Guidelines for the Management of Pre-Gestational and Gestational Diabetes Mellitus from Pre-Conception to the Postnatal Period

QUALITY IN PRACTICE COMMITTEE

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This quality of care may be dependent on the appropriate allocation of resources to practices involved in its delivery. Resource allocation by the state is variable depending on geographical location and individual practice circumstances. There are constraints in following the guidelines where the resources are not available to action certain aspects of the guidelines. Therefore individual healthcare professionals will have to decide what is achievable within their resources particularly for vulnerable patient groups.

The guide does not however override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of individual patients in consultation with the patient and/or guardian or carer.

Guidelines are not policy documents. Feedback from local faculty and individual members on ease of implementation of these guidelines is welcomed.

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All women with diabetes of childbearing age should be offered contraception if not planning a pregnancy.

The possibility of pregnancy should be discussed at each diabetes consultation.

All women with diabetes, who are contemplating pregnancy, should ideally be referred for specialist preconception and antenatal care.

Preconception Care
1. Avoid conception until tight glycaemic control achieved. Insulin is preferred to oral hypoglycaemic agents
2. Start Folic Acid 5mg daily
3. Replace or discontinue teratogenic medication e.g. ACE inhibitors, Statins, ARBs, GLP 1, DPP4 inhibitors, SGLT2
4. Screen for diabetes complications
5. Refer for specialist care
6. Encourage diet & lifestyle modification/refer to dietician

Antenatal Care
1. Refer for specialist multi-disciplinary care
2. Screen for diabetes complications
3. Self monitoring of blood glucose 7 times a day
4. Maintain normoglycaemia HbA1c <43 (6.1%)

Postnatal Care
1. Discuss future pregnancies and contraception
2. Discuss diet and lifestyle

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1 A Practical Guide to Integrated Type 1 Diabetes Care, HSE/ICGP
Women known to be at high risk of developing diabetes include those who:
- Have had previous gestational diabetes
- Have had a baby weighing over 4.0 kilos
- Have a strong family history (parent or sibling with diabetes)
- Have marked obesity – especially abdominal obesity (BMI≥30)
- Are members of a population group with a high prevalence of diabetes
- Have a macrosomic foetus, polyhydramnios or glycosuria in their current pregnancy.

**Risk assessment for GDM should be undertaken at the first ante-natal visit.**

identified at risk women should be screened for GDM between 24-28 weeks
Using 75g OGTT (116mls Polycal) with bloods drawn fasting, one hour and two hours post Polycal using IADPSG criteria (F≥5.1, 1hr≥10, 2hr≥8.5 mmol/l)
- Any abnormality in any of the 3 tests are indicative of GDM
- If GDM is suspected at any gestation – perform OGTT immediately

**If negative**
1. **before 24 weeks:** repeat OGTT between 24-28 weeks
2. **between 24-28 weeks:** continue routine antenatal care
3. **After 28 weeks:** repeat OGTT if GDM suspected

**If positive**
1. Refer for combined Diabetes-Obstetric Care
2. Educate regarding diet, lifestyle modification and diabetes management
3. Monitor glycaemic control
4. Plan of care as for T1DM / T2DM once on insulin therapy

**Postnatal Care**
1. Perform 75g OGTT at 6-12 weeks postnatal
2. If negative, perform OGTT yearly thereafter
3. If positive, consider referral if necessary
4. Encourage breast feeding

**Postnatal Advice**
1. Risk of T2DM in future
2. Risk of GDM in future pregnancies
3. Diet & lifestyle modification
4. Normoglycaemia prior to all future pregnancies

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