

# New Gestational Diabetes Guidelines

## SUMMARY

New guidelines for testing and diagnosis of hyperglycaemia in pregnancy have been released by the Australasian Diabetes in Pregnancy Society<sup>1</sup>. The guidelines incorporate findings from the Hyperglycemia and Adverse Pregnancy Outcome (HAPO) study, which evaluated glucose levels and pregnancy outcomes in more than 23,000 women.

The new guidelines recommend the routine use of the 75g oral glucose tolerance test (OGTT) and distinguish between the categories of diabetes mellitus in pregnancy and gestational diabetes mellitus. The recommendations of the new guidelines are summarised below.

*It is essential that the pregnancy status item on the request form is completed to ensure the patient's results are compared against the appropriate diagnostic criteria.*



## INTRODUCTION

Hyperglycaemia in pregnancy is associated with adverse outcomes for mother and baby. Untreated, it is associated with increased perinatal mortality as well as foetal macrosomia, neonatal hypoglycaemia, hyperbilirubinaemia and respiratory distress syndrome<sup>2</sup>. There is also evidence that maternal hyperglycaemia increases the long-term risk of the baby developing obesity and/or diabetes during its lifetime<sup>3</sup>.

For the mother, the risk of developing diabetes in the future is increased, with up to 50% developing type 2 diabetes within 20 years. Therefore, the accurate detection and management of hyperglycaemia in pregnancy is important and universal screening for the condition is recommended. ADIPS now classifies hyperglycaemia in pregnancy into 2 groups depending on the degree of glucose elevation. If the hyperglycaemia is more severe, patients are labelled as having diabetes mellitus in pregnancy, while those with lesser elevations of glucose attract the label **gestational diabetes mellitus** (GDM).

Women with **diabetes mellitus in pregnancy** are at higher risk of major pregnancy complications and require urgent attention, including evaluation for other complications of undiagnosed diabetes.

## TESTING FOR HYPERGLYCAEMIA IN PREGNANCY

Women with risk factors for hyperglycaemia in pregnancy (Table 1) should undergo testing for hyperglycaemia early in pregnancy. There are no formal recommendations about the test to use in these individuals. The choice will be guided by clinical judgement and local health care policy: Those at higher risk should have an oral glucose tolerance test or HbA1c, while a fasting or random glucose level may be deemed appropriate for those at lesser risk (with further testing if clinically indicated).

It is recommended that **all women** (who are not known to have diabetes) undergo a 75 g oral glucose tolerance test at 24 – 28 weeks gestation.

The 50 g glucose challenge test is no longer recommended because of concerns about the test's sensitivity and specificity.

**Table 1: Risk factors for hyperglycaemia in pregnancy**

### Risk factors for hyperglycaemia in pregnancy

- Previous hyperglycaemia in pregnancy
- Previously elevated blood glucose level
- Age  $\geq$  40 years
- Ethnicity: Asian, Indian subcontinent, Aboriginal, Torres Strait Islander, Pacific Islander, Maori, Middle Eastern, non-white African
- Family history of DM (1st degree relative with diabetes or a sister with hyperglycaemia in pregnancy)
- Pre-pregnancy BMI  $>$  35 kg/m<sup>2</sup>
- Previous macrosomia (baby with birth weight  $>$  4500 or  $>$  90th centile)
- Polycystic ovarian syndrome
- Medications: corticosteroids, antipsychotics

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