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Research Article

**PREVALENCE OF GESTATIONAL WEIGHT GAIN IN
PREGNANT FEMALES****Dr. Ayesha Saddiqa¹, Dr. Aqsa Ibraheem², Dr. Farwa Naseem³****Article Received:** October 2020 **Accepted:** November 2020 **Published:** December 2020**Abstract:**

Gestational weight gain is defined as the amount of weight gain a woman experiences between conception and birth of an infant. The Institute of Medicine (IOM) recommendations for gestational weight gain are based on body mass index (BMI) of women prior to pregnancy. A total of 129 pregnant females presenting in obstetrical clinics were included in this study. Name, maternal age, gestational age, history of weight before and during the pregnancy were noted on a predefined proforma. All the data was entered and analyzed in SPSS Ver. 23.0. The qualitative variables were presented as number and percentages. The quantitative variables were presented as mean and standard deviation. The mean age of the patients was 29.31 ± 2.34 years. The minimum age of the patients was 24 years, and the maximum age was 31 years. Out of 129 patients, 43 had had normal weight before and during the pregnancy. 23 patients were of normal weight before being pregnant but gained became overweight during this course of time.

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INTRODUCTION:

Gestational weight gain is defined as the amount of weight gain a woman experiences between conception and birth of an infant. The Institute of Medicine (IOM) recommendations for gestational weight gain are based on body mass index (BMI) of women prior to pregnancy. However, early first trimester BMI appears to be a valid proxy for pre-conception BMI. BMI is split up into four categories: underweight (<18.5 kg/m²), normal weight (18.5-24.9 kg/m²), overweight (25.0-29.9 kg/m²), and obese (≥ 30.0 kg/m²). The IOM has recommended the ranges of weight gain to be 12.5–18 kg, 11.5–16 kg, 7.0–11.5 kg, and 5–9 kg respectively. That is, the smaller the BMI pre pregnancy, the more weight a woman is expected to gain during her pregnancy.

Excessive GWG has been shown to adversely affect maternal and baby health postpartum. Only a little over a quarter of women have adequate GWG, meaning that their weight gain during pregnancy falls within the IOM recommended range. A little less than a quarter of women have inadequate GWG. However, excessive GWG is the most prevalent occurring in around half of pregnant women. Having a higher BMI pre-pregnancy may leave you at a greater risk for excessive gestational weight gain and ultimately for cardio-metabolic diseases prenatally and postpartum. Overweight and obese women are significantly more likely to expect excessive gestational weight gain compared with normal-weight women, and women who report expecting to gain excessively are three times more likely to actually gain excessively than those who expect to gain within the guidelines. Regardless of a relation to food security, having a low income might also predispose women to excess gestational weight gain, yet the reasoning is unclear. One possibility is related to stress. Financial stress has been shown to be positively correlated with levels of CRP postpartum, a stress hormone associated with weight gain most likely because people eat increasingly unhealthy when stressed. Women with a higher monthly budget for food may have a healthier gestational weight gain, while those with less money allocated for food may be more likely to experience excessive gestational weight gain. However, the opposite may also be true: wealthier women may be more likely to suffer from excess gestational weight gain. Women in wealthy communities have been reported to have higher postpartum weight retention than those in more poverty, and since women who have excessive gestational weight gain are more likely to retain weight postpartum women in less poverty might be more likely to have excess gestational weight gain. This suggests that a greater household income

does not necessarily provide protection against excess gestational weight gain (1-3).

MATERIAL OF METHODS:

A total of 129 pregnant females presenting in obstetrical clinics were included in this study. Name, maternal age, gestational age, history of weight before and during the pregnancy were noted on a predefined proforma. All the data was entered and analyzed in SPSS Ver. 23.0. The qualitative variables were presented as number and percentages. The quantitative variables were presented as mean and standard deviation.

RESULTS:

The mean age of the patients was 29.31 ± 2.34 years. The minimum age of the patients was 24 years, and the maximum age was 31 years. Out of 129 patients, 43 had had normal weight before and during the pregnancy. 23 patients were of normal weight before being pregnant, but gained became overweight during this course of time.

DISCUSSION:

The adequacy of accumulated weight gain or achieved weight status at any given stage of pregnancy can be determined only when the length of gestation is known. An accurate estimate of length of gestation is also essential for research on gestational weight gain and fetal growth. By far the most common method of estimating length of gestation is calculation of the time since the last menstrual period (LMP) based on dates provided by the woman at her first prenatal visit. There is an established literature (e.g., Oates and Forrest, 1984; Wilcox and Horney, 1984) dealing with the accuracy of recall of this date. Recall becomes increasingly problematic as the LMP becomes more distant in time and memory becomes less reliable. Also, a small percentage of conceptions in the United States occur during amenorrheic cycles. In some pregnancies, vaginal bleeding occurs within the first 4 to 6 weeks after conception and is falsely reported as a menstrual flow. Moreover, the date of the LMP does not denote the beginning of the pregnancy but only the presumed beginning of the cycle that produced the ovum that was fertilized 10 to 14 days later. Actual gestational length, or time from conception, is rarely known and is even less likely to be accurately self-reported several months after conception.

Actual length of gestation is generally calculated from the estimated date of conception up to the date of the prenatal exam or delivery, whichever is applicable. In the clinic, a gestational age calculator or table, special computer program, or programmed hand calculator

should be used to estimate the length of time since last menstruation, rather than calculations made in the head or on paper. Early (prior to 20 weeks) ultrasound measurement of the fetal biparietal diameter represents an alternative for estimating gestational duration. Although errors in estimating gestational duration may pose problems of interpretation when one uses incremental weight gain from conception to a point later in gestation, they do not do so when estimating the rate of weight gain between two or more prenatal visits after the first trimester. A shift of several weeks in the gestational age estimate does not affect the interpretation of the rate of gain, since it is generally linear over a broad range of pregnancy from 13 to 35 weeks of gestation (4-6).

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