Introduction

Obesity is a big problem getting bigger. The prevalence of obesity now exceeds the critical threshold of 15%, as defined by the World Health Organization (WHO), to be described as an epidemic. The WHO defines normal weight as a body mass index (BMI) 25.0–29.9 kg/m², overweight as 25.0–29.9 kg/m² and obese as a BMI >30.0 kg/m².1

The ’2005 American Committee on Obstetrics and Gynecology Opinion on Obesity in Pregnancy’ stated that one-third of pregnant women in the USA are obese and recognised that these women are at increased risk of complications.2 Furthermore, it is well known that the incidence of obesity is increasing in pregnancy, with investigators in Scotland and in the Thames Region, Sebire et al, found that gestational diabetes, pre-eclampsia, induction of labour, emergency Caesarean section, postpartum haemorrhage, genital tract infection, wound infection, birth weight above the 90th centile and intrauterine fetal death are all significantly more likely to occur in the obese parturient than her normal-weight counterpart.3

This under-use may also illustrate the difficulties of some obese women in accessing health care. Whilst possible weaknesses in the study may have occurred because the BMI was calculated from self-reported height and weight, and bias could have been introduced as data were only gathered from 11 states, it is an interesting paper and highlights the need for advice and action in relation to preventative health care and contraception in this group.


In this research article, the same multi-state database was accessed, but from 1999, and information on pregnancy intention, BMI and contraceptive use at the time of conception was analysed. Unintended pregnancy was defined as an ‘unwanted’ or ‘mis-timed’ pregnancy. The BMI data were again self-reported and the method of contraception at the time of conception was determined. Unfortunately the database only included women who used some form of contraception. The other half occur spontaneously and are therefore not included in this study. The other half occurs because the BMI was calculated from self-reported height and weight, and bias could have been introduced as data were only gathered from 11 states, it is an interesting paper and highlights the need for advice and action in relation to preventative health care and contraception in this group.


In this research article, the same multi-state database was accessed, but from 1999, and information on pregnancy intention, BMI and contraceptive use at the time of conception was analysed. Unintended pregnancy was defined as an ‘unwanted’ or ‘mis-timed’ pregnancy. The BMI data were again self-reported and the method of contraception at the time of conception was determined. Unfortunately the database only included women who used some form of contraception. The other half occur spontaneously and are therefore not included in this study. The other half occurs because the BMI was calculated from self-reported height and weight, and bias could have been introduced as data were only gathered from 11 states, it is an interesting paper and highlights the need for advice and action in relation to preventative health care and contraception in this group.

Conclusions

Several anti-obesity interventions including drugs, surgery, diet and behavioural therapies have been shown to be effective in the short term for the treatment of obesity. Therefore, obstetricians and gynaecologists need to develop strategies in order to care for women with obesity and related problems in order to maximise health and minimise complications.

Unfortunately, the above studies suggest that obese women may be more likely to be using a contraceptive method other than the COC. The studies demonstrate that there is a positive association between body weight and contraceptive use and outcomes of obesity intervention in this group would be of value.

References