



Gestational Diabetes

Testing & Treatment

What is Gestational Diabetes?

Gestational diabetes has many names: pregnancy diabetes, gestational diabetes mellitus, GDM, glucose intolerance of pregnancy. It is related to the normal change in sugar metabolism during pregnancy that promotes growth of your baby. Sometimes the mechanism that allows this gets out of balance, and blood sugar levels get excessively high.

How might GDM affect me?

The primary risk of GDM is growing a large baby. (On a population level “large” is defined as more than nine pounds, or four kilograms.) If you grow a baby that is larger than you might have without GDM, then you are at increased risk of having a difficult labour or birth. The possibilities include induction, forceps delivery, shoulder dystocia, postpartum hemorrhage and/or cesarean section. Of course there are healthy reasons for having a large baby, such as genetics and good diet, and these are not reasons for concern. By far the majority of large babies are born to women who do not have GDM.

Unlike overt diabetes, which may cause symptoms such as intense thirst, unusual hunger, and passing large amounts of urine, mothers with GDM feel perfectly healthy. After birth, blood sugar levels return to normal right away.

Being diagnosed with gestational diabetes does indicate that you have a high chance of developing adult-onset diabetes within 10-15 years if you are already overweight. Knowing this gives you the chance to implement lifestyle changes that may prevent this from happening, (Some people think this fact alone is a good reason to be tested for GDM.)

How can GDM affect my baby?

Besides the effects of a difficult labour or birth, babies of moms with GDM are at higher risk of hypoglycemia after birth. Feeding immediately after the birth can prevent this.

It is believed that complications for both mom and baby are proportional to the degree of glucose intolerance – the higher your blood sugar measurements, the more at risk you and your baby are.

What are risk factors for GDM?

- Previous gestational diabetes
- Previous baby >4kg
- Obesity (BMI >25)
- Age >25
- Sugar in the urine

- Mother/father/sibling with Type II diabetes
- Unexplained pregnancy losses
- Native, Black, Asian or Hispanic ethnicity
- Pregnancy induced hypertension

How is GDM diagnosed?

1. SCREENING

In the clinic: At every prenatal appointment, your caregiver will palpate your growing belly, as well as measure your uterine size (symphysis-fundal height) after you reach 20 weeks. This alone can give feedback on whether your baby feels or measures larger than



average. After 20 weeks gestational age, you will be asked to do a urine dipstick for glucose. If you frequently spill glucose, then further testing would be warranted.

At the lab: There is a blood test specifically for GDM that is offered between 24 and 28 weeks gestation, although it can be done at any time in pregnancy. Two to three hours after your last meal you drink 50g of glucose – much like a very sweet, flat, orange soda – and then have your blood drawn 60 minutes later. If the lab values come back higher than 7.8mmol/l, then the next step is the diagnostic test.

2. DIAGNOSTIC TEST (ORAL GLUCOSE TOLERANCE TEST)

This is similar to the screening test in that it consists of drinking glucose and having your blood drawn. The difference is that this test involves drinking twice as much sugar, 100 grams, after an overnight fast. Your blood is drawn just before, and then one, two and three hours after drinking the glucose. Diagnosis of GDM is made if two or more of the four results are higher than normal:

Are there drawbacks to testing?

Some women find consuming the sugar causes them to be nauseous or even vomit. There may also be concerns about the effect on the baby of fasting and then sugar loading. It may help to make your last meal one of high quality protein such as eggs, beans or lentils to aid in stabilizing the blood sugars.

GDM is said to occur in 2-3% of women, but testing is not considered very reliable. Of the mothers who test positive, 70% will have babies weighing less than 9 pounds even with no treatment. Also, the majority of babies weighing more than 9 pounds are born to mothers with normal blood sugars. Research has shown that women with diagnosed GDM – whether or not they receive treatment - have an increased risk of cesarean section without any demonstrated improvement in outcome for mom or baby.

Of note: if you pass the test, this does not mean that you are free to eat lots of sugar and forget about good nutrition! Even if you are not diabetic, you can still grow an overly large baby by eating a diet full of refined sugars and highly processed food.

What are my options for treatment?

If you are diagnosed with GDM, treatment centres on making lifestyle changes – modifying your diet and changing/increasing your exercise habits. To help you with this, your midwife will refer you to the Diabetic Clinic.

Counseling at the Diabetic Clinic will include information about how to maintain a Low Glycemic Index diet, and use exercise to keep your blood sugars low. You will be asked to record daily blood sugars for a number of days. Follow-up will depend on the results of these blood sugars – if they are within normal limits, then you likely won't need further follow-up; or you may need a few adjustments to your regime; in rare instances, you may need insulin to control your blood sugars.

Unless you become insulin-dependent, you will still be eligible for midwifery care.

What about follow-up after the birth?

Your baby will have its blood sugar tested soon after the birth, to make sure that it is not experiencing hypoglycemia. (Breastfeeding immediately after birth is the best way to prevent this.)

At six weeks postpartum, you will be tested again with the OGTT to make sure you haven't developed Type II Diabetes.