



WEBINAR SERIES - 01

Gestational Diabetes Uncovered : A Case-Based Webinar

*Organized by the
Perinatal Society of Sri Lanka*

"Beyond Survival: Thriving with Advanced Maternal and Neonatal Care"



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The Lancet series on Gestational Diabetes

Gestational Diabetes Mellitus (GDM) is the most common medical pregnancy complication worldwide. Early diagnosis and treatment of GDM is greatly needed to improve the health of both woman and child.

The current state

14% of pregnancies are affected by GDM



Estimated GDM cost in the US and China largely due to complications



Historically, GDM is tested for and treated late into the second or third trimester



North America and Caribbean
7.0 (6.5–11.9)

South and Central America
11.2 (7.1–16.6)



30- 70%* of women with GDM experience hyperglycaemia from early pregnancy (<20 weeks' gestation, early GDM) and these pregnancies have worse outcomes for woman and child compared to women diagnosed with late GDM

*depending on population and screening method



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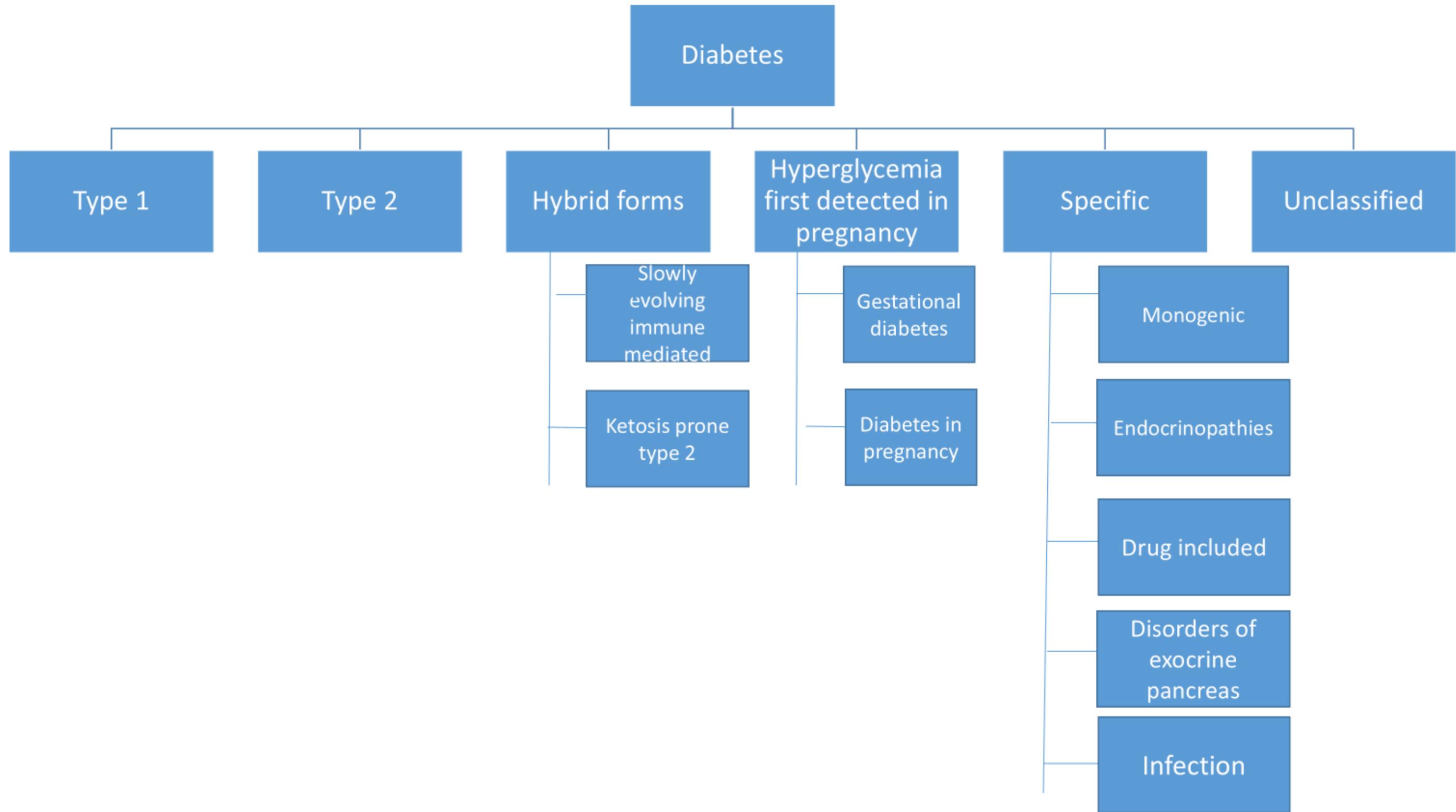
Case Scenario

A thirty-three-year-old woman in her second pregnancy was found to have a booking OGTT with following values.

Fasting blood sugar of	95 mg/dl,
1-hour value of	220 mg/dl,
2-hour value of	160 mg/dl

She had **no history of pre-existing diabetes** or other chronic illnesses prior to this pregnancy. Also, her booking TSH was 20 mIU/L for which she was started on oral thyroxine therapy. Anomaly scan performed at 22 weeks revealed a normal foetus.





