Background and Introduction

At least 2.8 million people die every year from being overweight or obese (1). It is estimated that 44% of cases of diabetes, 23% of cases of heart disease, and 7–41% of cases of cancer can be attributed to overweight or obesity (2). Between 2011 and 2014 the prevalence of overweight and obesity among women was 38.3%, and increased with age. During that period, 21% of females aged 12–19 years, 34.4% of women aged 20–39 years, and 42.1% of women aged 40–59 years were overweight or obese. Physical examinations are less accurate, cesarean delivery rates are increased, and gynecologic surgery is prolonged and more challenging in obese women. Physicians are held accountable for suboptimal patient outcomes, and obesity affects outcomes.

Some obstetrician–gynecologists or other health care providers may avoid a discussion of overweight and obesity, perhaps assuming that their patients do not want to discuss the problem or attempt treatment, or perhaps because they are concerned about alienating the patients. A study by the Rudd Center for Food Policy and Obesity at Yale University found that nearly one half of 4,000 respondents to an online survey said they would rather give up a year of their life than be overweight. Between 15% and 30% said they would rather walk away from their marriages, give up the possibility of having children, be depressed, or become alcoholic than be obese (3). Although weight can be a sensitive subject for many, patients who are in need of weight loss appreciate an empathetic factual approach and a sensible plan to help them deal with the disease of obesity.

As members of the American College of Obstetricians and Gynecologists (ACOG), obstetrician–gynecologists are in a unique position to recognize, discuss, and help reduce the effects of obesity in patients. Many of these patients are the primary individuals directing the health of their families. Because of the risks of obesity in pregnancy and the increased risk of obesity in their offspring, obstetrician–gynecologists can help optimize the health of patients and their children. Moreover, identifying and treating obesity before pregnancy can be very beneficial. A Duke University Medical Center study found that women who lost 10% of their total body weight reported a significant improvement in their sex lives (4). Clearly, overweight and obesity are factors that affect the quality of life of patients and future generations.

Nevertheless, an ACOG member survey found that the involvement of Fellows in obesity screening and referral is inconsistent. A weight management program referral, when indicated, occurred approximately 50% of the time, and counseling about physical activity and weight control occurred between 55% and 75% of the time, respectively (5).

The U.S. Preventive Services Task Force updated its guidelines in 2012 and recommended that physicians screen all adults for obesity and refer patients with a body mass index (BMI) (calculated as weight in kilograms divided by height in meters squared) of 30 or greater to intensive,
multicomponent behavioral interventions (grade B). The American College of Obstetricians and Gynecologists recommends that routine medical examinations include an assessment of the patient’s weight and BMI, and when overweight and obesity are diagnosed, consideration of referral for evaluation and treatment of obesity. A discussion about your patient’s BMI takes only a minute. This toolkit can make assessing and managing overweight and obesity easier and more efficient.

The Obesity Toolkit provides expanded resources, depending upon level of focus, to help ACOG Fellows address overweight and obesity (see Obesity Assessment Algorithm), and offers two pathways to treatment:

1. To consistently screen for overweight and obesity and to refer patients with an elevated BMI (yellow path)
2. To institute multicomponent treatments for patients with an elevated BMI (green path).

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**Obesity Assessment Algorithm**

**Assess risk factors:**
- AODM
- Dyslipidemia
- GERD
- Hypertension
- Immobility
- Obstructive sleep apnea
- Osteoarthritis
- PCOS
- Stress incontinence

1. **BMI ≥25–29 OR Waist ≥35 in. (88 cm)**
   - Yes → **Are ≥2 risk factors present?**
     - Yes → **Does patient want to lose weight?**
       - Yes → **Clinician and patient devise goals and treatment strategy for weight loss and risk factor control**
       - No → **Assess reasons for failure to lose weight**
     - No → **BMI ≥30**
   - No → **Every well-woman/annual visit**

2. **BMI ≥30**
   - Yes → **Measure weight, height, and waist circumference. Calculate BMI**
   - No → **Educate, reinforce, prevent obesity**

3. **BMI ≥27 and 2 or more risk factors or BMI ≥30**
   - **Pharmacotherapy**
   - **Lifestyle therapy**

4. **BMI ≥25–29.9 and 2 or more risk factors or BMI ≥30**
   - **Lifestyle therapy**

5. **BMI ≥35 and 2 or more risk factors or BMI ≥40**
   - **Weight loss surgery**
   - **Pharmacotherapy**

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Abbreviations: AODM, adult-onset diabetes mellitus; BMI, body mass index; GERD, gastroesophageal reflux disease; PCOS, polycystic ovary syndrome.

Color key: Yellow boxes=screening; green boxes=treatment.

References


