

# Information for you

Published in March 2013 (next review date: 2016)

## Gestational diabetes

### Who is this information for?

This information is for you if you wish to know more about diabetes that develops in pregnancy (gestational diabetes) or have been told that you have gestational diabetes.

It tells you:

- what gestational diabetes is
- how it is diagnosed
- what extra antenatal care you can expect
- what this diagnosis means for you and your baby, now and in the future.

### What is gestational diabetes?

Diabetes that develops during pregnancy is known as gestational diabetes. It occurs because your body cannot produce enough insulin (a hormone important in controlling blood glucose) to meet its extra needs in pregnancy. This results in high blood glucose levels.

Gestational diabetes usually starts in the middle or towards the end of pregnancy.

### How common is gestational diabetes?

Gestational diabetes is very common. It may affect up to 18 in 100 women during pregnancy.

You are more likely to develop gestational diabetes if you have any of the following risk factors:

- your body mass index (BMI) is 30 or higher
- you have previously given birth to a large baby, weighing 4.5 kg (10lbs) or more
- you have had gestational diabetes before



- you have a parent, brother or sister with diabetes
- your family origin is South Asian, Chinese, African-Caribbean or Middle Eastern.

## How will I be checked for gestational diabetes?

If you have any of the above risk factors, you should be offered a glucose test during your pregnancy. This may be a simple blood test in early pregnancy and/or a glucose tolerance test (GTT) when you are between 24 and 28 weeks pregnant.

A GTT involves fasting overnight (not eating or drinking anything apart from water):

- In the morning, before breakfast, you will have a blood test. You are then given a glucose drink.
- The blood test is repeated 1–2 hours later to see how your body reacts to the glucose drink.

If you have had gestational diabetes in a previous pregnancy, you may be offered a glucose test, or a kit to check your own blood glucose levels, early in pregnancy as well as a GTT at 24–28 weeks.

## What does gestational diabetes mean for me and my baby?

Most women who develop diabetes in pregnancy have healthy pregnancies and healthy babies but occasionally gestational diabetes can cause serious problems, especially if it goes unrecognised. Diagnosing and treating gestational diabetes reduces these risks.

It is important to control the level of glucose in your blood during pregnancy. If your blood glucose is too high, your baby will produce more insulin, which can make your baby grow bigger and increases the likelihood of having your labour induced, caesarean section, serious birth problems and stillbirth. These risks are higher if gestational diabetes is not detected and controlled.

A baby that is making extra insulin may have low blood glucose levels after birth (see below – What happens after my baby is born?) and is more likely to need additional care in a neonatal unit.

Your baby may also be at greater risk of developing obesity and/or diabetes in later life.

Controlling your levels of blood glucose during pregnancy and labour reduces the risks of all these complications for you and your baby.

## What extra care will I need during pregnancy?

If you are diagnosed with gestational diabetes, you will be under the care of a specialist healthcare team and will be advised to have your baby in a consultant-led maternity unit that has a neonatal unit.

Your healthcare team will usually include a doctor specialising in diabetes, an obstetrician, a specialist diabetes nurse, a specialist diabetes midwife and a dietician. You should start receiving extra antenatal care as soon as your gestational diabetes is diagnosed. Having gestational diabetes will mean more clinic visits at the hospital.

## Healthy eating and exercise

The most important treatment for gestational diabetes is a healthy eating plan and exercise. Gestational diabetes usually improves with these changes although some women, despite their best efforts, need to take tablets and/or give themselves insulin injections. You should have an opportunity to talk to a dietician about choosing foods that will help to keep your blood glucose at a healthy and stable level.

## Monitoring your blood glucose

After you have been diagnosed with gestational diabetes, you will be shown how to check your blood glucose levels and told what your ideal level should be.

If it does not reach a satisfactory level after 1–2 weeks, or if an ultrasound scan shows that your baby is larger than expected, you may need to take tablets or give yourself insulin injections (see below – Will I need treatment?).

## Monitoring your baby

You should be offered extra ultrasound scans to monitor your baby's growth more closely.

## Advice and information

During your pregnancy, your doctors and midwives will give you information and advice about:

- planning the birth, including timing and types of birth, pain relief and changes to your medications during labour and after your baby is born
- looking after your baby following birth
- care for you after your baby is born including contraception.

