/2016	1.2	Dr J Costa	Excellence and Governance Lead offered assistance in progressing this work
29/06/2016	1.2	Dr J Costa	Second draft onto BHSCT current policy template
08/09/2016	1.2	Dr J Costa	Circulated to all midwives, obstetricians, anaesthetists and neonatologists for comment. Comments to be received by 23rd Sept 2016
09/09/2016	1.3	Dr J Costa	Updated following comments received from Dr J Price
10/09/2016	1.3	Dr J Costa	Lead Midwife for intrapartum care had no comments to add
13/09/2016	1.4	Dr J Costa	Updated following comments received from obstetric anaesthetic lead
13/09/2016	1.5	Dr J Costa	Updated following comments received from Dr D Fogarty, Dr U Carabine and Dr S Atkinson (anaesthetics)
21/09/2016	1.6	Dr J Costa	Updated following comments received from Sr J Callow (Stand Alone Midwifery Led Unit)
05/10/2016	1.6	Dr J Costa	Author acknowledged comments and requested advice from Head of Midwifery
05/10/2016	1.6	Dr J Costa	Head of Midwifery requested meeting with Intrapartum Lead Midwife, Consultant Midwife and Intrapartum Midwifery Educator to address comments received from MLU Sister
24/10/2016	1.7	Dr J Costa	Further comments included
09/11/2016	1.7	Dr J Costa	Head of Midwifery, Intrapartum Lead Midwife, Consultant Midwife and Intrapartum Midwifery Educator met and agreed to amend and update guideline
25/01/2017	1.8	Dr J Costa	Obesity Management Pathway developed by Midwifery Education Team, forwarded to the author
31/01/2017	1.9	Dr J Costa	Comments regarding Obesity Management Pathway received from the author and incorporated into Guideline

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Obesity in pregnancy is associated with a number of adverse outcomes – both maternal and fetal

There is evidence to suggest obesity is a risk factor for maternal death. MBRRACE report 2009-2013 reported that 30% of mothers who died were obese

Obesity in pregnancy is recognised by the NHS Litigation Authority Clinical Negligence Scheme for Trusts as one of the high risk conditions requiring the availability of a local guideline in all maternity units

1.2 Purpose

The guidelines are drawn by incorporating joint CMACE/RCOG guidelines to provide all clinicians caring for obese pregnant women with evidence based interventions to improve the quality of care for this women.

Guidelines below are related to the index guidelines, and can be accessed through intranet.

1.3 Objectives

This guideline should ensure that medical/midwifery staff follows the same pathway when caring for the obese pregnant woman.

2.0 SCOPE OF THE GUIDELINE

All Medical/Midwifery staff who care for obese women antenatally, intrapartum and postnatally

3.0 ROLES/RESPONSIBILITIES

All medical/midwifery staff must adhere to this guideline

4.0 KEY GUIDELINE PRINCIPLES

4.1 Definitions

Obesity in pregnancy is usually defined by Body Mass Index (BMI) of 30kg/m ^{2} or more at first antenatal consultation.

Calculation of BMI

$$\mathrm{BMI} = \frac{weight\ (\mathrm{kg})}{height^2(\mathrm{m}^2)}$$

Classes of Obesity

BMI	Class
30.0 – 34.9	1
35.0 – 39.9	2
>40.0	3 – Morbid Obesity

- Each patients Weight, Height and calculated BMI should be recorded in their maternity record at booking and will be available as part of their NIMATS information.

- Some areas of this guideline will be more relevant to women in the higher classes of obesity (BMI > 40) – if so this will be stated

4.2 Guideline Principles

4.21 Preconception:

Opportunity should be taken where practical to discuss issues related to obesity in a sensitive manner and advice given about preconception Folic Acid supplementation. (see below)

GPs should be advised of the need for preconception care of obese women.
At present we do not have a formal preconception care facility for these women.

We do, however, come into contact with obese women of child bearing age in a number of other spheres e.g.: Gynae clinics, Admissions, EPPC.(Early Pregnancy Problems Clinic)

4.22 Antenatal:

Women with high BMI are at increased risk of neural tube defects and other congenital abnormalities. They are also less likely to receive adequate Folic Acid in their diet and Vitamin D deficiency is also common.

