“Gestational Diabetes Mellitus”
Mark B. Landon, MD, and Steven G. Gabbe, MD
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Questions written by:  
Adam F. Borgida, MD  
Maternal Fetal Medicine  
Hartford Hospital  
Hartford, Connecticut

Responses written by:  
Mark B. Landon, MD,  
Steven G. Gabbe, MD  
Department of Obstetrics and Gynecology  
The Ohio State University  
College of Medicine, Columbus, Ohio.

1. Is your pregnancy management different for women diagnosed with gestational diabetes mellitus (GDM) very early in pregnancy compared to those screened and diagnosed at 24 to 28 weeks of gestation?

Response from Drs. Landon and Gabbe:
We consider that women identified as having GDM early in pregnancy may in fact have preexisting type 2 diabetes. If they demonstrate an elevated hemoglobin A1C, then they may be at risk for a fetus with anomalies. The management of their diabetes is not altered, although they are likely to require medication in addition to dietary intervention.

2. Is there a one-hour glucose challenge screening value above which you would not proceed to a 3-hour oral glucose tolerance test (OGTT)?

Response from Drs. Landon and Gabbe:
In women with a screening value between 190 and 215 mg/dL, we recommend obtaining a fasting blood glucose reading before proceeding with an OGTT. If the fasting result is 95 mg/dL or greater, we treat the woman as having GDM.
3. For women who cannot tolerate the oral glucose challenge, is there some other novel glucose load that your institution uses?

Response from Drs. Landon and Gabbe:
Not really. Some years ago, a jelly bean feeding was proposed as an alternative to the glucose solution. If a woman cannot tolerate the glucose challenge, we may periodically assess fingerstick capillary fasting and postprandial glucose levels in an outpatient setting. The frequency depends on the perceived risk for GDM.

4. Do you feel that screening at 26 to 28 weeks of gestation with a 2-hour, 75-gram, OGTT one-step approach is more cost-effective than a two-tiered approach in populations with a high prevalence of GDM? Is this the future of screening for GDM with the increasing incidence of obesity?

Response from Drs. Landon and Gabbe:
We have not conducted a cost effectiveness analysis. However, a one-step approach might be the most expensive. It should be noted that a one-step approach does carry with it the greatest sensitivity.

5. Except for the fasting value, do you change pregnancy management for a single abnormal value on a 3-hour, 100-gram OGTT?

Response from Drs. Landon and Gabbe:
In general, we do not, although we recognize that such women are at increased risk for macrosomia. Women with prior GDM and one abnormal value may also deserve close monitoring.

6. For women who appear to be failing their dietary control of GDM, are there circumstances in which you would choose an oral agent instead of insulin?

Response from Drs. Landon and Gabbe:
We utilize glyburide, particularly if fasting levels are less than 115 mg/dL. With higher fasting levels, glyburide appears to have less efficacy.
7. If a woman on an oral agent for control of GDM requires the addition of insulin, do you recommend adding this to the oral agent or converting to insulin only?

Response from Drs. Landon and Gabbe:
We generally convert to insulin without maintaining the oral agent.

8. For women diagnosed with GDM and reporting well-controlled sugars on diet, if an ultrasonogram raises the suspicion of a large-for-gestational-age (LGA) fetus, is there a role for starting medical treatment? If so, what is your treatment of choice and what are the glucose end-points?

Response from Drs. Landon and Gabbe:
As long as glycemia is maintained at target thresholds, we don’t offer medical treatment based on the ultrasound diagnosis of an LGA fetus.

9. If a woman has a 32-to-34-week ultrasonogram that shows an LGA fetus but her screening results for GDM are normal at 24 to 28 weeks of gestation, do you favor rescreening or testing? If so, what test would you recommend?

Response from Drs. Landon and Gabbe:
This finding requires an individualized approach depending on the level of suspicion for underlying GDM.

10. For women with well-controlled glucose on medical treatment for GDM, at what gestational age would you recommend delivery if the fetus appeared normally grown? Would this change for an LGA fetus?

Response from Drs. Landon and Gabbe:
In a woman with well-controlled glucose and a normally sized fetus on examination, we will allow the pregnancy to proceed up to 40 weeks of gestation. If the cervix is favorable, we may induce at 39 weeks of gestation in such cases, as well. We don’t advocate earlier delivery for suspected macrosomia.
11. For women with GDM, under what circumstances would you recommend early-term delivery (37 weeks to 38 weeks of gestation) after an amniocentesis to document fetal lung maturity? What parameters would you use as an indication of fetal lung maturity for women being treated medically for GDM?

Response from Drs. Landon and Gabbe:
Early delivery following amniocentesis might be undertaken in women diagnosed late in pregnancy with apparent suboptimally controlled GDM. We suggest utilizing the same cut-offs for tests of lung maturity as in non-diabetic pregnancies unless there is institution specific data to rely upon. As with any other high risk pregnancy, the decision to proceed with early delivery with or without amniocentesis depends on careful consideration of the fetal risks associated with prolonging gestation versus the anticipated neonatal condition.

References