Q1

2. **Pre-existing Diabetes** - Diabetes diagnosed prior to conception: T1D, T2D, disease of exocrine pancreas, monogenic diabetes (eg:MODY).
3. **Diabetes in Pregnancy (DIP)** – Hyperglycaemia first detected in pregnancy that meets the usual diagnostic thresholds for diabetes outside pregnancy (fasting plasma glucose ≥ 126 mg/dL, or an HbA1c $\geq 6.5\%$, or a random plasma glucose ≥ 200 mg/dL).
4. **Early Gestational Diabetes Mellitus (Early GDM):** Hyperglycaemia first detected before 14 weeks' gestation that does not meet criteria for DIP but meets the diagnostic thresholds for early GDM informed by the TOBOGM study. (fasting plasma glucose 95 mg/dL to 125 mg/dL or 1-hr plasma glucose > 191 mg/dL or 2-hour plasma glucose 162 -199 mg/dl following 75 g oral glucose tolerance test [OGTT]).

Q1

	Glucose measure	ADIPS criteria
Gestational diabetes*	Fasting BGL 1-hour BGL 2-hour BGL	5.1-6.9mmol/L ≥10.0 mmol/L 8.5-11.0mmol/L
Diabetes in pregnancy*	Fasting BGL 2-hour BGL Random BGL HbA1c	≥7.0 mmol/L ≥11.1 mmol/L ≥11.1 mmol/L [†] ≥6.5% [‡]

* only one elevated BGL is needed for diagnosis

† in the presence of diabetes symptoms

‡ recommended in remote areas where OGTT is logistically difficult

Q1

Test	IADPSG GDM (any 1 of)	ADA GDM (at least 2 of) ^a	WHO IFG/IGT (any 1 of)
Fasting glucose (mmol/l)	≥ 5.1	≥ 5.3	≥ 6.1
1 h glucose (mmol/l)	≥ 10	≥ 10	
2 h glucose (mmol/l)	≥ 8.5	≥ 8.6	≥ 7.8

^a The ADA have recently endorsed the IADPSG criteria [19]

Q2

- End organ Screening
 - Diabetic Retinopathy
 - Diabetic Nephropathy

- Initial additional Investigations
 - HbA1c
 - Thyroid Profile
 - 2D ECHO
 - FBC / Blood Picture

Diagnosis: Early GDM

OGTT values meet ADIPS 2025 early GDM thresholds (6–14 weeks)

FPG 95–125 mg/dL diagnostic of early GDM

1-hour value >191 mg/dL confirms diagnosis

2-hour value 162 mg/dl, But single abnormal value sufficient

TOBOGM Trial (NEJM 2023): Simmons D, Devlieger R, van Assche A, Jans G, Galjaard S, Corcoy R, et al. Treatment of booking gestational diabetes mellitus (TOBOGM): a randomised controlled trial. *N Engl J Med.* 2023;388(22):2106–2117.

ADIPS 2025 thresholds adopted in SL guideline – Section C1.5

Antenatal Care

- Women with **Early GDM** (meeting ADIPS 2025 thresholds) should receive:
 - Individualised **medical nutrition therapy**
 - **Glucose monitoring**
 - **Pharmacotherapy** (e.g., insulin or metformin) if targets are not met.

Multi-disciplinary Care

Women with hyperglycaemia in pregnancy (HIP) should be ideally managed in a multi-disciplinary care set up.

- Women with 2-hour glucose 140–161 mg/dL have an increased risk of developing GDM later and should receive **lifestyle counselling** and **repeat testing** at 24–28 weeks.

Role of Aspirin in HIP



Women with diabetes in pregnancy and pre-existing diabetes have an increased risk of **preeclampsia**.



Low-dose aspirin (150 mg daily) is recommended from **12 weeks until 36 weeks of POA** in:



All women with **pre-existing type 1 or type 2 diabetes**.



Women with GDM plus additional risk factors (hypertension, renal disease, autoimmune diseases, strong family history of pre-eclampsia, obesity).

Risk category	Risk factors	Aspirin indication
High risk (≥ 1 factor sufficient)	<ul style="list-style-type: none"> • Previous pre-eclampsia requiring preterm delivery • Chronic kidney disease • Autoimmune disease (e.g., SLE, antiphospholipid syndrome) • Pre-existing diabetes (Type 1 or Type 2) • Chronic hypertension 	Yes – start low-dose aspirin (75–150 mg daily) from 12 weeks
Moderate risk (≥ 2 factors required)	<ul style="list-style-type: none"> • Nulliparity • Maternal age ≥ 40 years • Pregnancy interval >10 years • BMI ≥ 35 kg/m² • Family history of pre-eclampsia • Multiple pregnancy 	Yes if ≥ 2 factors present; otherwise No

National Institute for Health and Care Excellence (NICE). *Hypertension in pregnancy: diagnosis and management (NG133)*. London: NICE; 2019.

Low-dose aspirin in pregnancy to prevent pre-eclampsia. Guys and St Thomas' NHS Trust patient info; 2024.