Women with BMI > 30 should have:

- High dose Folic Acid 5mg daily from one month before conception until 12 weeks gestation

- Vitamin D 10 micrograms daily during pregnancy and breast feeding. Note: preparation of Vitamin D available on the market: Vitamin D with calcium.

  .
  Use of the relevant supplements should be checked with the woman and documented on the booking letter to their GP.

- Weight and Height of all women should be formally measured and recorded in the maternity notes

- The women should be provided with a patient information leaflet on Obesity in Pregnancy and given an opportunity to discuss any concerns (appendix 1).

- For women with BMI >40kg/m (class 3 obesity) “antenatal management of pregnant women with BMI>40” should be attached to the maternity notes at booking. (Appendix 2)

- Referral to “Weigh to Healthy Pregnancy Clinic” should be offered to all women with BMI > 40kg/m^2 and documented in the notes. Currently this service funded by PHA is offered to women with BMI >40 and this should be encouraged at booking

- If BMI>40 referral should be made to be reviewed in anaesthetic clinic, and this should be documented in the notes. The referral forms are available in antenatal clinic.

- If BMI>40 the risk of gestational diabetes should be discussed and the record of discussion should be documented in the notes

- Women with booking BMI >40 or with booking BMI 35-40 with additional risk factors should be booked to have Glucose Tolerance Test (GTT) performed at 28 weeks’ gestation. This can be arranged by contacting Day Obstetrics Unit (DOU) on 02890633562.

Screening for Hypertensive Disease and Preeclampsia

Maternal obesity is associated with an increased risk of preeclampsia.

- Women with BMI>35 (class 2 and 3 obesity) and additional risk factors (see Appendix 3), as above, should be seen by medical staff at booking and a plan made for appropriate surveillance during pregnancy.

- Women with BMI 35 - 40(class 2 obesity) and one or more other risk factor from the list (Appendix 3) may benefit from taking Aspirin 75mg daily from 12 weeks gestation till delivery and this should be offered at booking.

- Women with BMI >40 (class 3 obesity) women with BMI >40 even without any other risk factors may benefit from taking Aspirin 75mg daily from 12 weeks gestation till delivery and this should be offered at booking.

- Blood pressure should be taken with an appropriately sized cuff and the size of cuff used documented in the patients notes.

Thromboprophylaxis

Obesity increases the risk of venous thromboembolism. The rate of both deep venous thrombosis (DVT) and pulmonary embolism (PE) is increased in women with BMI>30. Risk is increased both antenatally and postnatally.

- All women with BMI>30 should have a formal risk assessment for thromboembolism at their booking visit. The risk should be monitored during pregnancy, delivery and postnatally.

- RCOG "Risk assessment for venous thromboembolism chart" will be available in all clinical areas and should be used to assess the women. **Please note that BMI >40 is considered as 2 risk factors.** (Appendix 4)

- Women with BMI>30 who also have two other additional risk factors for thromboembolism (see Appendix 4) should be offered prophylactic Low Molecular Weight Heparin (LMWH) antenatally from twenty eight weeks of gestation.

- Women with BMI>30 who also have three or more additional risk factors for thromboembolism (see Appendix 4) should be offered prophylactic (LMWH) antenatally from the first trimester.

- **Please note that BMI >40 is considered as 2 risk factors.** Women with BMI>40 who also have one additional risk factors for thromboembolism (see Appendix 4) should be offered prophylactic (LMWH) antenatally from from twenty eight weeks of gestation.

- Please note that BMI >40 is considered as 2 risk factors. Women with BMI>40 who also have two or more additional risk factors for thromboembolism (see Appendix 4) should be offered prophylactic (LMWH) antenatally from from the first trimester.

- The antenatal/ intrapartum /postnatal plan for LMWH treatment should be documented in the notes. Note: LMWH is not licensed for use in pregnancy.

- Women should be educated and shown how to inject subcutaneous LMWH at the clinic and prescription for the GP to provide rest of the supply should be completed.

- Delivery plan for women on prophylactic LMWH is available (printed in Purple) in the antenatal clinic and should be attached to the antenatal notes.

- All women receiving antenatal thromboprophylaxis should usually continue until six weeks postpartum.

