Gestational Diabetes Guidelines for Department of Family Medicine

Subject: Department of Family Medicine

Purpose: 1- To provide common practice guidelines in the department and outlying clinics for family medicine in the care of women with gestational diabetes
2- To optimize and reduce adverse outcomes in this population
3- To educate residents and faculty with review/updates in the management of GODM
4- It is understood that these are recommended and a guideline. While we can recommend these for our patients, each individual patient

Policy: This is a Guideline

Definition: Abnormal glucose tolerance with onset or first recognition during pregnancy that is not clearly overt diabetes or had not previously been diagnosed.

- **Type A1 GODM**: Patients typically have an abnormal glucose tolerance test but are able to keep blood glucose levels in the normal range with dietary changes alone.
- **Type A2 GODM**: Patients typically have an abnormal glucose tolerance test and abnormal glucose levels during fasting and after meals. Type A2 diabetes is usually managed with either oral medications or subcutaneous insulin.

**WHY This Matters:**

**Adverse outcomes associated with overt / GDM:**
Women with glucose problems in pregnancy are at risk for fetal anomalies. We now know that it is the level of hyperglycemia that can worsen this outcome.

<table>
<thead>
<tr>
<th>Maternal</th>
<th>Fetal</th>
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</thead>
<tbody>
<tr>
<td>Subsequent development of DM II</td>
<td>Macrosomia and large for gestational age infant</td>
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<tr>
<td>Preeclampsia</td>
<td>Subsequent adolescent and childhood obesity and/or metabolic syndrome</td>
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<td>Gestational HTN</td>
<td>Birth defects</td>
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<td>Operative delivery</td>
<td>Hydramnios</td>
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<td>Shoulder dystocia and birth trauma</td>
<td>Perinatal mortality</td>
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<tr>
<td>Macrosomia and large for gestational age infant</td>
<td>Neonatal respiratory problems and metabolic complications (hypoglycemia, hyperbilirubinemia, hypocalcemia)</td>
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</tbody>
</table>

**WHO is at risk:**

**Risk factors for overt DM and GDM / indications for early - 1st antenatal visit screening:**
- GDM in a previous pregnancy
- Known impaired glucose metabolism (pre-diabetes)
- BMI >30 kg/m² at the 1st antenatal visit
- Ethnicity: Hispanic, African-American, Native American, South or East Asian, Pacific Islander
- Diabetes in first degree relatives
- Macrosomia in previous pregnancy >9 pounds (4.1 kg)
- Previous unexplained perinatal loss or birth of a malformed infant
- Glycosuria at the first prenatal visit
- Personal history of metabolic syndrome, PCOS, current use of glucocorticoids, hypertension

**DFM Practice Guideline**

- High risk patients should undergo early antenatal screening (see risk factors at left)
  - use hemoglobin A1C at the first visit to determine risk in singleton pregnancies
  - In multiple gestation, 1 hour GTT at 12-16 weeks, and again at 24-28 weeks.
- Repeat screening at 24-28 weeks of gestation
- Pregnant women at low risk of GDM should be screen between 24-28 weeks with routine 1 hr GTT

Discussed and reviewed with OB MFM service January, 2016. Revised and approved by OB faculty at OB faculty meeting February, 2016
Overt diabetes or pre-existing diabetes mellitus in pregnancy: Patients never diagnosed with diabetes prior to being diagnosed in pregnancy still technically classified as gestational diabetes, even if during the early pregnancy, they have glucose level of the following:

- \( \text{HbA1c} \geq 6.5 \),
- \( \text{Fasting glucose} \geq 126 \text{ mg/dL} \),
- \( \text{Random plasma glucose} \geq 200 \text{ mg/dL} \)

These levels can possibly indicate that DM2 was present prior to pregnancy, however if not done prior to being pregnant, will still be classified as gestational diabetes.

Pregnant with impaired glucose tolerance – Includes patients with \( \text{HbA1C} - 5.7 - 6.4 \) known pre-pregnancy or diagnosed at the first prenatal visit.

For those with PCOS on metformin:
- Metformin will increase fertility
- Should continue on metformin during first trimester (till 12 weeks) as decreases miscarriage.
- If not other signs of GDM, should discontinue metformin after first trimester.