Blood glucose monitoring

1. Self-monitoring of blood glucose (SMBG)

For GDM managed with diet and/or metformin

- At minimum: on waking + post-prandial
- At least 1–2 days per week, with additional monitoring if glycaemic targets are not met or if foetal complications emerge

2. Blood Sugar Series (BSS) at outpatient and ward setup

- Fasting and 1 hour or 2-hour PPPG (1 hour preferred) after each meal.
- Frequency should be individualised based on glycaemic control.
- Insulin-treated women require more frequent monitoring than those on metformin alone.
- Due to practical reasons 2 weekly BSS is appropriate if adequate control.

3. Continuous glucose monitoring (CGM)

*Feig DS, Berger H, Donovan L, et al. Diabetes and pregnancy. Endocr Rev. 2024;45(1):1–48.
American Diabetes Association. 14. Management of Diabetes in Pregnancy: Standards of Care in Diabetes—2025. Diabetes Care. 2025;48(Suppl. 1):S254–S267.*

Blood glucose targets

Glucose Measurement	Type 1 or Type 2 Diabetes	GDM Treated with Insulin	GDM Not Treated with Insulin
Fasting glucose	70–95 mg/dL	70–95 mg/dL	< 95 mg/dL
1-hour postprandial glucose	110–140 mg/dL	110–140 mg/dL	< 140 mg/dL
2-hour postprandial glucose	100–120 mg/dL	100–120 mg/dL	< 120 mg/dL

Feig DS, Berger H, Donovan L, et al. Diabetes and pregnancy. Endocr Rev. 2024;45(1):1–48. American Diabetes Association. 14. Management of Diabetes in Pregnancy: Standards of Care in Diabetes—2025. Diabetes Care. 2025;48(Suppl. 1):S254–S267.

Foetal Surveillance



Serial ultrasound: Foetal biometry and DVP every four weeks from 28 to 36 weeks.



Growth chart plotting: should be plotted on standard growth charts. (INTER-GROWTH)



Monitoring before 24 weeks: Routine surveillance of foetal well-being prior to 24 weeks (e.g. umbilical artery Doppler studies, cardiotocography) is not recommended unless there is a specific concern for FGR



Anomaly scan: All women with pre-existing diabetes, DIP & Early GDM should undergo a detailed anomaly scan between 18 and 22 weeks of gestation to detect structural abnormalities.



Foetal echocardiography: Women with **pre-existing diabetes** should be considered for detailed foetal echocardiography performed by a foetal medicine specialist or paediatric cardiologist. Where access is limited, at least a minimum, a four-chamber view, outflow tract views, and a three-vessel trachea view should be obtained and documented.

OGTT, Is it the ideal test at booking ???

- Universal screening at booking is essential
- Usually around **6– 14 weeks** of gestation
- **At 22–24 weeks (optional):** For women at **high risk of GDM** consider an earlier rescreen if booking tests were negative/ or inability to perform OGTT
- **Alternative tests:**
 - 2-hour post-prandial plasma glucose
 - Fasting plasma glucose (FPG)
 - HbA1c

Risk factor	Notes
Maternal BMI >30 kg/m ²	Pre-pregnancy or at booking visit
Previous GDM	Strongest predictor of recurrence
Maternal age >40 years	Risk increases progressively with age
Family history of diabetes	First-degree relative with GDM
Previous macrosomia	Birth weight >4000 g or >90th percentile
Polycystic ovary syndrome (PCOS)	Associated with insulin resistance
South Asian ethnicity	All Sri Lankan women considered at high risk

Complications of Gestational Diabetes

Maternal complications	Pre-eclampsia and gestational hypertension Polyhydramnios Increased risk of caesarean section Induced labour Obstructed labour due to macrosomia Pre-term labour and birth	Postpartum haemorrhage Infection Birth trauma Recurrent GDM in future pregnancies Higher lifetime risk of type 2 diabetes
Fetal/neonatal complications	Macrosomia (birth weight >4,000 g) Shoulder dystocia and birth trauma Prematurity Neonatal hypoglycaemia Jaundice	Hypocalcaemia Polycythemia/ hyperviscosity Neonatal respiratory distress Increased perinatal morbidity and mortality
Long-term complications of the offspring	Increased risk of obesity, impaired glucose tolerance, metabolic syndrome and type 2 diabetes later in life.	

Q6 **Optimizing Glycemic Control**

- **Pharmacological**

- Metformin

- Insulin

- **Non Pharmacological**

- MNT

- Exercises

Optimizing the Glycemic Control

Factors to consider

- Health Education
- Compliance / Addressing drug side effects
- Monitoring Blood Glucose
- Prevention of Hypoglycemia
- Intercurrent Infections – UTI, Vaginal candidiasis, Resp. Tract Infections
- Associated Other Medical Disorders – HT, Endocrine Disorders, Connective Tissue Disorders
- Associated Psychiatric Disorders – Anxiety / Depression
- Drug Interactions – Thyroxine, Steroids
- Substance Abuse - Alcohol
- Don't forget – Mother of child – Addressing social issues

Q7 Blood Glucose Monitoring

- **Best Method**
 - Self Glucose Monitoring
- **Frequency**
 - Trimester
 - Changing drug doses
 - Intercurrent infections
 - Drug Interactions
 - Recurrent Hypoglycemic events

Case Scenario

Her growth scan done at 28 weeks showed a normal foetal biometry and normal umbilical artery Doppler indices.

