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OBG

Gestational Diabetes update

Prevalence of Diabetes is increasing worldwide in parallel with worldwide epidemic of obesity.

Specific

Risks of Diabetes in pregnancy include

1. Spontaneous abortion
2. Fetal anomalies
3. Preeclampsia
4. Fetal demise
5. Macrosomia
6. Neonatal hypoglycemia, hyperbilliirubinemia 7.ARDS

To avoid such complications we need to do pre conception counseling

1. To maintenance HbA1C <6.5%
2. For all women planning for pregnancy advised

T. Folic acid 400micmg and potassium iodide 150micgm every day

Target goals

FPS <95mg%

1 hr. <140mg%

2hrs < 120 mg%

Ideal HbA1C 6%

due to increased RBC turn over in pregnancy A1C is slightly lower in pregnancy

Women with diabetes should eat consistent amount of carbohydrate to match insulin

Rapid reduction in Indian requirement indicates development of placental insufficiency

Frequent hypoglycemia results in low birth weight

Time in Range

Target to maintain Time in Range are as follows

Maintain TIR 63mg% - 140mg% at least 70%

Time below range <63mg% to < 4%

< 54mg% to <1%

Time above range >140mg% <25%.

Diagnosis

Universal testing for GDM

Single test at first antenatal visit do 75gm OGTT irrespective of food intake at

2 hr glucose >140mg% is diagnostic of GDM .

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Management of Gestational Diabetes

1. Lifestyle behaviour is an essential component Insulin should be added if needed
2. Insulin is the preferred agent
3. Metformin and glyburide is not used as first line agent (cross the placenta) Cord blood level of Metformin is higher than the maternal plasma and the Glyburide is 50- 70 % of material blood .

Maternal nutrition therapy

Total caloris recommend per day - 2000 cal

1. Carbohydrate 175 gms (nutrient dense carbohydrates)
2. Protein 71gms
3. Fiber 28 gms
4. Emphasis on MUFA & PUFA
5. limiting saturated fat
6. Avoid Transfat

Physical activity

Aerobic, Resistance or both 20 - 50 minutes

Moderate intensity exercise 2 - 7 days per week

Metformin should not be used in patients with preeclampsia/ hypertension might cause placental insufficiency

In PCOD after conception no need to continue Metformin.

Aspirin in GDM

Start 100- 150 mg of Aspirin at the end of first Trimester to lower the risk of preeclampsia

Dose of Aspirin <100mg not effective

> 100 mg not required

Recommended BP systolic BP110- 135

DBP 85 mmHg.

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