## Will I need treatment?

Up to one in five women with gestational diabetes will need to take tablets and/or have insulin injections to control their blood glucose during pregnancy. Your healthcare team will advise you what treatment is best for you.

If you do need insulin, your specialist diabetes nurse will explain exactly what you need to do. This will include showing you how to inject yourself with insulin, how often to do it and when you should check your blood glucose levels.

## When is the best time for my baby to be born?

Ideally you should have your baby between at 38 and 40 weeks of pregnancy, depending on your individual circumstances.

## How will I have my baby?

If your ultrasound scans have shown that your baby is large, your healthcare team should discuss the risks and benefits of vaginal birth, induced labour and caesarean section with you.

## What happens in labour?

It is important that your blood glucose level is controlled during labour and birth and it should be monitored every hour during labour to ensure it stays at a satisfactory level. You may be advised to have an insulin drip to help control your blood glucose level.

During labour, your baby's heart rate should be continuously monitored.

## What happens after my baby is born?

- Your baby will stay with you unless he or she needs extra care.
- Breastfeeding is best for babies, and there's no reason why you shouldn't breastfeed your baby if you have gestational diabetes. Whichever way you choose to feed your baby, you should start

feeding him or her as soon as possible after birth, and then every 2–3 hours to help your baby's blood glucose stay at a safe level.

- Your baby should have his or her blood glucose level tested a few hours after birth to make sure that it is not too low. Your baby may need to be looked after in a neonatal unit if he or she is unwell, needs close monitoring or treatment, needs help with feeding or was born prematurely.
- Gestational diabetes usually gets better after birth and therefore you are likely to be advised to stop taking all diabetes medications immediately after your baby is born. Before you go home, your blood glucose level will be tested to make sure that it has returned to normal.
- You should have a test to check your blood glucose level after an overnight fast or a GTT about 6–8 weeks after your baby is born. It is important that you attend, as a small number of women continue to have diabetes after pregnancy.

## What follow-up should I have?

You should be offered a postnatal appointment during which the result of your blood glucose test or GTT will be discussed with you. If your blood glucose levels are still high, you will be referred to a doctor specialising in diabetes.

You should be given information about your lifestyle, including diet, exercise and watching your weight, to reduce your chance of diabetes in the future.

Women who have had gestational diabetes have a one in three chance of developing type 2 diabetes within the following 5 years. You will be advised to have a fasting blood glucose test once a year.

## Future pregnancies

Being the right weight for your height (having a normal BMI), eating a healthy diet and taking regular physical exercise before you become pregnant reduces your risk of developing gestational diabetes again.

If you are planning to become pregnant, you should start taking a high dose (5 mg) of folic acid daily before you stop contraception. You will need a prescription for this.

As soon as you find out you're pregnant, contact your GP, practice nurse or hospital antenatal team for advice about your antenatal care.

## Further information

NICE guidance on *Diabetes in Pregnancy*: [www.nice.org.uk/CG63](http://www.nice.org.uk/CG63).

Diabetes UK website: [www.diabetes.org.uk/Guide-to-diabetes/Life-stages/Gestational-diabetes/](http://www.diabetes.org.uk/Guide-to-diabetes/Life-stages/Gestational-diabetes/).

## Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the NICE clinical guideline *Diabetes in Pregnancy* (March 2008) and the RCOG Scientific Impact Paper *Diagnosis and Treatment of Gestational Diabetes* (January 2011) produced by the Scientific Advisory Committee. The latter contains a full list of the sources of evidence we have used and is available at: [www.rcog.org.uk/womens-health/clinical-guidance/diagnosis-and-treatment-gestational-diabetes-sac-opinion-paper-23](http://www.rcog.org.uk/womens-health/clinical-guidance/diagnosis-and-treatment-gestational-diabetes-sac-opinion-paper-23).

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

This information has been reviewed before publication by women attending clinics in Liverpool, Newcastle and Farnborough.

A glossary of all medical terms is available on the RCOG website at: [www.rcog.org.uk/womens-health/patient-information/medical-terms-explained](http://www.rcog.org.uk/womens-health/patient-information/medical-terms-explained).

### A final note

The Royal College of Obstetricians and Gynaecologists produces patient information for the public. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of the clinical data presented and the diagnostic and treatment options available. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

All RCOG guidelines are subject to review and both minor and major amendments on an ongoing basis. Please always visit [www.rcog.org.uk](http://www.rcog.org.uk) for the most up-to-date version of this guideline.