



Maternal Gut Microbiome Composition and Gestational Weight Gain in African American Women

Sara Mitchell Edwards PhD, MN, MPH, CNM

Assistant Professor

Nell Hodgson Woodruff School of Nursing



Emory University

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Disclosures

- Author: Sara M. Edwards PhD, MN, MPH, CNM
- Objectives:
 - At the conclusion of this presentation, the participants will be able to:
 - Identify the incidence and risk of preexisting and gestational obesity among African American women in the U. S.
 - Summarize the state of the science related to gut microbiome composition in pregnancy
 - Describe the relationship between maternal gut microbiome composition during pregnancy and interval and total gestational weight gain.
 - Examine implications for future research and clinical practice.
- Employer: Emory University
- There was no commercial support for this research

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2/3 of American women of childbearing age are overweight or obese (**80% of AA**)



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EGW and failure to lose weight postpartum predictors of **lifelong** obesity



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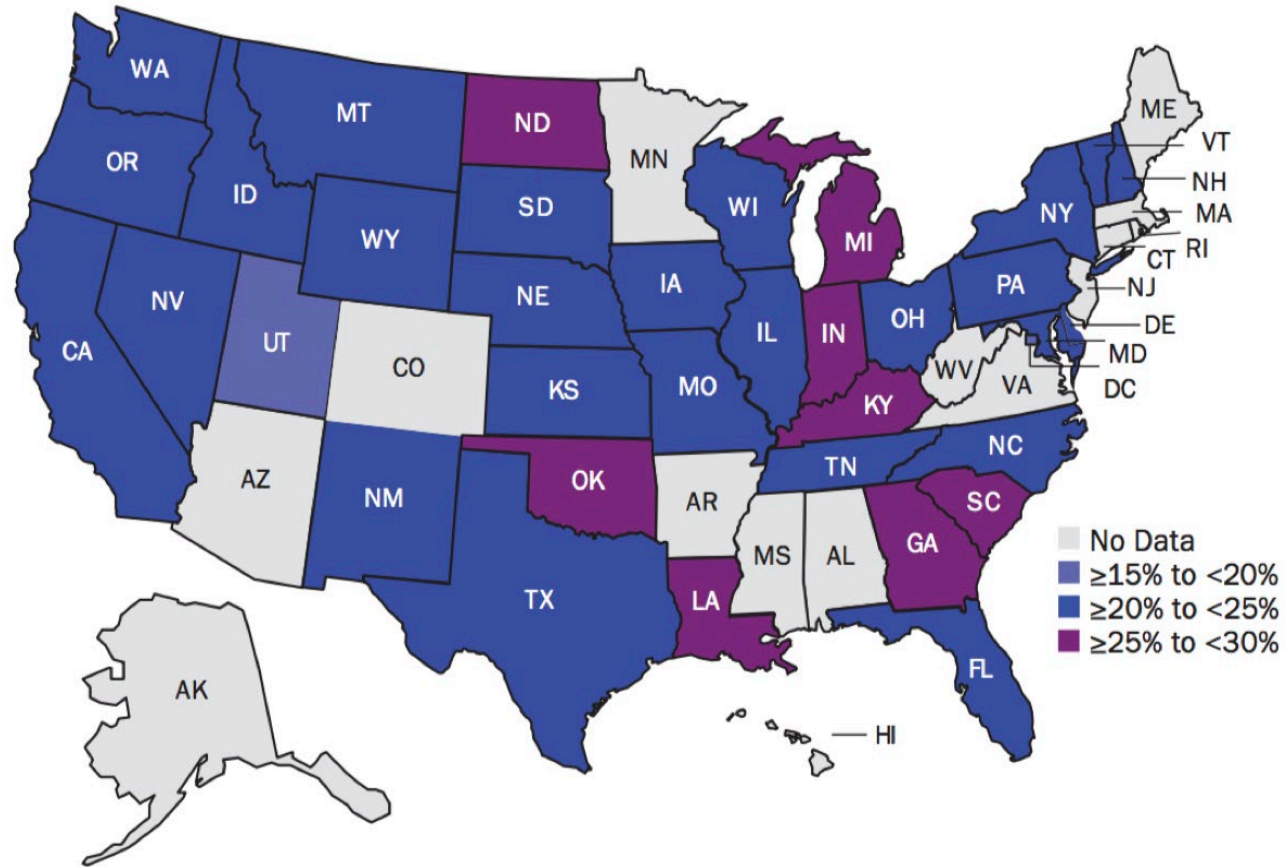
Overweight women are **6** times more likely than normal weight to gain EGW

