GESTATIONAL DIABETES

What is gestational diabetes (GDM)?

According to Diabetes Australia GDM is the fastest growing type of diabetes in Australia, affecting one in six pregnancies. GDM is a type of diabetes that only occurs in pregnancy and in most cases will resolve once your baby is born. Some ladies will continue to have higher blood sugars after the baby is born and need further medical involvement.

What causes GDM?

During pregnancy your placenta produces hormones that help your baby grow and develop. These hormones will also block the action of your body's insulin, which is called insulin resistance. Insulin is the hormone your body makes after eating food to help glucose enter the body's cells where it can be stored for energy or future use. Due to insulin resistance, the need for insulin in pregnancy is up to three times higher than usual. If you are already predisposed to insulin resistance, then your body will struggle to manage the glucose in your food and your blood sugar levels will be higher.

How is GDM diagnosed?

It is usually diagnosed by monitoring your body's response to a sugar drink at 26-28 weeks pregnant (called OGTT). Some ladies will have risk factors and we may screen for this earlier in the pregnancy – your midwife or obstetrician will talk to you about this in your early pregnancy appointments.
The OGTT is done at a pathology clinic – your obstetrician will give you a pathology form to have this done and you will need to prebook this appointment. You will need to fast overnight.

The steps are:

- Blood is taken to check fasting sugar
- 75g sugary drink
- 1 hour and 2 hours after the drink another blood test
- You will need to sit and wait between tests, so it is a good idea to take something to do to fill in the time. Expect to be in the clinic for approximately 2.5-3 hours.
- The result will usually take around 24-48 hours to come back and we will notify you of this result.

Risk factors for GDM

Women at increased risk of developing GDM (and may be screened earlier in pregnancy)

- Aged over 40 years
- Previous pregnancy with GDM
- Strong family history of diabetes or mother or sister who had GDM
- Above healthy weight range (BMI ≥30)
- Family background: Aboriginal or Torres Strait Islander, Melanesian, Polynesian, Middle Eastern, Southeast Asian, Chinese or Indian
- Polycystic Ovary Syndrome (PCOS)
- Previously given birth to a baby more than 4.5kg
- Taking antipsychotic or steroid medication
- Rapid weight gain in first the 20 weeks of pregnancy
- Multiple pregnancy (twins, triplets)

It is important to note that GDM can affect women without any risk factors, and this is why we recommend screening all pregnant women.

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What do I do if I have a positive OGTT?

Your obstetrician or midwife will notify you of the result. Firstly, be kind to yourself. Whilst a diagnosis can feel disappointing and overwhelming you have taken the first step in improving both you, and your baby's, health. Testing positive can be nothing more than an inconvenience, but identifying and managing GDM will reduce the complications that can arise from missing the diagnosis and poor blood sugar control.

Following a diagnosis, we would usually:

- Link you in with a diabetes educator to better discuss lifestyle modifications, blood sugar monitoring and set you up with a monitoring system, and register you for NDIS (National Diabetes Insurance Scheme) - we have an inhouse Diabetes Educator - Rachel Kunde who can provide information and support
- Lifestyle modifications – diet changes and regular exercise
- Regular blood sugar level (BSL) monitoring using target ranges given to you by your
- Close follow-up and monitoring of BSLs and growth of baby.
- Sometimes earlier delivery of baby is recommended – your obstetrician will discuss this with you if this is required.

The main aim is to normalise blood sugar levels and ensure baby grows normally.
50-70% of ladies with GDM will manage it with lifestyle modifications, however; in some cases, we need to use oral medication (metformin) or insulin if lifestyle modifications are not enough.
Remember the placenta continues to grow throughout the pregnancy (we want this) but this can mean that BSLs become higher and harder to control. Once baby is born, we will monitor baby's BSLs using heel prick test to ensure that they adjust well to their new environment.

Testing positive provides us with the opportunity to educate you regarding weight management and lifestyle modifications to reduce risks associated with glucose tolerance in later life and improve the outcomes of your pregnancy.

What are the longer-term implications of GDM?

In most cases, GDM resolves after you give birth. We recommend a follow-up OGTT at 6-12 weeks after baby's birth to ensure this is the case.

If you are taking metformin or insulin to help manage your GDM this will be stopped after baby is born; however, we will usually check a few BSLs afterwards to ensure that they are normal.
Women who have had gestational diabetes have a 7-fold increased risk of developing type 2 diabetes later in life, so it is recommended that they be tested for diabetes every 2-3 years.
You have a 30-70% chance of having GDM again in future pregnancies, however; lifestyle modifications, weight loss and diet changes can reduce this chance even further.

Rachel Kunde
Endorsed Midwife (RM BMid) and Diabetes Educator

Eve Health Diabetes Educator

Rachel Kunde, our certified Endorsed Midwife and Diabetes Educator, is available for consultations at our Spring Hill practice. With over a decade of experience in midwifery, Rachel is passionate about empowering women to make the most out of their pregnancies for themselves and their babies.

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