Help Guide Management of Gestational Diabetes

Gestational diabetes rates have risen sharply in the past few years...likely driven by obesity, which was worsened by the pandemic.

These patients develop diabetes during pregnancy, usually around the beginning of the 3rd trimester...leading to an increased risk of C-section, high birth weight, future diabetes, etc.

Emphasize a “lifestyle Rx”...with a healthy diet and exercise.

If that’s not enough, discuss meds. Think of a similar approach for gestational diabetes or preexisting diabetes in pregnancy.

Continue to recommend insulin first-line. It has the longest track record...and is easier to fine-tune as pregnancy progresses. Plus oral meds aren’t always enough in these patients.

If insulin isn’t an option, consider metformin. It causes less weight gain than insulin, but has less overall safety data.

Save glyburide as a last resort. It’s linked to worse outcomes (high birth weight, etc) than metformin or insulin.

Avoid other sulfonylureas AND other diabetes meds (GLP-1 agonists, SGLT2 inhibitors, etc)...due to lack of long-term data.

Recommend checking blood glucose 4 times a day...using a standard blood glucose meter. Evidence with continuous glucose monitors is limited in gestational diabetes.

Aim for a fasting glucose of less than 95 mg/dL...and less than 140 mg/dL 1 hour after meals OR less than 120 mg/dL 2 hours after meals.

If patients are well managed with lifestyle changes alone after a few weeks, it’s often okay to reduce to twice-daily glucose checks.

After delivery, emphasize follow-up to identify and manage possible prediabetes, type 2 diabetes, CV risks, etc.

Key References:

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Pharmacist's Letter. September 2022, No. 380907