- Women with booking BMI>30 requiring thromboprophylaxis with LMWH should have weight specific dose prescribed. Note: caution if Enoxaparin dose exceeds 100mg – discuss with haematologist before prescribing.
  (may be given as a once daily dose or divided into two doses as preferred)

Weight (Kg)	Dose
50-90	Enoxaparin 40mg daily
91-130	Enoxaparin 60mg daily
131-170	Enoxaparin 80mg daily
>170	Enoxaparin 0.6mg/kg/day

- Mobilisation as early as it is practical after delivery and maintaining good hydration should be encouraged.

- All inpatient women with BMI >30 should have TEDS stockings prescribed and used.

- All women with BMI>40 (class 3 obesity) should be offered postnatal thromboprophylaxis and given TEDS stockings for ten days after delivery, regardless of their mode of delivery

- Women with BMI>30 and one or more additional persisting risk factors for thromboembolism (appendix 4) should be considered for postnatal thromboprophylaxis and given TEDS stockings for ten days after delivery

- Any plans to prescribe LMWH thromboprophylaxis to continue after discharge from hospital should be clearly communicated to the patient's GP and Community Midwife including detail of dose and duration of treatment in accordance to the Share Care Guideline for prescribing Enoxaparin

Communication:

- The Lead Midwife for Intrapartum Care should be informed in advance of the EDC of women who weigh > 180kg at booking to enable preparation of equipment etc
- The BMI of all women should be documented on the Induction of Labour (IOL)/Caesarean section list

4.23 Labour and Delivery

Women who are obese in pregnancy are at increased risk of having slow progress in labour, shoulder dystocia, and emergency Caesarean section. There is also increased risk of primary postpartum haemorrhage. Caesarean section can be technically difficult. There is a higher risk of anaesthetic complications in obese women. Fetal monitoring in labour can be difficult to achieve.

- Women with BMI>30 should be encouraged to read the patient information leaflet on obesity in pregnancy and to discuss any concerns regarding delivery with a senior doctor at antenatal clinic. Any discussion and its outcome should be fully documented in the notes.

- Maternal obesity is not a clinical indication for induction of labour in the absence of other factors. Women with BMI >30 should have induction of labour in accordance with the present IOL protocol. All effort should be made

to increase chances of spontaneous onset of labour such as membrane sweep, avoiding early inductions unless clinically indicated.

- When IOL is required for women with BMI >40, it is safe practice to avoid weekend and bank holidays to ensure the availability of a senior staff to make decisions and undertake delivery.

- When the induction process is commenced, all efforts must be made to perform Artificial Rupture of Membranes (ARM) as early in the morning as possible, especially when the BMI is >40 to allow appropriate decision making during the day with regard to failure to progress needing emergency Caesarean section. It is quite difficult to confirm presenting part by abdominal examination in women BMI>40 and it would be considered safe practice to confirm the presentation by ultrasound scan before performing ARM.

- An Obstetrician and an Anaesthetist at Specialty Trainee year 6 and above, or with equivalent experience in a non-training post, should be informed and available for the care of women with a BMI >40 during labour and delivery, including attending any operative vaginal or abdominal delivery and physical review during the routine medical ward round.

- The use of a fetal scalp electrode should be considered especially where there is difficulty in monitoring the fetal heart or during the insertion of regional anaesthesia**.** Note: standard contraindications for use of scalp electrode apply

- Women in labour with BMI>40 (class 3 obesity) should be regularly reviewed by the most senior Obstetrician on duty

- Elective Caesarean sections being performed on women with BMI>40 (class 3 obesity) require the Consultant Obstetrician in charge to supervise trainees

- Women with BMI>30 have increased risk of wound infection and should receive antibiotic prophylaxis in accordance with Belfast Trust guidelines and in conjunction with allergy status

- Women with >2cm of subcutaneous fat should have suturing of the subcutaneous fat space to prevent wound infection and breakdown

- For women with BMI >35 (class 2 and 3 obesity) undergoing Caesarean section topical skin adhesive with microbial properties may be considered - in conjunction with allergy status, (Dermabond, available in Belfast Trust). Sutures with antibiotic (Vicryl plus) and a special type of dressing with a film over an island type pad (Premierpore UP) will reduce the risk of infection.