EGW and failure to lose weight postpartum predictors of **lifelong** obesity

60% women retain 10-20 lbs > 6 months postpartum

Percentage of childbearing-age women with obesity, 2011

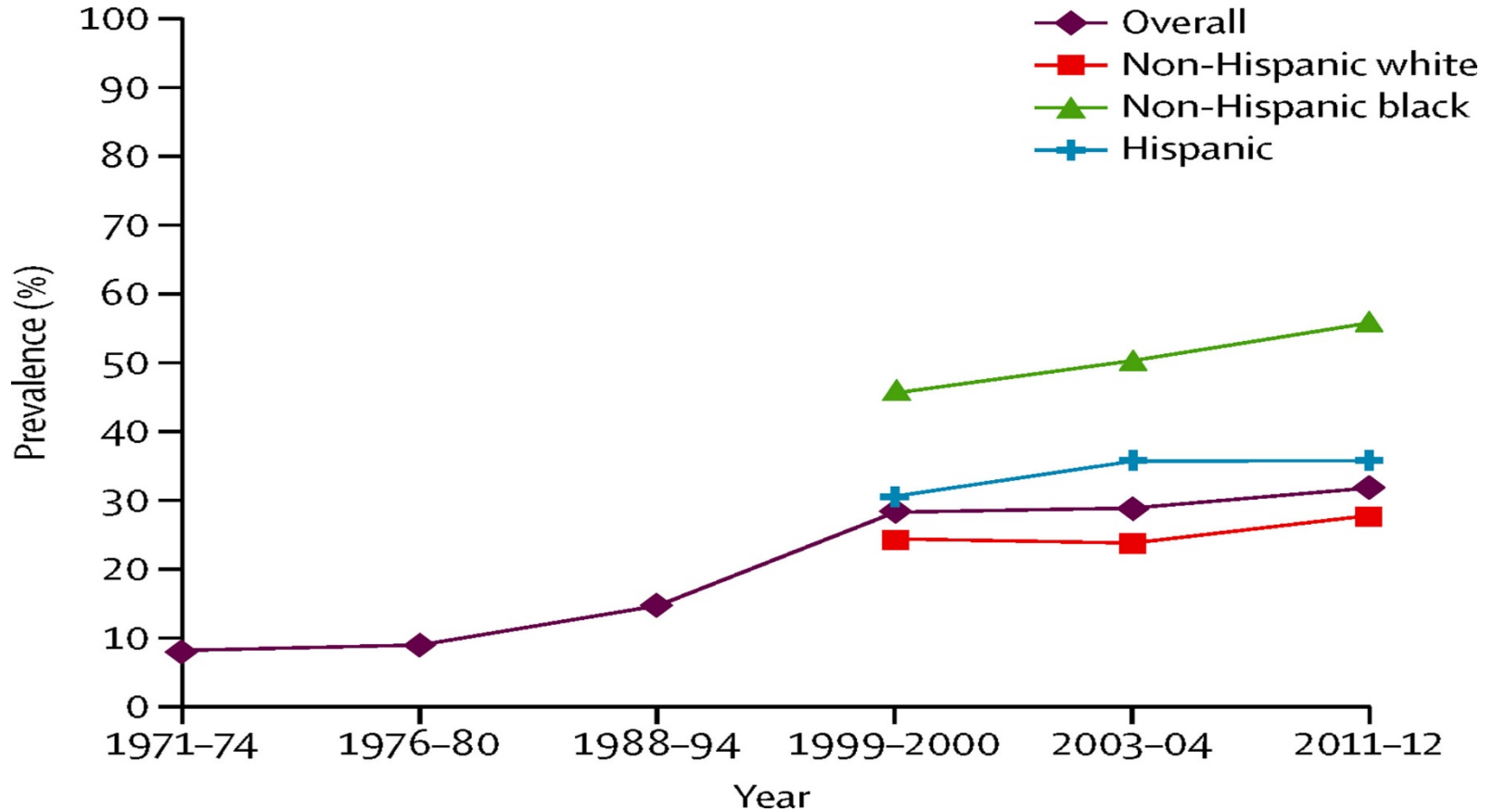
Percent of Women Classified as Obese Prepregnancy by State, 2011



