Pregnancy weight gain raises the risk of excessive gestational weight gain.

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Introduction

Women who gain more weight before pregnancy, regardless of their starting weight, are more likely to gain too much weight during pregnancy. Pregnant women with anorexia are more likely to have a stillbirth, a baby who is underweight, or a baby who is born prematurely, but there are no clear standards for how doctors should treat the illness. According to a new study, researchers have identified hidden concerns and developed suggestions and principles for multidisciplinary therapy of anorexia nervosa in pregnancy [1].

The findings include a focus on the mental health, obstetric, medical, and nutritional care that women and their infants require to achieve optimal outcomes. Pregnant women with anorexia are more likely to have a stillbirth, a baby who is underweight, or a baby who is born prematurely, but there are no clear standards for how doctors should treat the illness.

Anorexia nervosa is more common in women during their reproductive years, with up to one in every 200 pregnant women suffering from the disorder. It's usually linked to either limiting or bingeing and purging, or both. According to globally, there are few studies and clinical recommendations on how to manage pregnant women with anorexia [2].

Unlike mood disorders, anxiety disorders, and psychotic disorders, anorexia nervosa in pregnancy has little guidance and study. The assessment and management of eating disorders in pregnancy is only included briefly or not at all in perinatal mental health recommendations, including those in the United Kingdom and Australia. Measures of assessment employed outside of pregnancy, such as the Eating Disorder Inventory or relying on BMI, have been demonstrated to have poor validity in pregnancy.

Clearly, the assessment and monitoring of anorexia nervosa methods and procedures must be modified in the setting of pregnancy. The importance of maternal antenatal nutrition, pregnancy weight gain, and the infant's birth weight as critical risk factors and vital intervention points for improving lifelong health, including areas such as heart disease, diabetes, and obesity, has been highlighted in research into managing the health of pregnant women in general [3]. Anorexia nervosa may influence obstetric and neonatal outcomes due to low calorie intake, nutritional and vitamin deficiencies, stress, fasting, low body mass, and issues with placental function, according to the study. Psychological and emotional concerns, such as perinatal depression and anxiety, are also associated with untreated or undertreated anorexia nervosa during pregnancy.

Obstetric problems are more commonly reported in women with anorexia nervosa. Women with anorexia nervosa in pregnancy had 1.32 times the risk of preterm birth, 1.69 times the adjusted risk of a baby with low birth weight, and 1.99 times the adjusted risk of stillbirth compared to women without anorexia nervosa in pregnancy, according to a study published in 2020 in Canada [4].

Anorexia nervosa requires a multidisciplinary team approach with expertise in mental health, specialist medical care, and dietetics at a minimum; in pregnancy, key experts include obstetricians (particularly experts who manage high-risk pregnancies), physicians with pregnancy expertise, dieticians who also have expertise in pregnancy nutrition requirements, paediatricians, and mental health clinicians with perinatal expertise, according to the study [5]. Although many of the principles developed for the treatment of anorexia nervosa in adults apply in pregnancy, they require expert modification and adaptation due to the significant physiological, psychological, and social changes that occur during pregnancy, as well as consideration of foetal growth and wellbeing.

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***Received**: 26-April-2022, Manuscript No. AAGGS-22-61855; **Editor assigned**: 04-May-2022, PreQC No. AAGGS-22-61855(PQ); **Reviewed**: 18-May-2022, QC No. AAGGS-22-61855; **Revised**: 20-May-2022, Manuscript No. AAGGS-22-61855(R); **Published**: 25-May-2022, DOI:10.35841/2591-7994-6.3.111*

***Citation:** Vigna M. Pregnancy weight gain raises the risk of excessive gestational weight gain. Gynecol Reprod Endocrinol. 2022;6(3):111*