However, the ultrasound scan at 32 weeks showed an increased abdominal circumference (>90th centile) with an estimated foetal weight of approximately 2.6kg (>90th centile). The deepest vertical pool measured 10.5 cm which was suggestive of **polyhydramnios and macrosomia**.

Blood sugar series done at 32 weeks revealed a fasting blood sugar of 99mg/dl, 1-hour post- breakfast value of 160mg/dl, 1-hour post-lunch value of 135 mg/dl, 1-hour post-dinner value of 170 mg/dl.



Complicated Diabetes & Fetopathy

Key Features of Fetopathy

Fetus has already demonstrated **pathological sensitivity to maternal glucose**

Fetal macrosomia is defined as estimated foetal weight >90th centile.

Indirect markers of poor glycaemic control

- Abdominal circumference >90th centile – Altered fat distribution
- Presence of polyhydramnios – Fetal polyuria/ Osmotic diuresis

Risks: LGA fetuses are at increased risk of stillbirth and shoulder dystocia in both diabetic and non-diabetic pregnancies.

Control

Tighter glycaemic control is essential

Admit, Close monitoring, Possible insulin therapy

Role of HbA1C

HbA1c checks optimised outcomes for mother and baby , Evidence ??

Time point	Standard target	Escalated target (fetopathy present)	Evidence
Fasting	≤5.3 mmol/L (≤95 mg/dL)	≤5.0 mmol/L (≤90 mg/dL)	Reduces baseline fetal exposure
1-h post-meal	≤7.8 mmol/L (≤140 mg/dL)	≤7.0–7.2 mmol/L (≤126–130 mg/dL)	Strongest effect on AC, AFI
2-h post-meal	≤6.7 mmol/L (≤120 mg/dL)	≤6.1 mmol/L (≤110 mg/dL)	Secondary control

Consider early delivery

Catalano PM, McIntyre HD, Cruickshank JK, et al. The hyperglycemia and adverse pregnancy outcome study: associations of maternal glucose with fetal adiposity. Diabetes Care. 2012;35(4):780–786.

Further Management

- **Needs close monitoring**
 - Admit the patient
 - Frequent blood glucose monitoring
 - Reassess the patient
 - May need a MDT

Recommendations for time of delivery

- *SLCOG Guideline, Timing and mode of delivery – Section D2, Table 09*
- *Joint British Diabetes for in patient care. Managing diabetes and hyperglycaemia during labour and birth. JBDS 12 February 2023.*

Group	Recommended Time of Delivery
MNT only and uncomplicated	40–40+6 weeks
On Metformin and uncomplicated	38–39 weeks
On Insulin and uncomplicated	37–38 weeks
Complicated (metabolic/maternal/fetal)	Consider elective delivery at 36–37 weeks

Mode of Delivery

Delivery plan to be finalized by 36 weeks

Vaginal delivery by TIMED INDUCTION is preferred

Macrosomia
>4.0 kg: consider elective caesarean section

Brown J, Grzeskowiak LE, Williamson K, Downie MR, Crowther CA. Insulin for the treatment of women with gestational diabetes. Cochrane Database Syst Rev. 2017;11:CD012037.

INTRAPARTUM CARE

MULTIDISCIPLINARY TEAM APPROACH

- Labour and delivery planning should involve obstetricians, endocrinologists/ physicians, paediatricians/ neonatologists and midwives/nurses.
- Ensure neonatal care unit to prepare for potential neonatal hypoglycaemia.
- Ensure written management plans are in place before admission for delivery.

TARGET GLUCOSE RANGE: Maintain **72–126 mg/dL** throughout labour

FREQUENCY OF MONITORING:

- **2 - 4 hourly** monitoring can be considered **in the latent phase** for those with GDM/ T2DM on diet/ metformin only
- **Hourly** glucose monitoring **during active labour**
- **LSCS** under GA , **every 30-minutes** monitoring

OPTIONS FOR GLYCAEMIC MANAGEMENT DURING LABOUR

- Correctional Subcutaneous Rapid-Acting Insulin (SC)
- Variable Rate Intravenous Insulin Infusion (VRIII)

Correctional Subcutaneous Rapid- Acting Insulin (SC)

Suitable for:

- Those with gestational diabetes managed with diet or oral agents.
- Well-controlled pre-existing diabetes
- Early labour, taking oral fluids
- Repeat monitoring every 1–2 hours and adjust accordingly

Capillary BG (mg/dL)	Suggested Soluble Insulin Dose
< 72	Treat hypoglycemia per protocol (oral/IV glucose), re-check in 10 min
72 – 126	No insulin; continue monitoring
126 – 140	1 unit
141 – 160	2 units
161 – 180	3 units
181 – 200	4 units
>200	Consider VRIII if persistent hyperglycemia

Variable Rate Intravenous Insulin Infusion (VRIII)

Indicated for:

- Type 1 diabetes (start at onset of labour or when fasting >6 hours)
- Poorly controlled type 2 diabetes or GDM where blood glucose levels are persistently > 7 mmol/L
- Must be **used together with a dextrose-containing infusion** to prevent hypoglycaemia.