Note: Puerto Rico = 20.5 percent

Source: CDC, National Vital Statistics Reports, U.S. Birth Certificate

Estimated prevalence of maternal obesity in the USA





Gap

in the Literature



Gap in the Literature

Weight and Gut Microbiome



Gap in the Literature

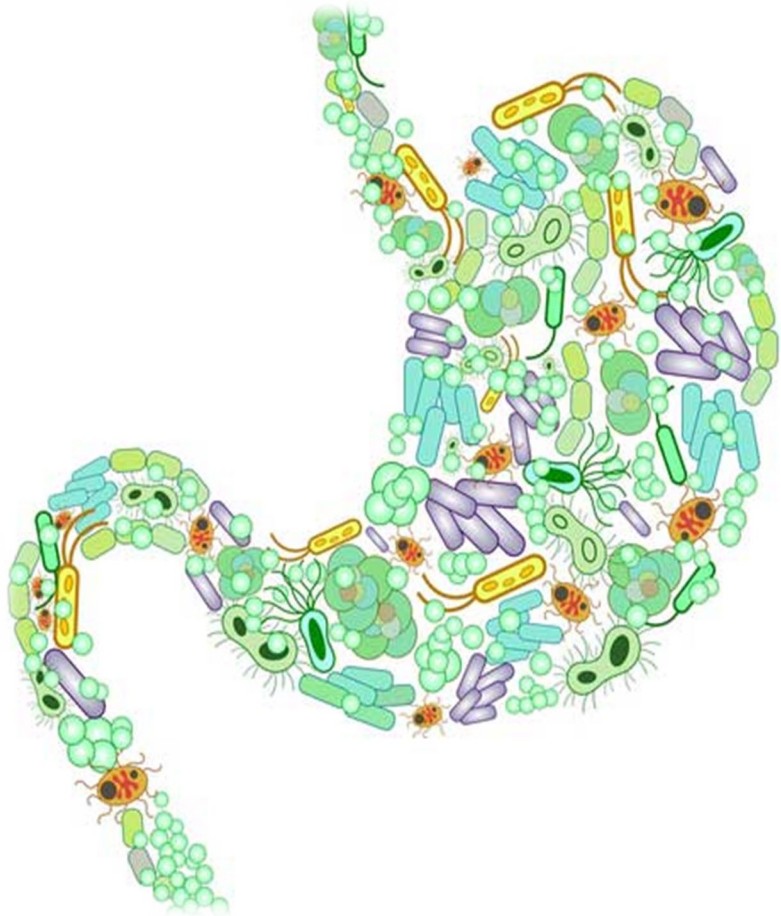
Weight and Gut Microbiome

Differences in Gut Microbiome by Race,
especially in Pregnancy



Purpose of this Study:

To explore the relationship
between gut microbiome
composition and
gestational weight gain in
AA women



Gut Microbiome Composition:

Firmicutes to *Bacteroidetes*
(*FTB*) Ratio

Bruce-Keller, A.J. et al (2017). Maternal obese-type gut microbiota differentially impact cognition, anxiety and compulsive behavior in male and female offspring in mice. *PLoS one*, 12(4).

Power, S. E., et al. (2014). Intestinal microbiota, diet and health. *The British journal of nutrition*, 111(3), 387-402.

Turnbaugh, P. J., et al. (2006). An obesity-associated gut microbiome with increased capacity for energy harvest. *Nature*, 444(7122), 1027-1031.



Phyla Level

Firmicutes

Gram Positive
Dominant in Obese

Bacteroidetes

Gram Negative
Dominant in Lean

Bruce-Keller, A.J. et al (2017). Maternal obese-type gut microbiota differentially impact cognition, anxiety and compulsive behavior in male and female offspring in mice. *PloS one*, 12(4).

Power, S. E., et al. (2014). Intestinal microbiota, diet and health. *The British journal of nutrition*, 111(3), 387-402.