- In women considered to be in extremely high risk of infection such us BMI >40 (class 3 obesity) or BMI 35-40 with coexisting diabetes or other significant risk factor for infection a Topical Negative Pressure Dressing (Pico) should be considered

Obesity is associated with increased risk of post-partum haemorrhage

Women with BMI>35:

- Should be strongly encouraged to have active management of the third stage
- Should have intravenous access established early in labour
- Women with BMI>40 (class 3 obesity) should be strongly advised to have active management of third stage

Vaginal birth after Caesarean section (VBAC)

Obesity is a risk factor for unsuccessful VBAC. Deciding mode of delivery after previous Caesarean section can be more complex in obese patients and should take into consideration the indication for the previous caesarean section and the patient's current clinical situation. Morbid obesity (class 3 obesity, BMI>40) in particular carries additional risk for uterine rupture in labour and neonatal injury. Trial of labour carries the risk of emergency caesarean section which could be technically challenging and carries additional risk if done out of working hours.

- Decision for VBAC or Elective Repeat Caesarean section should be made by a Consultant. The woman should be informed of the individual risks and benefits and this should be documented in the notes

Water birth

Water birth is generally contraindicated for women with BMI>35

- Any woman with BMI>35 wishing to have a waterbirth should have an individualised discussion antenatally regarding the risks.
- Labour Ward Co-ordinator, the senior Obstetrician on duty and the Anaesthetist should be involved in decision making for women of BMI >35 wishing to birth in water. These should be documented in the notes.

4.24 Labour and Delivery

Breastfeeding has numerous well recognised benefits. Breastfeeding rates are low in women with BMI>30

- All obese women should be informed of the benefits of breastfeeding, including postnatal weight loss, and given support to initiate and maintain breastfeeding.
- Postnatal ward staff should be vigilant to the risk of wound infection and seek senior review at an early stage if concerned.
- If the wound shows any signs of breakdown early antibiotic administration and antimicrobial dressing (for dry wounds - honey based dressing, for wet

wounds silver based dressing) should be initiated. Tissue Viability Nurse should be contacted via call manager 02890565565

- Reducing weight between pregnancies has been shown to reduce overall risks and specifically the risk of developing gestational diabetes

- Women should be encouraged to lose weight before embarking on their next pregnancy.

- Referral to dietetic services should be discussed if not pursued antenatally

- Women who have had gestational diabetes are at increased risk of developing Type 2 diabetes later in life

- Women should be informed of the risk of Type 2 diabetes and advised to seek review with their GP after their pregnancy

Algorithm for the management of obese women during pregnancy, labour and postnatally see Appendix 5

5.0 IMPLEMENTATION OF GUIDELINE

5.1 Dissemination

- Obstetricians
- Midwives
- Anaesthetists
- Maternity Services Liaison Group

Following the approval from Standards and Guideline Committee, the guideline will be available to access for all staff through BHSCT intranet site.

6.0 MONITORING

This guideline contains the current evidenced based thinking on this topic, however data and statistics are routinely collected and correlated and should the need arise the guideline will be updated.

7.0 EVIDENCE BASE / REFERENCES

CMACE/RCOG Joint Guideline: Management of Women with Obesity in Pregnancy. March 2010

Knight M, Tuffnell D, Kenyon S, Shakespeare J, Gray R. Kurinczuk JJ, editors. on behalf of MBRRACE-UK. Saving lives, improving mothers' care – lessons learned to inform future maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2009–13. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2015.
RCOG Greentop Guideline No 37a. Reducing the risk of thrombosis and embolism during pregnancy and puerperium. London, RCOG 2015.
GAIN, guideline for admission to midwife-led units in Northern Ireland, September 2016

8.0 CONSULTATION PROCESS

Insert a list of those groupings consulted in the development of this policy e.g. Trade Unions, Specialist Committees, User groups, Carer Groups, Section 75 groups,

9.0 APPENDICES / ATTACHMENTS

Appendix 1: Patient Information Leaflet (Hyperlink)
Appendix 2: Antenatal Management of Pregnant Women with BMI>40
Appendix 3: Additional Risk Factors for Hypertensive Disease and Preeclampsia
Appendix 4: Obesity Management Pathway

10.0 EQUALITY STATEMENT

The Trust is committed to ensuring equality of opportunity for all service users and staff in terms of disability and complies with the Disability Discrimination Act 1995, the United Nations Convention on the Rights of people with disabilities. The Human Rights Act 1998 and Section 75 of the Northern Ireland act 1998. The Trust has a number of policies/strategies in place including the Disability Action Plan, aimed at encouraging disabled people to participate in public life and promote positive attitudes towards disabled people. All staff has access to Disability awareness training.

