Health
Hunter New England
Local Health District

Planning for pregnancy with DM

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Learning Outcomes

- Discuss pre-pregnancy planning for women of child bearing age with pre-existing DM
- Gestational Diabetes
- When & where to refer
- Follow up after delivery

Pregnancy planning

- As a specialty service we may not get to see young women with Type 2 diabetes because they are newly diagnosed, relatively good control, no complications.
- Reliant on GP's & Nurses who are seeing these women to identify & educate.
- Pencat data retrieval to identify how many women within your practice have diabetes and who are within child bearing age.
- Assessment for any women of child bearing age with diabetes should always include:
  - Sexually active?
  - Contraception?
  - Plans for pregnancy?
  - Current DM control
  - Current medication regime

Pregnancy planning

Planned or unplanned pregnancy with sub-optimal DM control is associated with :

1. Increased risk of congenital malformations
2. First trimester miscarriages
3. Pre-eclampsia
4. Prematurity
5. C-section
6. Bigger or smaller baby
7. Dislocated shoulder during birth process (shoulder dystocia)
8. Low BGL (Neonatal hypoglycaemia)
9. Extra amniotic fluid (polyhydramnios)

When & where to refer

- As soon as possible
- If planning pregnancy- referral to JHH Antenatal clinic for Endocrinologist & Obstetric pre pregnancy counselling
- If unplanned – refer to JHH Antenatal clinic as soon as positive pregnancy test

Important point

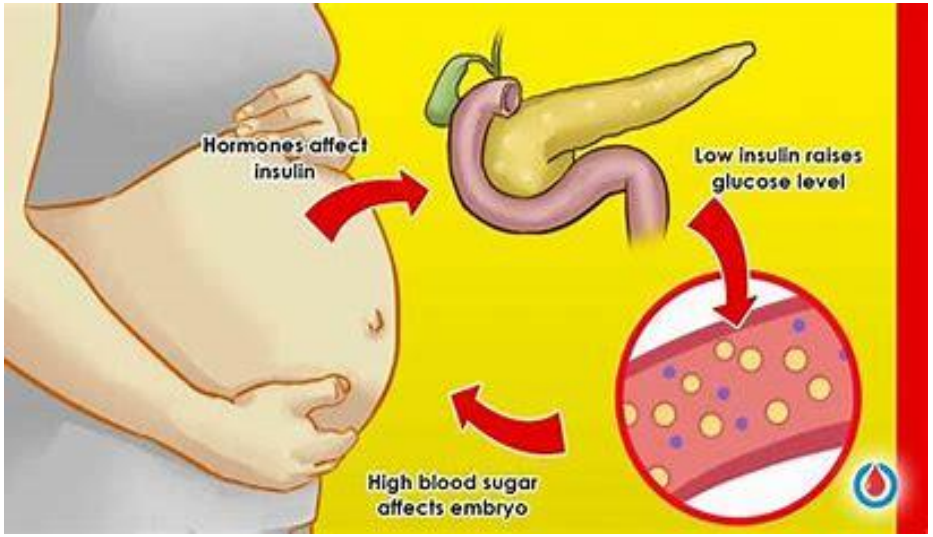
Women with Type 2 DM,PCOS or irregular periods must be advised that improved fertility may occur with metformin – so pregnancy is possible

Counselling

- Optimal diabetes management through nutrition, glycaemic management
- Ideal A1c is less than 7%
- Folate 5mg rather than usual dose of 500mcg
- ? Stop or switch anti-HTN/statin meds
- Metformin does cross placenta but overall we say its safe in pregnancy, used for many years at JHH without ill effects to mum or bub
- Insulin does not cross placenta = safe in pregnancy

Gestational Diabetes Mellitus

- High blood glucose levels diagnosed in pregnancy
- Pregnant women need to produce double or triple the amount of insulin normally required
- Placental hormones block insulin from working properly
- Approx 20% pregnancies in HNE (higher than state average 8-14%)
- 95% of GDM goes once baby is born



Gestational Diabetes Mellitus

Universal screening 24-28 weeks pregnant with 2 hr OGTT

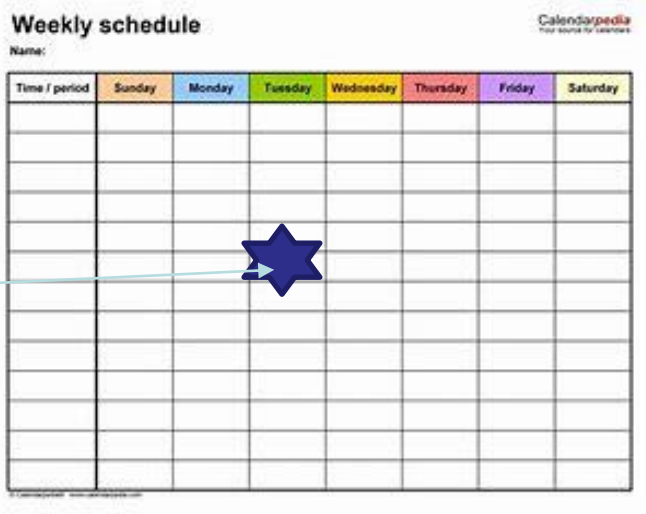
DO NOT give OGTT to

- Women who have had bariatric surgery
- Women who have Type 1 or 2 diabetes
- Fasting BGL is >5.0
- Women < 12 weeks gestation

Risk of Type 2 Diabetes after Pregnancy

- 50% Increased risk for T2DM in later life for mum
- Increased risk for baby of Type 2 diabetes in their lifetime also
- Education for whole family to prevent T2DM, centred around diet (limiting saturated fat intake, good quality CHO choices) & lifestyle (physical activity aiming for 30 mins moderate intensity exercise most days of the week)
- Breastfeeding is encouraged as it has been shown to help prevent T2DM.
- Have repeat OGTT 6-12 weeks after delivery to ensure GDM has been resolved
- If negative see GP for screening every 1-2 years
- We look after in antenatal clinic but as soon as baby is born no further follow up, reliant on NDSS reminders and GP follow up .

Important - OGTT follow up



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Who needs an early OGTT

Women who have one or more risk factors for GDM

- Are aged 40 years or over
- Have a family history of type 2 diabetes or a first-degree relative (mother or sister) who has had gestational diabetes
- Are above the healthy weight range » have had elevated blood glucose levels in the past
- Come from Aboriginal or Torres Strait Islander backgrounds
- Are from a Melanesian, Polynesian, Chinese, Southeast Asian, Middle Eastern or Indian background
- Have had gestational diabetes in a previous pregnancy
- Have polycystic ovary syndrome (PCOS)
- Have previously had a large baby (weighing more than 4.5kg)
- Are taking some types of antipsychotic or steroid medications
- Have gained weight too rapidly in the first half of pregnancy

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Questions