WELLINGTON

OBSTETRICS

GESTATIONAL DIABETES

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GESTATIONAL DIABETES

Gestational diabetes mellitus (GDM) is a specific type of diabetes that only occurs during pregnancy. It is temporary and goes away after the birth of your baby. It occurs because your body cannot produce enough insulin to meet the extra needs of pregnancy. This results in high blood glucose levels. Approximately one in 20 pregnant women will develop gestational diabetes, usually between 24 and 28 weeks of pregnancy. Gestational diabetes can have significant effects for both you and your baby if not well controlled.

You have an increased risk of developing GDM if you:

- are aged over 30
- have a family history of Type 2 diabetes (parent, brother or sister)
- are overweight (BMI ≥ 30)
- are from certain ethnic backgrounds– Maori, Pacific Islander, Indian, Vietnamese, Chinese, or Middle Eastern
- have had GDM in a previous pregnancy
- have previously had difficulty carrying a pregnancy to term
- have previously birthed a baby weighing more than 4 kg.

Following a healthy diet, having a healthy weight gain during pregnancy and exercising regularly will help to minimise your risk of developing GDM.

HOW DO I KNOW IF I HAVE GDM?

All pregnant women are now screened for GDM. This involves an oral polycose screening test performed at 26-28 weeks. A blood test is taken before, and one hours after a sugary drink. If this is above the normal range a formal two hour oral glucose tolerance test (OGTT) will be required to confirm the diagnosis. This test may be performed earlier in your pregnancy if there is a clinical reason to do so.

HOW IS GDM TREATED?

The aim of treatment is to maintain your blood glucose levels (BGL) within a normal range for the rest of your pregnancy. For most women this can be achieved by:

- following a healthy diet–a dietitian or diabetes educator will give you information to assist you with this having a healthy weight gain during pregnancy.
- exercising regularly monitoring your blood glucose levels every day, as instructed.

Up to one in five women with GDM will require tablets &/- insulin injections during pregnancy to maintain normal BGL.

HOW DOES GDM AFFECT MY BABY?

GDM usually occurs later in pregnancy so your baby's physical development is not affected. However, glucose (sugar) crosses the placenta so your baby is exposed to your higher BGL. This stimulates your baby's pancreas to produce more insulin–it is the extra insulin that causes your baby to grow bigger and fatter. It may also make labour and birth more difficult. This also increases the likelihood of having your labour induced, caesarean section, serious birth problems and stillbirth. These risks are higher if gestational diabetes is not detected and controlled.

Your baby may also be at greater risk of developing obesity and/or diabetes in later life.

Your baby will be monitored closely in the first few days after birth. It can take several days for their body to adjust and their own BGL may drop. Your baby's BGL will be tested regularly until their levels remain within normal range.

You can help your baby by:

- controlling your BGL during pregnancy
- breastfeeding within one hour of birth and continuing to feed, at least every three hours, until your milk comes in (this usually occurs on the third day after birth).

HOW WILL MY BABY BE MONITORED?

You will be offered extra ultrasound scans to monitor your baby's growth more closely.

WHEN IS THE BEST TIME FOR MY BABY TO BE BORN?

You should have your baby between at 38 and 40 weeks of pregnancy, depending on your individual circumstances.

WHAT HAPPENS AFTER THE BIRTH OF MY BABY?

Usually GDM goes away after the birth of your baby. However, there is a 40 per cent chance of developing GDM in your next pregnancy and an increased chance of developing Type 2 diabetes later in life. You will be asked to repeat your glucose tolerance test six to eight weeks after your baby's birth. If this test is in the normal range, you will be asked to check your blood glucose levels every one to two years with your family doctor. Following a healthy diet, maintaining a healthy weight and exercising regularly will help to minimise these risks.

FUTURE PREGNANCIES

Being the right weight for your height (having a normal BMI), eating a healthy diet and taking regular physical exercise before you become pregnant reduces your risk of developing gestational diabetes again.

If you are planning to become pregnant, you should start taking a high dose (5mg) of folic acid daily before you stop contraception. You will need a prescription for this.

As soon as you find out you're pregnant, contact your GP, practice nurse or hospital antenatal team for advice about your antenatal care

GLOSSARY OF TERMS

- **Blood glucose levels (BGL):** sugar levels in your blood
- **Insulin:** a hormone produced by your pancreas that helps the body use glucose for energy.
- **Pancreas:** The pancreas is a gland located in your abdomen that produces a hormone called insulin.
- **Type 2 Diabetes:** in Type 2 diabetes, your pancreas makes some insulin but usually not enough for your body's needs. It affects 85–90 per cent of all people with diabetes. Type 2 diabetes results from a combination of factors such as high blood pressure, being overweight or obese, insufficient physical activity, poor diet and the classic apple shape body that carries extra weight around the waist.

References:

NICE guidance on Diabetes in Pregnancy: www.nice.org.uk/CG63 RCOGUK: Diagnosis and treatment of GDM. SAC Paper, 2011.