



**Wolverhampton
Diabetes Care**

Diabetes developing in pregnancy - Gestational Diabetes

Why does gestational diabetes develop?

Gestational Diabetes can occur at any time of pregnancy but usually in the middle or later stages. It affects about 3 percent of pregnant women, but it is more common in the ethnic minority groups. It is usually easily dealt with but, if not properly controlled, it can lead to problems for mother and baby.

Why does gestational diabetes develop?

There are increases in the amounts of certain hormones during pregnancy which can affect the blood sugar levels. Gestational diabetes can happen if the mother's body cannot produce enough extra insulin to cope with this effect.

What are the risk factors?

Gestational diabetes is commoner in women who are overweight, older, have a family history of diabetes or are from an ethnic minority background. It will re occur in those who have had Gestational Diabetes in a previous pregnancy.

What are the symptoms?

Gestational Diabetes usually causes no symptoms. Symptoms of high blood sugar, such as increased thirst or increased need to pass urine, are common in pregnancy anyway. If there is a concern about diabetes you must get properly tested.

How is gestational diabetes diagnosed?

All women should have their urine and blood tested for sugar early in pregnancy. Simple urine and blood tests do not always pick up the problem so, in the middle of pregnancy, around the 26th week, it is usual to do a more specific blood test. Gestational Diabetes will also be tested for if there are any other concerns such as with the growth of the baby, or excess fluid in the womb.

What does this mean for the mother during pregnancy?

Gestational Diabetes is not an immediate threat to the women's health. You will have full advice, more regular check ups and you may need to start treatment.

What is the usual treatment for Gestational Diabetes?

You will be advised about diet, exercise and weight control. You will be taught how to test your own blood and the range you should be aiming for. Many women can be treated by diet alone but about a third of women will need insulin injection treatment. If so, you will be fully trained and supported in how to do this

What does this mean for the mother during labour?

Most women with gestational diabetes whose blood sugar levels stay within the safe range deliver their babies without complications. Labour carries little or no extra risk unless the baby is large. Providing all is well and blood sugars are controlled, mothers can expect a normal delivery at term. If the baby is large or if insulin has been started during pregnancy, induction of labour may be suggested. The chance of a caesarean delivery is greater than in non diabetic pregnancies, due to the increased likelihood of a larger baby. Your birth and labour should be discussed with you in advance. You will be specially monitored during the delivery.

Can I breast feed?

Yes, breastfeeding is strongly encouraged.

What does this mean for the mother after delivery?

Most women will return to having perfectly normal blood sugar levels 12-24 hours after delivery. Insulin treatment can usually be stopped. Women should have a blood test to re-check at the 6 week postnatal visit, to fully ensure it is normal. After that, it is important to have an annual test for diabetes and to be sure you are seen early in any further pregnancy when the problem will likely re occur.

What does this all mean for the baby before and after birth?

Having high blood sugar can affect the baby's growth in the womb. This can cause the baby to grow larger, which can sometimes make delivery difficult but it can also slow down the baby's growth and both can affect development.

Shortly after birth, the baby may continue to make extra insulin even though high levels of blood sugar are no longer present. This may cause the baby to have low blood sugar (hypoglycaemia). About half of all babies born to mothers with diabetes may be hypoglycaemic at birth. Your baby's blood glucose will be regularly measured soon after birth, every hour for the first 3 hours, and then every 6 hours for the first 24 hours after birth. If it is low it will be treated straight away. Usually the hypo is easily treated by feeding the baby straightaway, including breast feeding. If the hypo is more severe, your baby might need a glucose drip into a vein. The hypo generally does not harm the baby.

It is more likely that the newborn baby will develop jaundice. This usually fades over a few days, without the need for medical treatment. Some babies may need photo light treatment for jaundice in the first few days after birth.

Sometimes newborns, particularly if born early, can have breathing problems because their lungs have not fully matured. Again, this usually clears up with time. Extra oxygen may be needed at this time but only for few days.

There is a very slightly higher risk of still birth, but if the glucose levels are reasonably controlled throughout pregnancy, this risk is much lessened and is rare.

Will my baby be taken away to a special baby unit at birth?

Babies born to mothers who are treated with insulin do not go to the special care baby straight away after birth, they stay with their mothers and are observed there. Only babies with breathing problems or low blood sugars that need a drip need go to the special baby unit.

Will diabetes occur in subsequent pregnancies?

Yes, it is very likely to recur in your next pregnancy. Please inform your general practice, diabetes specialist team or antenatal team as soon as you become pregnant.

Is there a risk of developing diabetes in later life?

Yes, over the next 10 to 20 years the risk of your developing diabetes is approximately 50% and the risk is even greater if you are or become overweight or have a family history of diabetes. That's why you should be tested every year to check for diabetes.

Can future diabetes be prevented?

Yes, to minimise the risk of developing diabetes in the future, women should make healthy lifestyle choices like eating a balanced diet, take regular exercise, and keep your weight down to the ideal weight for your height.

Seeking advice and what care to expect

If you have gestational diabetes you should be looked after by a specialist team including diabetes nurses, dietitians, midwives and the obstetric and diabetes consultants. You should expect to know exactly who your diabetes and antenatal team will be. You should have full advice about the problem and be confident in how to look after your diet, weight and exercise programme. You will be taught how to do your own blood sugar tests. If you need insulin, you will be fully trained in how to do this. You will have more frequent antenatal checks to look at your progress and that of the baby. You should expect to have a clear birth plan and a discussion of whether labour should be induced. You will have special monitoring during labour with careful control of your diabetes. After delivery you and your baby will be checked. Later, you will have a special blood test to double check that the diabetes has gone. You will be advised on how to look after yourself in the future and have blood test at last once a year by your GP to check to see if it has come back.

If you are unclear about what is happening seek advice from your GP or from the diabetes or antenatal teams.