Suggested infusion setup:

- **Insulin solution:** 50 units of soluble insulin in 49.5 mL of 0.9% NaCl (1 unit/mL).
- **Start rate:** As per glucose level (Please refer the next slide).
- The recommended substrate fluid to be administered alongside the VRIII is 5% glucose in 0.9% saline with 0.15% KCl at a rate of 50 mL/h.
- **Monitor glucose hourly, and serum electrolytes/VBG** every 4–6 hours if infusion continues >6 hours.

Variable Rate Intravenous Insulin Infusion (VRIII)

Finger prick blood glucose (mg/dL)	Algorithm 1 (For most women)	Algorithm 2 (For women needing >80 units/day, on steroids or not controlled on Algorithm 1)
< 72	Stop insulin for 20 minutes. Treat hypoglycemia per guideline. Recheck BG in 10 minutes	
72 – 99	0.2 units/hour	0.5 units/hour
100 – 126	0.5	1.0
127 – 153	1.0	1.5
154 – 198	1.5	2.0
199 – 252	2.0	2.5
253 – 306	2.5	3.0
307 – 360	3.0	4.0
> 360	4.0	6.0

From a neonatology point of view, what complications would you anticipate in the neonate?

Complications of infants born to mothers with GDM

Perinatal complications include Increased perinatal mortality due to:

- Congenital malformations (4-8 fold increase)
- Prematurity (4.8 times)
- fetal demise
- Macrosomia (52%), IUGR (poor outcome)
- intrapartum asphyxia (10 times)/chronic hypoxia
- High CS rate (42%)
- Respiratory distress syndrome

Perinatal complications

Birth injury may be caused by:

- shoulder dystocia(2 folds)
- brachial plexus trauma (10 times)

Neonatal complications of diabetes in pregnancy

- **Polycythaemia and hyperviscosity due to:**
 - increased erythropoiesis secondary to fetal arterial hypoxaemia secondary to hyperinsulinism
 - shift in blood from placenta to fetus during hypoxia
- **Hypoglycemia**
 - incidence varies from 25-40 per cent
 - defined as BSL < 2.6 mmol (46mg/dl)
 - note: many infants who are hypoglycaemic may be asymptomatic

Neonatal complications of diabetes in pregnancy

- **Hyperbilirubinaemia due to:**
 - polycythaemia (increased RBC mass)
 - increased extravascular haemolysis (bruising, cephalhaematoma)
 - delayed oral feeding (increased enterohepatic circulation)
 - liver immaturity

Neonatal complications of diabetes in pregnancy

- **Hypertrophic and congestive cardiomyopathy**
 - usually asymptomatic
 - usually resolve by eight to 12 weeks
 - Asymmetrical septal hypertrophy common
- **Respiratory distress**
 - delayed fetal lung maturation (insulin impedes glucocorticoid effect)
 - prematurity
 - increased incidence of Caesarean section in near-term deliveries/complicating 'wet lung syndrome.
 - Increased risk of PPHN

Neonatal complications of diabetes in pregnancy

- **Hypocalcaemia**

(due to functional hypoparathyroidism and hypomagnesaemia). Occurs in approximately 50 per cent of insulin-dependent diabetics.

- **Hypomagnesaemia**

(due to maternal hypomagnesaemia/increased renal losses with glycosuria)

Case Scenario

Baby boy is delivered by emergency Caesarean section at 37 weeks of gestation with a birthweight of 3.3kg.

He is found to have grunting since the 2nd hour from birth, which is supported with non-invasive ventilation.

FiO₂ requirement continues to stay at 70% without pre-post ductal difference.

CXR is suggestive of surfactant deficiency.

His blood sugar at 2 hours of life is 26mg/dl.

Respiratory distress with persistently high oxygen requirement and hypoglycaemia, how would you handle this situation?

Baby born

- Mode of delivery : EM LSCS
- 37 wks, 3.300kg (Not really macrosomic)
- 2hrs, Grunting on NIV 70%
- CXR- RDS (Ideally need to see by myself)
- Blood sugar 26mg/dl (1.4mmol/l)

I would be very worried!

**Management based on
current UK guidelines**

Management

- Urgent IV access including UVC
- Bloods for lab glucose / blood gas
- Septic screen
- (and consider hyposcreening -minimum -Insulin, cortisol, Lactate if two hypoglycemic episodes recorded or one measurement $<1\text{mmol/l}$)
- Severe hypoglycaemia ($<1.0\text{ mmol/L}$) at any time
- Persistent hypoglycaemia (>2 measurements $<2.0\text{ mmol/L}$ ≥ 37 weeks gestation or $<2.6\text{ mmol/L}$ <37)

Management

- Unable to manage orally due to respiratory concerns
- Glucose bolus 10% 2.5ml/kg
- Remember to re-check sugar in 30 min
- 10% Glucose 60ml/kg/d infusion

RDS

If clinically unstable/distress++

- Intubate after pre-med
- Surfactant
- VG ventilation 5ml/kg-SIMV
- Good sedation-Morphine
- UAC and IBP
- Pre/post ductal sats
- Aim pre ductal 95-96%, adjust FiO₂
- Blood gas in 1-2 hrs
- Parent communication

