Gestational Diabetes

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Diagnosis: IDF recommend all pregnant women should be tested for hyperglycemia during pregnancy using one step of the WHO and the International Association of Diabetes in Pregnancy Study Groups (IADPSG) criteria for diagnosis of GDM. With regard to diagnostic criteria to define early gestational diabetes, WHO has expanded on the IADPSG criteria for the diagnosis of early gestational diabetes to include the same postload 1-hour and 2-hour glucose thresholds from the oral glucose tolerance test recommended for diagnosis from 24 weeks’ gestation. However, there are some arguments suggesting that an early HbA1c of at least 5%-9% (41 mmol/mol) may better identify women at higher risk for adverse pregnancy outcomes.

Management: If lifestyle modification alone fails to achieve glucose control, metformin, glyburide, or insulin should be considered as safe and effective treatment options for GDM. Even though both glyburide and metformin can pass placenta, there is no evidence of these two drugs harmful to mothers and infants. Glyburide and metformin are comparable oral treatments for GDM regarding glucose control and adverse effects. Their combination demonstrates a high efficacy rate with a significantly reduced need for insulin and possibly an advantage for metformin over glyburide as first-line therapy.

Postpartum follow-up: The new HAPO follow up data reported in ADA meeting 2017 showed that during 10 years after delivery, 10.7% women diagnosed GDM by IADPSG criteria could develop type 2 diabetes by ADA criteria. The risk is 5.44 times of the women with no GDM. Children born from mothers with GDM also have higher BMI, waist circumference, fat mass and abnormal glucose tolerance than those from mothers without GDM.

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