If support is required in terms of the communication of this policy regarding interpreting or translated information this will be provided.

The outcome of the Equality screening for this policy is:

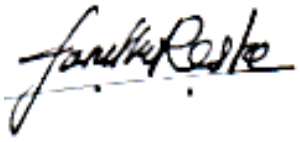
Major impact ☐

Minor impact ☐

No impact. X

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



_____ Date: ___July 2017____

Author

_____ Date: ___July 2017____

Director

Appendix 1

Patient Information Leaflet:
Pregnancy and your weight.

http://intranet.belfasttrust.local/policies/Documents/Obesity%20Booklet.pdf

Appendix 2:

Antenatal management of pregnant women with BMI > 40

Gestation	Review by	Management Plan	Comment
<12 weeks	GP Midwife	Folic Acid 5mg Vitamin D 10 micrograms	
12 – 14 weeks	Booking MW Consultant/senior reg	• Booking scan • **For TVS if abdominal scan not clear** • Risk assessment for thrombopophylaxis (see overleaf) Measure for Ted stockings • Record the correct size of BP cuff • Aspirin 75mg till delivery • Refer to WHP clinic • Anaesthetic referral • Book GTT for 28 weeks • Arrange Uterine Ar Doppler at 20 weeks	
16 weeks	Midwife/GP	BP, Urine	
20 weeks	Ultrasonographer Specialty Midwife	• Anomaly Scan • Arrange fetal growth at 24 weeks if Uterine Ar Doppler is abnormal	
24 weeks	Midwife/GP (**Consultant/senior reg if Uterine Ar Doppler is abnorma**l)	BP, Urine (BP, Urine, Fetal growth Uterine Ar Doppler is abnormal)	
29 weeks	**Consultant/senior reg**	• BP, Urine, Fetal growth • **Review GTT results** • 29 weeks bloods/anti D • **Risk assessment for**	

		thromboprophylaxis (overleaf)	
33 weeks	**Consultant/senior reg**	BP, Urine, Fetal growth	
34 weeks	Midwife/GP	BP, Urine, Fetal heart	
36 weeks	Midwife/GP	BP, Urine, Fetal heart	
37 weeks	**Consultant/senior reg**	BP, Urine, Fetal growth	
38 weeks	Midwife/GP	BP, Urine, Fetal heart	
39 weeks	**Consultant/senior reg**	• BP, Urine, Fetal growth • Delivery plan • Inform LW sister/Theatre sister	

Appendix 3

Additional Risk Factors for hypertensive disease and preeclampsia

Additional Risk factors for Preeclampsia
First pregnancy
Previous PET
>10 years since last baby
Age >40 yrs
Family history of PET
Booking Diastolic BP >80mmHg
Booking Proteinuria >1+ OR >0.3g/24hrs
Multiple pregnancy
Antiphospholipid syndrome
Essential Hypertension
Renal Disease
Diabetes

Appendix 4

OBESITY MANAGEMENT PATHWAY

BHSCT Guidelines for the management of Obesity in Pregnancy, during Labour and Postnatal