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Firmicutes
Bacteroidetes

Ratio



Higher Ratio with Obesity, High Stress, and High Fat Diet

Lowers with weight loss

Inconsistent findings with pregnancy (some find lower, some higher as pregnancy advances)

Overall Health Status

Brain

(Neuroendocrine immune pathway activation)



Healthy CNS Function
(Mood stable, emotions well-regulated, no symptoms of excessive anxiety or depression, adequate sleep)

Abnormal CNS Function
(Anxiety, depression, sleep disturbance, emotional dysregulation)

Healthy State

Systemic Communication
HPA axis, neurotransmitters,
bacterial metabolites,
cytokines



Neural Communication
Vagal, sympathetic

Disease State

Healthy Gut Function
(Microbiome eubiosis)

Normal Weight

Abnormal Gut Function
(Microbiome dysbiosis)

Obesity or Cachexia



Gut

(Energy harvest and storage, nutrient absorption, visceral cues of hunger or satiety)

Conceptual Framework of Brain-Gut Axis and Its Influences on Gestational Weight Gain

Specific Aims

To test the hypothesis, I **enrolled a socioeconomically diverse cohort of healthy pregnant AA women** to consider the following Aim:

Describe the relationship between maternal gut microbiome composition during pregnancy and interval and total gestational weight gain.

Interval and Total Weight

- Most studies of pregnant women have considered pre-pregnant weight and total gestational weight gain, ignoring interval gain.
- Timing of weight gain is relevant to the risk of poor obstetric outcomes and obesity in the mother and child.
 - Early inadequate gains increase risk of preterm birth and fetal growth restriction
 - Early excessive gains increase risk of excessive neonatal body fat

Rectal Microbiome (FTB Ratio), Total and Interval Weight Gain

Describe the relationship between maternal gut microbiome composition and interval and total GWG

Healthy Gut Function
(Microbiome eubiosis)



Normal Weight



Gut

(Energy harvest and storage, nutrient absorption, visceral cues of hunger or satiety)

Abnormal Gut Function
(Microbiome dysbiosis)



Obesity or Cachexia



- Design
- Sample
- Setting
- Inclusion/Exclusion Criteria
- Data Collection and Procedures

Research Methods and Design

- Design: Prospective, longitudinal cohort design, sub-study of the Parent Study, “***Biobehavioral Influences on the Microbiome and Preterm Birth***”, IR01-NR014800
- Sample: socioeconomically diverse cohort of 27 pregnant AA women
- Setting: 2 local area hospitals (Emory Midtown and Grady) in Metro Atlanta and/or home visits

Design, Sample,
and Setting

- Data collection occurred at 3 time points in the *Parent Study*
 - 8 to 14 weeks gestation
 - 24 to 30 weeks gestation
- This *Sub-Study* added a 3rd time point
 - 35 to 41 weeks
- Compensated \$20-30 at each visit
- Chart Review conducted post delivery for select labor and birth variables

Data Collection and Procedures

Firmicutes



Bacteroidetes



Data Analyses



Data Analyses

I analyzed the data using the planned approach for the hypothesis of this Aim:

Aim: Describe the **relationship** between maternal gut microbiome **composition** during pregnancy and **interval and total GWG**.

Hypothesis: Maternal gut microbiome composition at the 1st and/or 3rd trimester, or the change in composition from the 1st to 3rd, will be associated with interval and/or total GWG.

Sample Characteristics

Sociodemographic Characteristic (N=27)	Distribution
Age, Mean (Range, Min-Max)	25.2 (17, 18-35)
Insurance Type, n (%)	
Medicaid	21 (77.8)
Private	6 (22.2)
Race, n (%)	
Black, African American	27 (100)
Educational Level, n (%)	
HS or less	12 (44.4)
College or greater	15 (55.5)
Marital Status, n (%)	
Married	4 (14.8)
Single	23 (85.2)
Relationship Status, n (%)	
Not in relationship	6 (22.2)
In relationship, no cohabitation	9 (33.3)
In a relationship, cohabitation	12 (44.4)
Parity, n (%)	
0	11 (40.7)
1	9 (33.3)
2 or 3	7 (25.9)

Weight-Related Characteristics

Weight-Related Characteristics	Frequency (Percent)
BMI at First prenatal care visit Underweight (<18.5) Healthy Weight (18.5-24.9) Overweight (25-29.9) Obese (30 or more)	1 (3.7) 11 (40.7) 3 (11.1) 12 (44.4)
Gain by recommendation at midpoint of pregnancy Inadequate Adequate Excessive	13 (48.1) 8 (29.6) 6 (22.2)
Total Gain by recommendation for pregnancy Inadequate Adequate Excessive	9 (33.3) 7 (25.9) 11 (40.7)

