

Pregnancy After Bariatric Surgery

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INTRODUCTION

Obesity in Australia is at an alarming state with almost two thirds of Australian adults being overweight or obese in 2014-2015¹. Overweight defined as adults having Body Mass Index (BMI) of 25 or more, whereas BMI of 30 or more falls into obesity category.

As lifestyle measures and pharmacological treatments have limited weight-reduction results, bariatric surgery is now in increasing demand as a more effective alternative. More than 80% of bariatric surgeries are performed in women with close to half of these are of reproductive age².

CASE REPORT

16 weeks: Presented with abdominal pain with poor oral intake. Obstetrics ultrasound (US) revealed live intrauterine gestation with no apparent complication. Managed as presumed viral gastroenteritis.

17 weeks: Presented with severe back pain aggravated by meals, bowels not opened for 4 days, minimal oral intake for a week. MRI spine indicates degenerative disease of lumbar spine. US renal tract and US obstetrics were unremarkable. Surgical team consulted and patient was commenced on fleet enema for constipation and subsequently discharged with Obstetrics medicine follow-up.

21 weeks: Represented with loose bowel motion, abdominal pain and nausea, with ongoing poor oral intake and weight loss of 15kg. Stool MCS was unremarkable with negative Clostridium Difficile PCR. Commenced on FODMAP diet by dietitians. Following Gastroenterology consult, metronidazole and loperamide were prescribed for presumed irritable bowel syndrome or increase gastric transit post Roux-en-Y.

23 weeks: Represented to hospital under Gastroenterology with 6 weeks of further loose bowel motion, vomiting and severe generalized abdominal pain with raised inflammatory markers; WCC 13.7^{A9}/L (4-10^{A9}/L) and CRP 99 (<5). Examinations consistent with clinical peritonitis and patient was consented for emergency laparotomy. Surgical findings were ischemic bowel secondary to internal hernia with intraabdominal pus. Partial bowel resection of Roux limb and ends over-sewn. Given nature of surgery, patient was admitted to Intensive Care post operatively and required blood pressure support overnight. Planned relooked laparotomy performed with further ischemic bowel resected.

38 weeks: Elective caesarean section performed, a healthy 2.74kg baby boy was born.

DISCUSSION

Clinical Implications of Bariatric Surgery on Pregnancy³

CONS	NEUTRAL	PROS
Preterm labour, NICU admissions, growth restriction (IUGR)	Congenital abnormality	Fertility
Nutrients & Vitamin deficiency	Miscarriage rates	Decrease incidence of hypertensive disorder & GDM
Increase risk of bowel obstructions & internal hernia	Incidence of pre-eclampsia	Decrease incidence of stillbirth & large for gestational age (LGA)

Management of Pregnancy Following Bariatric Surgery⁴



Schematic representation of Roux-en-Y Bypass⁵

CONCLUSION

Weight loss after bariatric surgery reduces pregnancy complications associated with obesity, it is however associated with an increased risk of intrauterine fetal growth restriction due to nutritional deficiency and malabsorption, as well as surgical complications during pregnancy such as internal hernia or bowel ischemia.

As bariatric surgery becomes more prevalent, it is crucial to be able to appreciate the complications arise from bariatric surgery in pregnancy and manage them promptly, ensure the optimal care for these women and their babies.

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