a long-acting insulin (for the control of the endogenous hepatic gluconeogenesis). There is no major difference in the glycaemic control of either continuous subcutaneous injections and the multiple-dose injection regimen. The major risk of insulin therapy is hypoglycaemia, including hypoglycaemia unawareness.

The attainment of optimal glycaemic control is extremely complicated and is influenced by multiple factors, e.g. the transient insulin resistance of the early morning, and the increased insulin resistance of advancing pregnancy, especially after the second half of pregnancy. There are large fluctuations in blood glucose levels during the day in diabetic patients, even in patients with apparently normal pre- and postprandial blood sugar levels.

The optimal values for pre- and postprandial blood sugar levels are 3.3 mmol/l to 5.0 mmol/l and 5.5 mmol/l to 7.0 mmol/l (two hours), respectively (as set by the American Diabetes Association). The route of administration can be either by multiple-dose injections or continuous subcutaneous infusion.

During labour, insulin can be administered by infusion or subcutaneous injection every two hours. The target blood sugar level is in the region of 4.8 to 8 mmol/l. One needs to be vigilant for symptoms of hypoglycaemia and possible electrolyte abnormalities.

Insulin requirements are radically diminished following delivery of the baby. All hypoglycaemic therapy should be stopped in GDM patients immediately post-delivery.

Antenatal management of diabetes in pregnancy

For this, please go to www.nice.org.uk/CG063.

Postnatal management

Oral hypoglycaemic agents (metformin, glyburide and glibenclamide) can be recommended post-delivery. Other oral agents should preferably be avoided while the mother is breastfeeding. All GDM patients should be screened six weeks post-delivery to exclude diabetes mellitus.

Conclusion

Great strides have been made in the diagnosis and management of hyperglycaemia in pregnancy, with an important paradigm shift to focusing on outcomes for mother and baby in the short and long term. The IADPSG consensus statement is a critical step towards achieving international uniformity in diagnosis of hyperglycaemia in pregnancy, thereby facilitating research comparison(s). The addition of oral hypoglycaemic agents to the treatment of diabetes in pregnancy has greatly enhanced quality of life and choice for the patient without compromising outcomes for the mother or baby.

References


