

Gestational Diabetes Mellitus (GDM) is defined as diabetes diagnosed in the second or third trimester of pregnancy that is not Type 1 diabetes (T1DM) or Type 2 diabetes (T2DM).

Scope of the problem:

- In New Mexico from 2015-2016, an estimated 2,370 women giving live birth, or 10.2%, had gestational diabetes. The prevalence of GDM was 10.6% among Hispanic women, 17.8% among Native American women, 4.9% among White women (Low N and confidence interval width of 22.5 so insufficient data for women of other race/ethnic groups).¹
- In the United States, women with GDM have up to a 70% chance of developing T2DM in the decades following the pregnancy. Yet only about 50% of women with GDM receive a postpartum visit and even less are screened for diabetes.²

Risk factors for GDM include:

- Previous history of GDM
- Known impaired glucose metabolism
- BMI 30 or greater
- Advanced maternal age >35 years
- Member of a high-risk ethnic group (Native American, Black or Hispanic)



Gestational Diabetes Mellitus puts mother and baby at risk.

GDM Impact

INCREASED MATERNAL RISK FOR:

- Hypertension
- Preterm labor
- Caesarean delivery
- Cardiovascular disease and metabolic syndrome
- Type 2 diabetes

INCREASED BABY RISK FOR:

- Large for gestational age birth with associated complications such as shoulder dystocia
- Respiratory distress syndrome/delayed fetal lung maturity
- Neonatal hypoglycemia, including hypoglycemia-induced seizures
- Jaundice
- Future metabolic syndrome, obesity, diabetes and coronary artery disease



Screening, testing for and managing Gestational Diabetes Mellitus

Screen for preexisting diabetes in the first trimester:

- Test for undiagnosed diabetes at the first prenatal visit in those with risk factors, using standard diagnostic criteria.³
- Women newly diagnosed with diabetes in the first trimester are classified as having T2DM.³

Test all women for GDM at 24-28 weeks gestation using the 2-step approach⁴:

1. Screen (non-fasting) all women not previously known to have diabetes with administration of a 50 gram oral glucose solution followed by a 1-hour venous glucose.⁴
2. Women with glucose \geq 130 mg/dL at 1 hour should undergo a fasting 100 gram, 3-hour diagnostic oral glucose tolerance test (OGTT) to diagnose GDM.⁴

GDM management:

- Medical Nutrition Therapy³
- Physical activity³
- Weight management³
- Medications: Insulin is preferred; metformin, and/or glyburide may be used but both cross placenta and lack long-term safety data³
- Glucose monitoring to ensure that glycemic control has been established and maintained³

For continuity of care after GDM, providers should follow recommended standards of care, and refer their patients to programs that can help prevent diabetes.

GDM post-partum care:

- Administer a 2-hour 75-gram oral glucose tolerance test at 4-12 weeks postpartum, using non-pregnancy criteria.³
 - A1c is not recommended because A1c may be persistently lowered by the increased red blood cell turnover related to pregnancy or blood loss at delivery. OGTT is more sensitive at detecting glucose intolerance.³
- If the postpartum 75-gram OGTT is normal, women should receive lifelong screening for diabetes or prediabetes at 1-year postpartum, and every 1-3 years thereafter.³
 - Frequency of testing depends on other risk factors, including family history, prepregnancy BMI and need for insulin or oral glucose-lowering medications during pregnancy.³
 - Testing can be done with any recommended glycemic test (A1c, fasting plasma glucose, or 75-g OGTT using non-pregnant thresholds).³

Women with a history of GDM should receive intensive lifestyle interventions. Use of Metformin is appropriate if hx GDM and A1c 6.0-6.4 and/or for use with PCOS 2/2 insulin resistance.

Clinician workflow strategies:

- Ask women about a history of GDM during well woman visits.
- Consider referring women with a history of GDM to an intensive behavioral lifestyle intervention program modeled on the Diabetes Prevention Program.
- Resources for clinicians and patients:
 1. National Diabetes Prevention Program: <https://www.cdc.gov/diabetes/prevention/index.html>
 2. MyPlate: <https://www.choosemyplate.gov/>
 3. American Association of Diabetes Educators: <https://www.diabeteseducator.org/>
 4. American Diabetes Association: <http://www.diabetes.org/>
 5. New Mexico Department of Health Diabetes Prevention and Control Program: <https://nmhealth.org/about/phd/cdb/dpcp/>
 6. In New Mexico contact: **National Diabetes Prevention Program: 505-850-0176 or 575-703-2343**
 7. Paths to Health CDSMD/DSMD/NDPPClasses, Provider referrals: Pathstohealth.org

ICD-10 CODES	
Gestational Diabetes in Pregnancy	
----Diet-controlled	O24.410
----Insulin controlled	O24.414
----Controlled by oral hypoglycemic drugs	O24.415
----Unspecified control	O24.419
Personal History of Gestational Diabetes	Z86.32

References:

1. New Mexico Pregnancy Risk Assessment Monitoring System, New Mexico Department of Health and U.S. Centers for Disease Control and Prevention (CDC).
2. Owens-Gary M, Ware JL. Diabetes Spectrum. 2012; Volume 25:26-28.
3. American Diabetes Association Standards of Medical Care in Diabetes—2017. *Diabetes Care*. 2017;40(Suppl1): S1-S135.
4. The American College of Obstetricians and Gynecologists. Practice Bulletin: Clinical Management Guidelines for Obstetricians-Gynecologists, Number 137, August 2013.

Developed by the Chronic Disease Prevention Council Gestational Diabetes Workgroup with representatives from: New Mexico Department of Health Diabetes Prevention and Control Program, New Mexico Primary Care Association, University of New Mexico Hospitals Center for Diabetes and Nutrition Education and University of New Mexico Hospitals Women’s Specialties, Molina Healthcare, First Choice Health Clinics, UNM-HSC: Project ECHO.

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