

Alaska Native Medical Center - PROBLEM: Diabetes Mellitus in Pregnancy (outpatient management)

Gestational DM Class A-1

Definition: Diet controlled diagnosed during pregnancy

- Nutrition Consult
- Exercise physiologist consult
- Home glucose monitoring (fasting and postprandial)

Glucose Monitor Goal: 90% normal
 Fasting glucose \leq 95 mg/dL
 1 hour post prandial \leq 130 mg/dL
 2 hour post prandial $<$ 120 mg/dL

Ultrasound

- 18-20 weeks
- 29-33 weeks (Low dose insulin if abdominal circumference $>$ 90th percentile, or $>$ 3 wks past biometry)

Monitoring

28 wk - 26.0; 29 wk - 27.2; 30 wk - 28.3; 31wk - 29.4; 32 wk - 30.4; 33 wk - 31.5)

- Kick counts at 32 weeks

Prenatal visits: Every 4 weeks until 36 weeks, then weekly

Delivery: 40-41 weeks if in good control

Post partum: 75 gm OGTT evaluated by non pregnant adult ADA DM criteria at 6 weeks and then FPG q 3 year

Gestational DM Class A-2

Definition: Unsuccessful control of blood glucose levels following two weeks of nutritional counseling

- Ongoing nutritional counseling
- Exercise physiologist consult
- Home glucose monitoring (Goal = 90% normal BS)
- Insulin therapy, Metformin, Glyburide (counsel oral agents not FDA approved)

Possible initial insulin regimens

1. Short (1/3) and intermediate(2/3) Insulin: 2/3 a breakfast; 1/3 a dinner
 First trimester 0.8 units/kg
 Second trimester 1 units/kg
 Third Trimester 1.2 units/kg
2. NPH 20 units q AM, 10 units with dinner
 Regular 5-10 units 30 min before meals or Lispro 5-10 units with meals

Ultrasound

- 18-20 weeks
- At diagnosis and then every 4 weeks

Monitoring (see monitoring flowsheet)

- Kick counts at 32 weeks
- 32 weeks NST twice weekly and amniotic fluid volume (AFV) q week

Prenatal visits: After glycemic control then at least every 4 weeks until 36 weeks, then weekly

Poor control ($<$ 90% normal BS) – weekly visits

Delivery: If good early dating, then cervical ripening at 39 weeks – if not optimal control ($<$ 90% normal), polyhydramnios, etc then 38 wks

Post partum: 75 gm OGTT evaluated by non pregnant adult ADA DM criteria at 6 weeks and then FPG q 3 year

Pregestational or Overt Diabetes Mellitus Diagnosed this pregnancy

- Insulin therapy, Metformin, Glyburide (counsel oral agents not FDA approved)
- Ongoing nutritional counseling
- Exercise physiologist consult
- Ophthalmologic exam
- Fetal echo - 18-24 weeks

Admission criteria

poor adherence or persistent hyperglycemia, ketoacidosis
 pyelonephritis or severe infection, hypertension or pre-eclampsia

Labs: Baseline – Cr, BUN, 24 hour urine (protein & CrCl)
 11-14 weeks PAPP-A / NT or 15-20 weeks quad test

Ultrasound

- Early first trimester
- 18-20 weeks
- Every 4 – 6 weeks
- Kick counts start 32 weeks
- NST twice a week s, AFV q week start 32 weeks

Prenatal visits: daily visits or frequent phone f/u until glycemic control is achieved; at least q 4 weeks till 36 weeks, then weekly

Delivery: (tailor to Diabetes class)

If good early dating, then cervical ripening at 39 weeks – if not optimal control ($<$ 90% normal), polyhydramnios, etc then 38 wks

Diagnosis

1st Visit: Random glucose, Hgb A1c, or fasting plasma glucose (FPG)

Overt DM

Hgb A1c \geq 6.5%
 FPG \geq 126 mg/dL
 Random plasma glucose \geq 200 mg/dL + confirmation

Indeterminate Results

If Hgb A1c 5.7-6.4%, or Random glucose 140-199 mg/dL, then consider FPG testing prior to 24 weeks

GDM

FPG \geq 92 mg/dL

24-28 wks, or later 75 gm OGTT - one abnormal value
 FPG \geq 92 mg/dL
 1HR \geq 180 mg/dL
 2 HR \geq 153 mg/dL

Patient Identification:	Lab/Ultrasound Results	
	Name	Initials