# Gestational Diabetes (GDM) & Neonatal Hypoglycemia

## Who should you screen for GDM ?

EVERYONE!

Screening should occur between 24-28 weeks
Two options :

a) 1-step 75g OGTT
b) 2-step 50g GCT + 75g OGTT if positive first test

SOGC website for table with diagnostic cut offs: https://www.pregnancyinfo.ca/your-pregnancy/routine-tests/glucose-testing/
Diabetes Canada Healthcare Tool : https://guidelines.diabetes.ca/health-care-provider-tools/gdm

Involve Friends as Needed !

- Diabetes Nurse Educators
- Dieticians
- OBGYNs
- MFMS

## Management :

### Goal 1 : Optimize blood sugars

a) Diet modification (spreading meals out in the day, selecting low glycemic index foods)
b) Medications (Insulin)

***Why :*** Improved sugar control reduces the risk of fetal macrosomia, which helps reduce risk of delivery complications such as shoulder dystocia, assisted vaginal delivery, or C-section.

### Goal 2 : Ensure fetal well-being

Discuss with local providers regarding typical protocol for additional ultrasounds to assess growth as well as other antenatal screening tests (may include NST, AFI, BPP).

***Why :*** Antenatal testing helps assess fetal status and can help inform delivery planning (e.g. assesses fetal well-being & growth)

### Goal 3 : Delivery planning

Induction of labour typically occurs between 38+0 and 40+6 weeks depending on individual patient factors (type & degree of control, fetal complications, etc.). Organize for delivery in a centre with capabilities to manage neonatal hypoglycemia.

***Why :*** The risk for stillbirth increases at earlier gestation in pregnancies complicated by GDM as compared to pregnancies without GDM. Newborns are at higher risk of hypoglycemia when born to parents with gestational diabetes.

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## Risk Factors for Neonatal Hypoglycemia

- Gestational parent with diabetes (GDM, T1DM, T2DM)
- Large for Gestational Age (LGA)
- Small for Gestational Age (SGA)
- Labetalol exposure
- Preterm infants
- Perinatal asphyxia

*Hypoglycemia beyond*

**72 hours**

*requires further investigation!*

## Hypoglycemia Cut Off : ≤ 2.6mmol/L

## CPS Management Sequence

https://cps.ca/uploads/documents/Management_of_Hypoglycemia_algorithm_FINAL-EN.pdf

Mainstay of Treatment is INCREASE SUGAR availability

1) Breastfeed (if infant is well & maintaining blood sugars)
2) Supplement with formula (if no maternal desire to breastfeed/no colostrum or milk to supply)
3) 40% Dextrose Gel
4) IV D10%W (FIRST LINE if infant is symptomatic or cannot feed or glucose ≤ 1.8mmol/L)

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