RDS

If stable and not much of distress and no high CO₂ in gas, (also consider CXR appearance)

- May consider LISA and NIV (HF or CPAP)
- Make sure FiO₂ req is less than 40% and good pre/post ductal stats
- Can avoid UAC and IBP
- Repeat gas in 1-2 hrs
- Parent communication

Further Mx of Hypoglycaemia

- Persistent Hypoglycaemia
- Increase glucose concentration –even up to 20% but central IV access
- Consider Glucagon infusion (2.5-15mcg/kg/hr)
- Single dose of glucagon 200 micrograms/kg IM can be given while IV access obtained
- Remember to calculate GIR

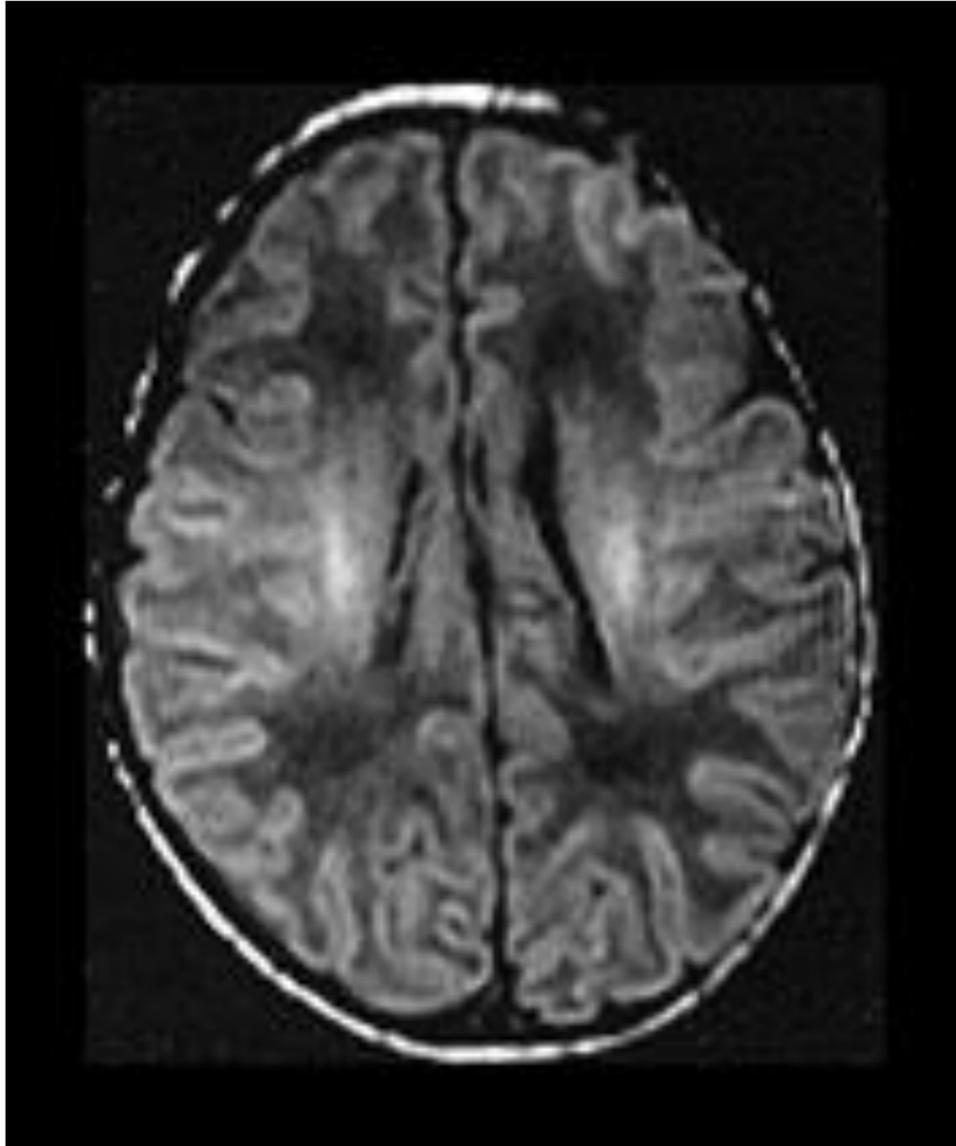
Further Mx of Hypoglycaemia

If hyperinsulinaemia is confirmed.