Firmicutes



One-Way Between Groups Analysis of Variance Tests

-Initial BMI Category

-Total Gestational Weight Gain

-Weight Gain at the Midpoint of
Pregnancy

BY

-Change in FTB Ratio during the
Pregnancy

Bacteroidetes



Firmicutes to Bacteroidetes (FTB) Ratio by Initial BMI Category

	Underweight and Healthy Weight (<25), N=12, 44%	Overweight (25-29.9), N=8, 11%	Obese (30 and >), N=12, 44%	One-way, between groups ANOVA
FTB Ratio 1st visit Mean (SD)	1.49 (2.60)	2.45 (1.42)	10.57 (23.92)	<i>F(2,24)=1.00, p=.38</i>
FTB Ratio 3rd visit Mean (SD)	2.14 (1.06)	1.23 (1.06)	2.90 (3.95)	<i>F(2,24)=0.32, p=.73</i>
FTB Ratio 1st to 3rd visit Mean (SD)	0.66 (0.46)	-1.22 (2.39)	-7.66 (24.55)	<i>F(2,24)=0.77, p=.43</i>

All ANOVA results with Levene statistic >.05, thus no violation of assumption of homogeneity of variance.

Firmicutes to Bacteroidetes (FTB) Ratio by Total Gestational Weight Gain

	Inadequate Gain N=9, 33%	Adequate Gain N=7, 26%	Excessive Gain N=11, 41%	One-way, between groups ANOVA
FTB Ratio 1st visit Mean (SD)	2.19 (3.18)	1.57 (1.98)	11.04 (25.00)	$F(2,24)=1.03, p=.37$
FTB Ratio 3rd visit Mean (SD)	4.10 (5.08)	1.98 (2.92)	1.23 (0.64)	$F(2,24)=1.93, p=.17$
FTB Ratio 1st to 3rd visit Mean (SD)	1.91 (3.24)	1.23 (0.64)	-9.80 (24.80)	$F(2,24)=1.54, p=.24$

All ANOVA results with Levene statistic $>.05$, thus no violation of assumption of homogeneity of variance.

Firmicutes to Bacteroidetes (FTB) Ratio by Weight Gain at mid-gestation

	Inadequate Gain at midpoint N=13, 48%	Adequate Gain at midpoint N=8, 30%	Excessive Gain at midpoint N=6, 22%	One-way, between groups ANOVA
FTB Ratio 1st visit Mean (SD)	2.34 (2.79)	1.18 (1.17)	18.69 (33.08)	$F(2,24)=2.85, p=.08$
FTB Ratio 3rd visit Mean (SD)	3.62 (4.49)	1.33 (1.71)	1.09 (0.70)	$F(2,24)=1.76, p=.19$
FTB Ratio 1st to 3rd visit Mean (SD)	1.28 (3.27)	0.15 (2.23)	-17.59 (32.68)	$F(2,24)=3.48, p=.05^*$

(Mid-gestation = 20-25 weeks estimated gestational age)

*Correlation significant at 0.05 level (2-tailed), Eta squared = .22, Tukey HSD revealed Mean difference between inadequate gainers was significantly different from the excessive gainers. Adequate gainers did not significantly differ from either other group.

All ANOVA results revealed Levene statistic >.05, thus no violation of assumption of homogeneity of variance.



Conclusions



No relationships among **initial** BMI or weight or category of **total weight gain** and the **change in FTB** ratio during the pregnancy



The category of weight gain at the **midpoint** was found to be significantly associated with the **change in FTB ratio** during the pregnancy ($F= 3.48, p = .05$)



Additional Findings

Higher FTB ratio initially

Drops steadily during pregnancy

Significant reduction in FTB ratio for
overweight and obese versus women at
healthy weight who have a slight increase



Limitations

Focus at the Phylum level (FTB ratio) limits conclusions as many species within them are commensal or pathogenic.

Benefit of within-race analysis can be seen as a limitation in terms of generalizability to other races.



Implications for Future Research

Distinct gestational **weight gain patterns** and **specific obstetric risks** more prevalent in AA women could be related to the **intra-racial differences** in the gut microbiome.



Implications for Future

Clinical Practice

Certain risks may be *modifiable* if **prepregnant weights are lowered and weight gain patterns are normalized** to ensure recommended rates by **mid-pregnancy** and at **term**, especially for **AA** women entering pregnancy overweight or obese and harboring a dysbiotic gut microbiome.



Ultimately, the wide racial disparity in obstetric morbidity and mortality must be addressed. Perhaps, the gut microbiome and weight are novel considerations that will one day make a clinical difference in outcomes for AA women and children.

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