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 ≤ 95 mg/dL
1 hour post prandial ≤ 130 mg/dL
2 hour post prandial < 120 mg/dL

Ultrasound

- ☐ 20-22 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 ā breakfast;1/3 ā 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

- ☐ 20-22 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
- ☐ 20-22 weeks
- ☐ Every 4 – 6 weeks

Monitoring
- ☐ 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

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

Overt DM
Hgb AIc ≥ 6.5%
FPG ≥ 126 mg/dL
Random plasma glucose ≥ 200 mg/dL + confirmation

Indeterminate Results
If Hgb AIc 5.7-6.4%, or Random glucose140-199 mg/dL, then consider FPG testing prior to 24 weeks

GDM
FPG ≥ 92 mg/dL

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

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

Patient Identification:	Lab/Ultrasound Results	
	Name	Initials

Reviewed 9/26/16njm