Screening and diagnostic testing for GDM:
**Two step approach:**
1) Screening 1-hour (50 gm) nonfasting GTT
   - Abnormal: glucose \( \geq 130 \text{ mg/dL} \) or \( \geq 135 \text{ mg/dL} \) or \( \geq 140 \text{ mg/dL} \) (hospital / practice choice)

2) Diagnostic 3-hour (100-gm) fasting GTT
   - Normal fasting glu \( < 95 \text{ mg/dL} \)
   - Normal 1-hour glu \( < 180 \text{ mg/dL} \)
   - Normal 2-hour glu \( < 155 \text{ mg/dL} \)
   - Normal 3-hour glu \( < 140 \text{ mg/dL} \)

Abnormal: TWO or MORE glucose values meet or exceed the thresholds

**TREATMENT**

*New data is suggesting targeting treatment based on 3 hour testing*
*This will not be a DFM Practice Guideline, but can be considered for your patients.*

Fasting glucose in 3 hour testing

<table>
<thead>
<tr>
<th>Less than 95</th>
<th>Start diet control</th>
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<tbody>
<tr>
<td>96-126</td>
<td>Start Glyburide</td>
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<tr>
<td>&gt;126</td>
<td>Start insulin</td>
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**Lifestyle modifications:**

*Diet*
- Dietitian referral to educate regarding reduced carbohydrate diet

Discussed and reviewed with OB MFM service January, 2016. Revised and approved by OB faculty at OB faculty meeting February, 2016
- Carbohydrates – 33-40% kcal / day, protein – 20% kcal / day, fat – 40% kcal /day
- Exercising for 30 min most days of the week
- Follow up in 1-2 weeks

Glucose monitoring following diagnosis of GDM (4 times daily: morning fasting, and after 3 meals):
- Fasting glucose <= 95 mg/dL
- 1-hour postprandial <= 140 mg/dL
- 2-hour postprandial <= 120 mg/dL

Medication
Oral medications and/or insulin:
- Indicated if glucose levels remain elevated despite lifestyle modifications
- No consensus was found regarding the threshold values to start medications:
  - ≥ 50 % of glucose values are elevated during a 1 week period
  - > 2 glucose values are elevated by > 10 mg/dL at the same meal during a 2 week period
- Oral medications and insulin are equivalent in efficacy

<table>
<thead>
<tr>
<th>Metformin</th>
<th>Glyburide</th>
<th>Insulin</th>
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<tr>
<td><strong>Should only use one oral medication. Do not use both together. If not controlled on one, need to initiate insulin.</strong></td>
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<tr>
<td>- Not FDA approved for GDM</td>
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<td>- Pregnancy category B, but are considered first-line treatment for GDM treatment</td>
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<td>- Cross the placenta</td>
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<td>- Not associated with birth defects or short-term adverse neonatal outcomes</td>
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<td>- Long-term metabolic effects on children with in utero exposure are limited</td>
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<tr>
<td>o Initiated at 500 mg daily with food</td>
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<td>o Follow up in 1-2 weeks</td>
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<tr>
<td>o Max dose 2,000 mg daily divided BID</td>
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<tr>
<td>o Lower failure rate comparing to Metformin</td>
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<tr>
<td>o Initiated at 2.5 mg daily 1 hour before meal</td>
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<td>o Follow up in 1-2 weeks</td>
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<tr>
<td>o Max dose 15 gm daily divided BID</td>
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<tr>
<td>o Should not be used in patients with sulfa allergy</td>
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<td>- Can add to the regimen for pregnant who have uncontrolled GDM despite lifestyle modifications and oral medications OR elect do not use the oral medications</td>
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<tr>
<td>o Referral to High risk OB</td>
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<tr>
<td>o Does not cross the placenta</td>
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<td>o Rapid-, intermediate-, long-acting insulin can be used</td>
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</table>
| o Total daily dose: 0.7-1.0 units/kg:
  - ½ total daily dose – rapid-acting insulin (Humalog, Novolog) in 3 divided doses at mealtime |
| o Follow up in 1-2 weeks |

Fetal surveillance in pregnancies complicated by GDM:
Diet controlled GDM/Class A1:
- Managed as regular pregnancy
- Early induction of labor is not necessary (can deliver at 41 weeks)

GDM on oral medications or/and insulin:
- No consensus on the optimal approach
- Biweekly NSTs vs weekly biophysical profile beginning at 32 weeks of gestation
- Monthly US to monitor fetal growth starting at 28 weeks. Alternatively, if starting BMI is normal and with normal fetal growth, may consider US ONLY at 38 weeks to assess for macrosomia.

Timing of delivery of woman with GDM on oral medications or insulin:
- Induction of labor at 39 weeks if glycemic control remains poor despite oral medications / insulin use or if additional another indication for early delivery

Discussed and reviewed with OB MFM service January, 2016. Revised and approved by OB faculty at OB faculty meeting February, 2016
• Induction of labor at 39 weeks decreases the risk of macrosomia, shoulder dystocia and stillbirth

Route of delivery:
  ▪ C-section should be offered to pregnant with GDM and EFW ≥ 4.5 kg
  ▪ Plan for vaginal birth if EFV < 4.5 kg

Intrapartum management of pregnant with GDM on oral medications or insulin:
Per L&D protocols

Postpartum management of GDM:
  ▪ Do not need to continue oral medications or insulin after delivery
  ▪ Get fasting glucose prior to discharge
  ▪ Overt DM screening at 6-12 weeks postpartum
  ▪ Repeat overt DM screening every 3 years

References:


