Adelaide Mums & Babies Clinic

GESTATIONAL DIABETES

All pregnant women should be screened for gestational diabetes at around 26-28 weeks, and those with risk factors may need to be screened at 14-16 weeks too. Unfortunately, the test can be a little unpleasant – it involves fasting, having 3 sets of bloods taken over 2 hours, and drinking a very sweet, mildly fizzy drink. However, it is a very important test as many women who get diagnosed with gestational diabetes have no, or very few, risk factors for it. Importantly, it is nothing that YOU have done to cause this condition. It is entirely due to your placenta and your genetic predisposition to Type 2 diabetes. To reiterate: you cannot cause gestational diabetes by eating too much sugar.

If you are diagnosed with gestational diabetes, there are many things you can do to make sure your pregnancy continues to be healthy. You will be referred to see a diabetes nurse educator and dietician. The diabetes nurse educator will give you a glucometer, which is how you will measure your blood sugar levels. This will need to be done 4 times a day initially: fasting in the morning and then 2 hours after the start of each main meal. The results need to be written in a blood sugar diary so that the doctor or diabetes educator can see your results and advise on changes.

WHY DOES BLOOD SUGAR CONTROL MATTER?

With gestational diabetes, it is all about the baby. If a mother has poorly-controlled gestational diabetes, then her blood sugar levels will be consistently high. This means the baby will be getting extra sugar across the placenta which can result in a baby growing larger than it otherwise would have. This may pose issues for delivery (such as an obstructed labour, shoulder dystocia and trauma to the perineum). It can also cause excess amniotic fluid (polyhydramnios), which may make it more uncomfortable for mum, but can also result in baby having an unstable lie and not getting engaged in the pelvis.

After delivery, there is a risk that the baby will develop LOW blood sugars. This is because the baby has been used to receiving the high sugars from mum, and has been compensating by producing excess insulin. When the baby is delivered, the supply from mum is instantly cut off, but the baby's pancreas is still producing the extra insulin. Insulin works to push sugar from the blood into the tissues, and therefore may drop the baby's blood sugar. The colostrum that the baby receives from breastfeeding may not be enough to keep the blood sugars up, and the baby may need to receive antenatally-expressed colostrum, formula, glucagon (an injection), glucose gel, or intravenous dextrose.

DIET

It is important to eat a wide variety of foods still, including carbohydrates, fats and proteins. Carbohydrate choices may need to be different in gestational diabetes. Foods that have a low Glycaemic Index (GI) will help slow the rise of blood sugar levels after eating. Carbohydrates that are brown or orange have a lower GI compared to white carbohydrates (ie brown rice/pasta, wholemeal/multigrain bread, sweet potato). It is also usually important to add in an evening snack. Fats and proteins also result in a more even blood sugar.

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EXERCISE

Exercise does wonders for keeping blood sugar levels even. Just a walk around the block will help enormously. If there is a particular time of day that you are struggling to keep your sugars down, a walk at this time may be useful.

MEDICATION

If, despite good dietary changes, the blood sugar levels are still too high, please do not feel like you have "failed". It is simply a result of the interplay between your placenta and genetics. Medication may be needed to help manage your blood sugars. Often the tablet Metformin is used first. This tablet is taken between 1-3 times a day. It is usually well tolerated although can produce some gut upset.

If metformin doesn't control the sugar levels, then insulin will need to be used. Insulin can be used before metformin - it usually depends on who is managing your pregnancy and which hospital you are having your baby at. An Obstetric Physician may be needed to oversee insulin regimes. Often, an injection of long-acting insulin at night is all that is needed. Needing insulin to manage blood sugar levels increases the chance of your baby requiring additional support postnatally, and delivery at an appropriate hospital may be necessary.

CHANGES IN THE CARE DURING YOUR PREGNANCY

Once diagnosed with gestational diabetes, you will need to see your doctor more frequently so they can check your blood sugar diary and make changes to your diet, exercise or medications. Due to the risk of baby being larger (or sometimes struggling to grow), extra ultrasounds will be needed.

Depending on the level of control of the diabetes, plans for induction of labour may be advised. If your blood sugar levels have been well controlled, and the baby is of normal size with no other complications, then we do not have to intervene until 6 days overdue. Induction from 38 weeks is advised if your blood sugars have been above target, the baby is large, there is excess fluid around baby, or other obstetric complications have occurred. If the baby is believed to be below 4 kg, a vaginal delivery can be planned for. If it is in excess of 4-4.5 kg, a discussion about an elective Caesarean Section should take place.

After delivery, the baby will need its blood sugar level tested at 1 and 4 hours of age. Generally, any medication needed during pregnancy can be ceased after delivery and no further finger prick blood sugar testing needs to happen. A repeat Oral Glucose Tolerance Test needs to be done at 6 weeks postnatal to make sure Type 2 Diabetes is not present..