Macleod Diabetes & Endocrine Centre
Royal Devon & Exeter Hospital

Diabetes in pregnancy: advice for primary care

Pre-existing diabetes (type 1 or type 2 diabetes)

All women considering pregnancy should be referred to the pre-pregnancy diabetes clinic.

This is because women with diabetes have increased rates (2-5 times higher) of stillbirth, congenital malformation, perinatal mortality, premature delivery and macrosomia. All of these can be substantially reduced (>50%) with optimal pre-pregnancy care.

The aim is to get pre-pregnancy glucose control as good as possible (ideally HbA1c ≤ 48 mmol/mol).

Actions for primary care:

1) **For women with diabetes who are planning pregnancy or already pregnant**

   i. **If pregnant, refer to diabetes ante-natal clinic urgently.**
   ii. **If planning pregnancy, refer to diabetes pre-pregnancy clinic.**
   iii. Prescribe high dose **folic acid 5 mg** once a day.
   iv. **Stop statins.**
   v. **Stop ACEIs** (ramipril, perindopril etc), **ARBs** (losartan, candesartan etc). Substitute with pregnancy-safe drugs if needed. For women with renal disease, continued these medications for renal protection until conception and then stop as soon as pregnancy is confirmed.
   vi. **Stop all glucose-lowering agents except metformin and insulin.** Start metformin or insulin if needed.
   vii. **Arrange retinal screeeing** if not done in last 6 months.
   viii. **Check renal function and urine albumin:creatinine.** Refer to renal clinic (Dr Rhian Clissold) if eGFR<45 or creatinine >120 µmol/l or ACR >30 mg/mmol.
   ix. Advise smoking cessation

Referral to Pre-pregnancy or Ante-natal clinic: **email to rde-tr.DiabeticPregnancies@nhs.net**

For urgent queries regarding the referral call 01392 402282/403823.

2) **Identify women with diabetes who might be pregnant in the future**

   i. Discuss pregnancy at each visit for women of childbearing age (16-45 years).
   ii. Provide pre-pregnancy care leaflet to all (see RD&E website).

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Women with gestational diabetes

"Gestational diabetes mellitus" (GDM) refers to raised blood glucose that develops during pregnancy and usually disappears after giving birth. Women with GDM have increased risk of future type 2 diabetes. According to NICE (2015), the primary care role is early identification of type 2 diabetes and lifestyle interventions to reduce risk of type 2 diabetes.

Actions for primary care after delivery for women who had GDM:

1. Organise HbA1c at 13 weeks post-partum and yearly thereafter for all women.
2. Refer all women with previous gestational diabetes to the National Diabetes Prevention Programme after delivery. You will find the referral form on the Formulary website.

Diagnosis of GDM

Diagnosis is based on a 75-g 2-hour oral glucose tolerance test (OGTT) at 24-28 weeks of pregnancy. An OGTT will be organised by community midwives.

Thresholds for diagnosis of gestational diabetes

- Fasting plasma glucose 5.6 mmol/l or above, and/or
- 2-hour plasma glucose 7.8 mmol/l or above.

Who should be screened with OGTT

An OGTT at 24-28 weeks is recommended in the following circumstances:

- BMI > 30 kg/m2;
- previous baby weighing 4.5 kg or more;
- previous gestational diabetes;
- family history of diabetes in first-degree relative (parent or siblings);
- ethnic origin with a high prevalence of diabetes;
- ≥2+ glycosuria once or 1+ glycosuria on two occasions on routine testing (note that renal changes in pregnancy mean this can be a normal finding).

For women who have had gestational diabetes in a previous pregnancy, offer:

- Early self-monitoring of blood glucose or
- An OGTT as soon as possible after booking (whether in the first or second trimester), and a further OGTT at 24 to 28 weeks if the results of the first OGTT are normal