Managing women with lower risk gestational diabetes

The Obstetrician's Guide

Centre universitaire de santé McGill — McGill University Health Centre

Women with GDM who are considered stable and lower risk will be transferred back to their obstetricians for follow-up of their GDM. The MUHC Diabetes in Pregnancy Clinic Team considers a woman low risk if her gestational diabetes is well controlled and she has no co-morbidities; she may have diet controlled GDM (class A1) or insulin controlled GDM (class A2) with bedtime insulin. She will have already been taught her meal plan, how to use the glucometer and how to adjust her insulin if needed. The guide below outlines the principles and goals of management.

	PRINCIPLES	GOALS	TOOLS*
Blood sugar control	Targets may be adjusted based on sonographic assessment; smaller fetuses may benefit from more liberal glycemia control and vice-versa. Normal plasma glucose (PG) levels in pregnancy are lower than in non-pregnant women; optimal levels for maternal-fetal outcome are fasting (FPG) 4.2-4.7 mmol/L and 1hour post-meal (1hPG) 5.5-7.2; obese women may generally have higher values. NOTE: some women may record normal-looking values that do not exist - check glucometer memory!	• **Targets: FPG < 5.1** **1hPG < 7.8** • **Test 4 x/d** fasting and 1h post meals • **Record all results** on self-care diary	1. Self-care diary 2. Glucometer - memory of results
Diet	Diet alone will control glycemia in up to 60% of women. TIPS include: eat from all food groups; small portions grains or starch; include protein at each meal and HS snack; avoid sweets, but occasional sweets may be tolerated. Energy intake should support BMI specific weight gain.	• **3 meals + 3 snacks**. • **Weight gain rate** (kg/wk): Healthy = 0.3-0.5; underweight = 0.4-0.6; overweight = 0.2-0.3; obese = 0.2	3. Food record
Physical activity	Mild exercise can have many health benefits during pregnancy and should be encouraged unless obstetrical contraindications exist. Post-meal walks of 10 minutes each will improve 1hPG values.	• **Light to moderate exercise 30 minutes per day 5 days/wk**	
Insulin	If the targets for FPG or 1hPG values are exceeded, insulin is considered on an individual basis. For fasting hyperglycemia intermediate insulin is injected at bedtime and adjusted each evening if needed based on the fasting glucometer result of that morning. Those taking more than 30 units of insulin/day prior to delivery will need Insulin orders for delivery.	• **Patient adjusts her own insulin** dose regularly - every 1-3 days depending on glucometer results	4. Insulin adjustment scale 5. Insulin orders for GDM during labour, delivery & postpartum
Fetal assessment	Ultrasound for growth, amniotic fluid level, position of fetus and placenta is done at first DM clinic visit (unless done within *past 3 weeks*) and repeated every 4 weeks. Patients should continue to monitor fetal movement, as taught. Biophysical Profile (BPP) assesses fetal well-being; modified BPP (NST + AFI) is also acceptable.	• **FM chart daily** by patient • **BPP weekly from 36 weeks** • **Book US at RVH US unit** for growth q 4 wks and for BPP as needed.	6. Fetal assessment algorithm

Please note: **If glycemia NOT controlled** refer back to *Diabetes in Pregnancy Clinic*.
If glycemia WELL controlled BUT you have other maternal-fetal concerns, refer to *MFM Clinic*.

***TOOLS can be found at:** www.mcgill.ca/obgyn/patientcare/muhc/gdm-resources