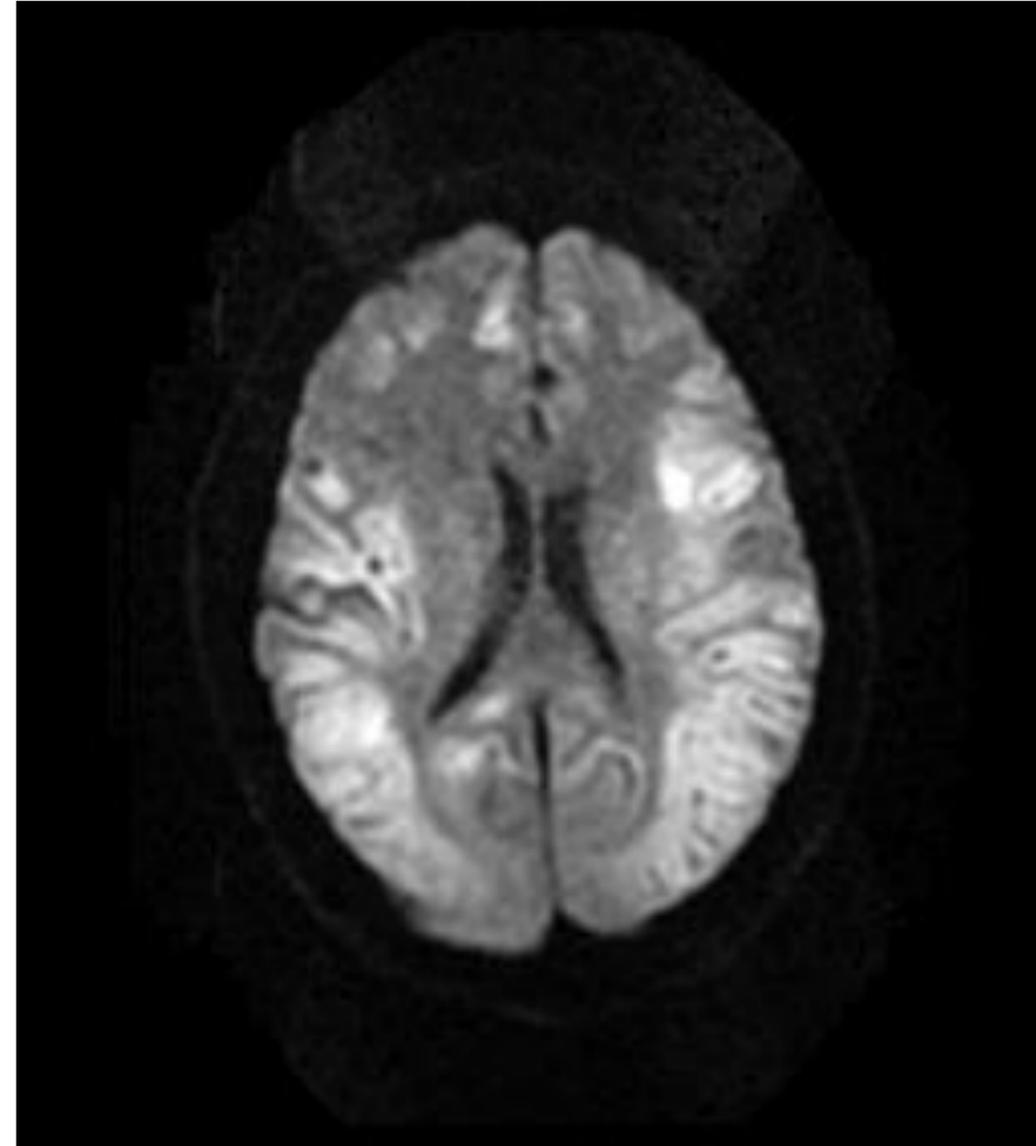
- Restrict fluid to 150ml/kg
- 2D echo (Exclude CHF and out flow tract obs)
- Start HCT and allow 24hrs
- Start Diazoxide
- Feeds can be mixed with 2.5-5% Maxi Jule
- Remember to chase other investigations
- Parent communication

What are the long-term complications that could occur if hypoglycaemia is poorly managed?

Complications of Hypoglycaemia



Normal



Hypoglycaemia

Complications of Hypoglycaemia



Also has higher risks for autism, ADHD

Long-term complications for infants with a diabetic mother

- Obesity
- risk of subsequent overt diabetes
- adverse neurodevelopment in 4 per cent of cases (may relate to maternal ketosis).

POSTPARTUM MATERNAL CARE

Immediate postpartum

- Stop all glucose-lowering medication after placenta delivered.
- Consider monitoring fasting and post-meal glucose for 24 hrs.
- Diagnostic thresholds for persistent diabetes:
 - Fasting > 126 mg/dL
 - Post-meal > 200 mg/dL

At 6 -8 weeks post-partum

- Encourage to attend a **postnatal clinic at 6–8 weeks**, ideally linked with child immunisation visits.
- **Women with GDM** should be counselled on future diabetes risk and recurrence of GDM (**High risk south Asians – 50-70% risk**).
- Recommended testing: **75 g OGTT at 6–12 weeks postpartum**. If not feasible, FPG and 2-hour PPPG may be used.
- If results are normal, advise **annual glucose screening** (FPG or HbA1c).
- If abnormal, refer to a diabetes clinic for long-term management.

Recommendations for breast feeding & family planning

Exclusive breastfeeding is recommended

It reduces neonatal hypoglycaemia, maternal obesity and type 2 diabetes

Metformin and all insulins are safe during lactation.

Emphasise the importance of contraception with

- Preconception counselling for future pregnancies
- Testing for Chronic Diabetes before planning pregnancy
- **Peri-conception folic acid (5 mg/day)** and optimised glycaemic control

All reliable contraceptive methods can be used

- Tailored to maternal health status and preferences.