Belfast Health and Social Care Trust
caring supporting improving together

<table>
<tr><th colspan="3">Antenatal</th></tr>
<tr><td>BMI ≥ 30 = 1 VTE risk factor</td><td>BMI ≥ 35 = 1 VTE risk factor</td><td>BMI ≥ 40 = 2 VTE risk factor</td></tr>
<tr><td colspan="3">BMI ≥ 30
• High dose Folic Acid 5mg daily
• Vitamin D 10mcg daily
• Measure and Record height and weight
• Provide patient information leaflet ‘Obesity in Pregnancy’
• Use appropriate size BP cuff and record size in case notes
• Formal documented VTE risk assessment
• All A/N inpatients should have anti-embolism stockings prescribed and worn and consider and plan for equipment and handling
• Decision for VBAC or Repeat Elective Caesarean Section should be made by Consultant Obstetrician and risks discussed and documented</td></tr>
<tr><td></td><td colspan="2">BMI ≥ 35
• Women requesting water birth should have a documented individual discussion</td></tr>
<tr><td colspan="2">BMI 30 – 40
• 2 additional VTE risk factors offer prophylaxis from 28 weeks’ gestation
• 3 or more additional VTE risk factors offer prophylaxis from 1st trimester</td><td rowspan="2">BMI ≥ 40
• 1 additional VTE risk factor offer prophylaxis from 28 weeks’ gestation
• 2 or more additional VTE risk factors offer prophylaxis from 1st trimester
• Referral to ‘Weigh to a Healthy Pregnancy’ Clinic
• Referral to Anaesthetic Clinic
• Discuss risk of Gestational Diabetes
• Book for GTT at 28 weeks’ gestation
• Arrange Uterine Artery Doppler at 20 weeks
• If additional PET risk factors;
o medic to review at booking and document plan for surveillance
• Require Aspirin 75mg daily from 12 weeks’ gestation until delivery
• If IOL required avoid weekend and bank holidays</td></tr>
<tr><td></td><td>BMI 35 – 40
• If 2 additional risk factors – GTT at 28 weeks’ gestation
• If additional PET risk factors;
o medic to review at booking and document plan for surveillance
o Require Aspirin 75mg daily from 12 weeks’ gestation until delivery</td></tr>
</table>

N.B. Lead Midwife should be informed in advance of EDC of any woman booked who weighs > 180KG and consider discussion at MDT Meeting 01 17

OBESITY MANAGEMENT PATHWAY

BHSCT Guidelines for the management of Obesity in Pregnancy, during Labour and Postnatal

Belfast Health and Social Care Trust
caring supporting improving together

Intrapartum

BMI ≥ 30 = 1 VTE risk factor	**BMI ≥ 35** = 1 VTE risk factor	**BMI ≥ 40** = 2 VTE risk factor
BMI ≥ 30 • Consider FSE where there is difficulty monitoring FH, particularly during insertion of regional analgesia • Strongly encourage active management of third stage of labour • Women with > 2cm of subcutaneous fat should have it sutured • Where IV access required it should be obtained early in labour		
	BMI 35-40 • Women requesting water birth should have a documented individual A/N discussion and further collaborative discussion intrapartum • Women with coexisting diabetes or other significant risk factor for infection a Topical Negative Pressure Dressing (PICO) should be considered	
		BMI ≥ 40 • Women requesting water birth should have a documented individual A/N discussion and further collaborative discussion intrapartum • If IOL required avoid weekend and bank holiday • It would be safe practice to confirm the presentation by ultrasound before ARM and all effort should be made to perform ARM early in the morning • Elective Caesarean Section requires Consultant Obstetrician to supervise trainees • Senior Obstetrician and Anaesthetist (year 6 and above) present during ward round and during labour and delivery responsible for undertaking regular review • PICO should be applied after CS

N.B. Lead Midwife should be informed in advance of EDC of any woman booked who weighs > 180KG and consider discussion at MDT Meeting 01 17

OBESITY MANAGEMENT PATHWAY

BHSCT Guidelines for the management of Obesity in Pregnancy, during Labour and Postnatal

Belfast Health and Social Care Trust
caring supporting improving together

Postnatal

BMI ≥ 30 = 1 VTE risk factor	**BMI ≥ 35** = 1 VTE risk factor	**BMI ≥ 40** = 2 VTE risk factor
BMI ≥ 30 • Early mobilisation and good hydration • Those women who received antenatal prophylaxis should continue up to 6 weeks postpartum • All P/N inpatients should have anti-embolism stockings prescribed and worn • Any wound issues contact Tissue Viability Nursing Team • Women should be encouraged to lose weight before embarking on their next pregnancy • Consider referral to dietitian • Encourage breastfeeding		
BMI 30 – 40 • 1 additional VTE risk factor consider P/N prophylaxis and anti-embolism stockings for 10 days • Communicate with C/M and GP		
		BMI ≥ 40 • Offer and encourage prophylaxis for 10 days Postpartum and anti-embolism stockings regardless of mode of delivery • Communicate with C/M and GP

N.B. Lead Midwife should be informed in advance of EDC of any woman booked who weighs > 180KG and consider discussion at MDT Meeting 01 17