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Phone/Fax 714.968.0735 ssep1@verizon.net www.sweetsuccessexpress.org

Editorial:

The 11th Annual Meeting of the Diabetes in Pregnancy Study Group of North America

By Janice Lazear, MN, FNP, CRNP, CDE & Nancy C. Lintner, MS, ACNS, RNC-OB, CPT

The 11th Annual Meeting of the Diabetes in Pregnancy Study Group of North America (DPSG-NA) was held in Baltimore, Maryland May 28-30, 2009. Participants throughout the United States and Canada met to review recent research findings and discuss practice implications.

A summary of the meeting which was provided to these authors states that the "DPSG-NA recognizes the value of recently published studies that have validated the importance of diagnosing and treating GDM" (DPSG-NA 2009). Studies discussed were the Hyperglycemia and Adverse Pregnancy Outcomes (HAPO) study, the Australian Carbohydrate Intolerance Study in Pregnant Women (ACHOIS) and the National Institute of Child Health and Human Development (NICHD) Maternal-Fetal Medicine Unit (MFMU) Network Study: A Randomized Clinical Trial for Mild Gestational Diabetes Mellitus.

The HAPO study was conducted in nine countries in 15 centers with greater than 23,000 subjects over a nine year time span. The purpose of the study was to "clarify the risks of adverse outcomes associated with various degrees of maternal glucose intolerance less severe than that in overt diabetes mellitus" (HAPO 2008). Findings of the HAPO study indicated that blood glucose values at upper levels previously considered within the normal range correlated with negative pregnancy outcomes.

Since completion of the HAPO study, two meetings were held to address potential practice changes based on the research findings. The International Association of Diabetes and Pregnancy Study Group (IADPSG) met in Pasadena California in June 2008 and the 5th International Symposium on Diabetes and Pregnancy was held in Sorrento, Italy in March 2009.

Currently, screening and diagnostic criteria are not uniform worldwide which may lead to "under diagnosis and under management of GDM" (Reece et al. 2009). The World Health Organization (WHO) criteria for diagnosing GDM is a one-step 2-hour 75 gram oral glucose tolerance test (OGTT). The two-step approach includes a 1-hour 50 gram glucose challenge test (GCT) followed by a 3-hour 100 gram OGTT if the patient fails the 1-hour GCT (WHO 1999).

In Pasadena participants met in work study groups to discuss the screening and diagnosis of gestational diabetes mellitus (GDM), the results of the HAPO study and what test(s) and values should be used. No consensus was reached. In Sorrento, participants met again to discuss the opinions of the first meeting and attempted to establish recommendations, using fasting plasma glucose (FPG), and 1-hour and 2-hour blood glucose thresholds as criteria. Participants concluded that the 1-hour 50 gram GCT should not be used alone to confirm diagnoses and that a 2-hour 75 gram OGTT should be considered.

Donald R. Coustan, MD, Professor, Department of Obstetrics and Gynecology from Brown University Medical School presented at the DPSG-NA meeting. Dr. Coustan stated that researchers from the HAPO study did not recommend specific thresholds. He suggested that healthcare providers make obstetrical and medical management changes based on international consensus. Dr. Coustan stated that "the world should decide" (DPSG-NA 2009). He then pointed out that as there is increased risk on a continuum, a threshold for diagnosis would be arbitrary.

Dr. Coustan reported that the IADPSG recommends the use of the 2-hour 75 gram OGTT as the diagnostic test for GDM and that the two-step 1-hour GCT and 3-hour OGTT process be abandoned. The group further recommended the following thresholds for diagnosing GDM: FPG of >92 mg/dL, 1-hour >180 mg/dL and 2-hour >153 mg/dL. The DPSG-NA notes the similarities between the existing Carpenter and Coustan (1992) diagnostic criteria and those suggested from the data in the HAPO study (DPSG-NA 2009). "The DPSG-NA supports the concept of a one-step diagnostic test for GDM using a 75 gram OGTT" (DPSG-NA 2009). One abnormal result, (fasting, 1-hour or 2-hour) constitutes a diagnosis of GDM.