Long term Management

- Factors to consider
 - Health Education
 - Post Partum period
 - Contraception
 - Screening for diabetes related Macro and Micro vascular complications
 - Regular monitoring for other medical disorders
 - Interpregnancy care pathway
 - Next Pregnancy – screening and optimizing

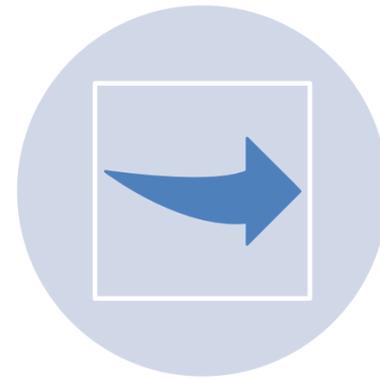
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Questions?

Key Take-Home Messages...



Early GDM requires proactive management - **TOBOGM Trial (NEJM 2023)**:



Fetopathy signals inadequate control



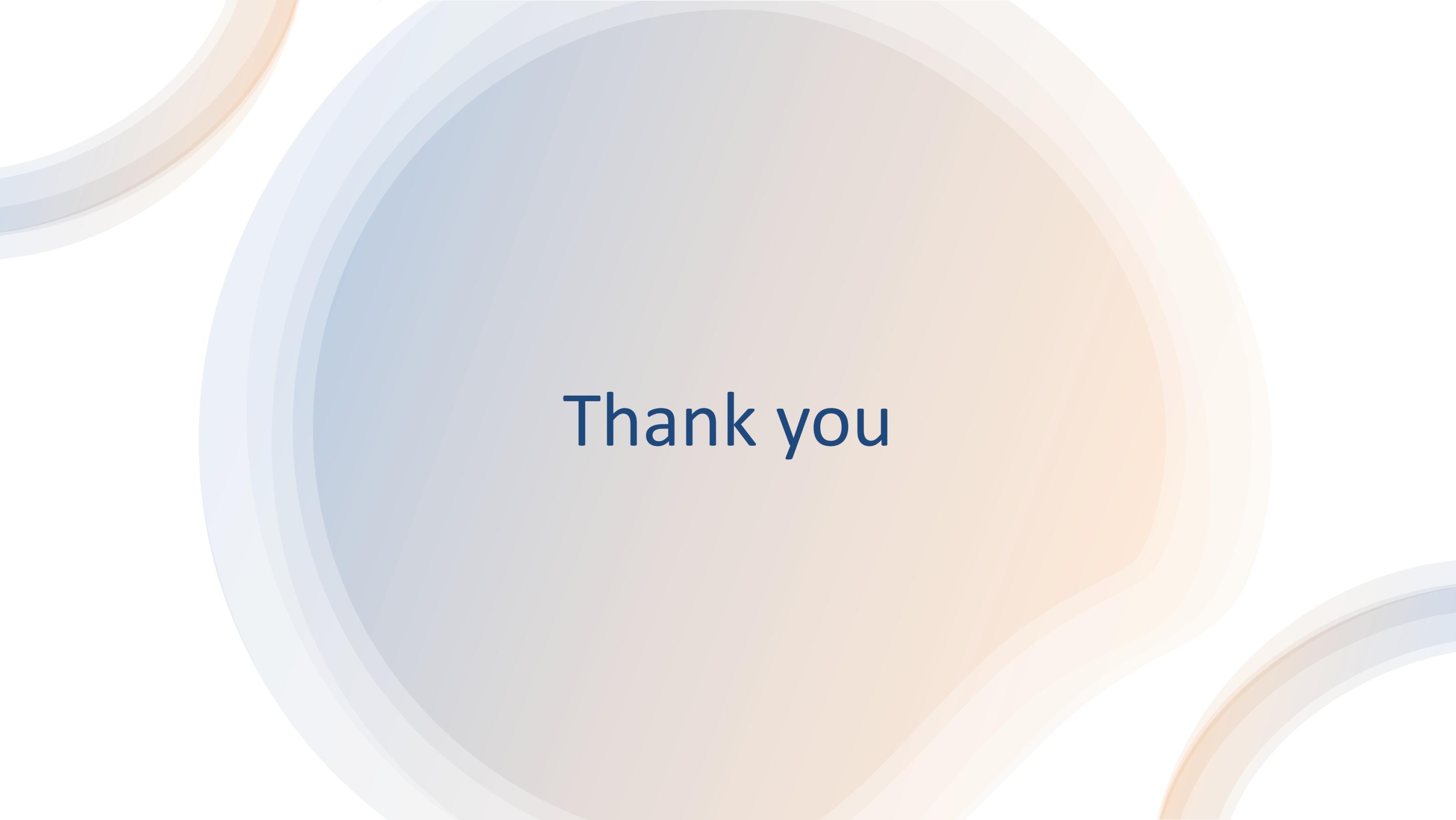
Insulin escalation is preventive, not a failure management



Guideline-driven care reduces adverse outcomes

Take home message

- Both hypoxia and hypoglycaemia cause severe and irreversible brain damage and should attend promptly.
- Delay in appropriate respiratory support can be detrimental specially in babies with maternal diabetes, due to increased risk of PPHN-act fast
- Promptly treat both the condition simultaneously. It's a team work and **never forget accurate documentation and parents communication.**



Thank you