The ACHOIS study conducted by Crowther et al. (2005) was designed to determine if treatment of women with milder forms of glucose intolerance resulted in improved perinatal outcomes. The study randomized 1000 study participants to an intervention group of 490

Continued on page 2

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Our goal is to publish useful information and/or tools to help team members provide quality diabetes and pregnancy care.

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Continued from page 1

women and a control group of 510 women who were assigned to routine care. Women in the intervention group were prescribed medical nutrition therapy (MNT), self monitoring of blood glucose (SMBG), and insulin if needed, based on SMBG results.

Primary newborn outcomes for this study included: fetal death, shoulder dystocia, bone fracture, nerve palsy, admission to the neonatal intensive care unit (NICU) and jaundice requiring phototherapy. Primary maternal outcomes monitored were labor induction and delivery by cesarean. Additional primary outcomes, maternal health and psychological status were assessed using standardized instruments. Crowther et al. (2005) demonstrated that there was a significantly lower rate of serious perinatal complications in the intervention group versus the control group. Serious complications, defined as one or more of the following: fetal death, shoulder dystocia, bone fracture and nerve palsy, were seen at a rate of one percent in the intervention group and four percent in the control group. Infants in the intervention group, however, had a higher rate of admission to the NICU.

Crowther et al. (2005) also found that the rate of labor induction was significantly higher in the intervention group. Cesarean delivery rates were similar for the intervention and control groups. Maternal health status was measured by analyzing a questionnaire given to patients at six weeks after enrollment in the study and three months postpartum. The authors reported that of the 57% of women who completed the surveys at three months postpartum, results indicated a more favorable perception of

Health status in the intervention group, although not all of the indicators achieved statistical significance. Measurement of depression and anxiety at three months postpartum indicated lower depression scores in the intervention group with anxiety scores similar for the two groups.

The MFMU Network Study results were presented at the DPSG-NA 2009 meeting by the principle investigator Mark Landon, MD. The goal of the study was to determine if pregnancies complicated by mild GDM would result in reduced neonatal morbidity and mortality if treated with MNT and SMBG versus routine prenatal care. In this study mild GDM is defined as having a normal FBG (<95 mg/dL) and two abnormal post glucose load values on the 3-hour OGTT (Landon et al. 2007). Landon (2007) points out that in the ACHOISE Study, subjects were admitted with higher levels of hyperglycemia than those in the MFMU Network Study. Consequently, the MFMU study may provide additional information about the efficacy of treating women with milder forms of GDM (Landon et al. 2007).

In the MFMU Network Study the control group and practitioners were blinded to the OGTT results. A cohort of women with normal OGTTs were also enrolled and placed in a control group. The primary neonatal outcomes were: stillbirth/perinatal death, hyperbilirubinemia, hypoglycemia, hyperinsulinemia and birth trauma. Secondary outcomes included birth weight, neonatal fat mass, admission to the NICU, incidence of cesarean sections, preeclampsia, maternal weight gain and length of stay. Cord blood C-peptide samples were collected. The treatment group had 485 subjects and the control group had 473 subjects (Landon et al. 2007). There was no difference in the following outcomes for the treatment versus control group: neonatal hypoglycemia, hyperbilirubinemia, birth trauma and hyperinsulinemia, as determined by cord blood C-peptide results. However mean birth weight, neonatal fat mass, birth weights >4000 grams/LGA weights, the incidence of shoulder dystocia and cesarean birth were all reduced with treatment for GDM. The conclusion reached by researchers is that treatment of women with milder forms of GDM lowers the risk of excess fetal weight gain, shoulder dystocia and increased cesarean section rates (Landon 2008).

The DPSG-NA recognizes that "further studies are needed to examine the economic implications and long-term clinical consequences for the mother and her offspring resulting from suggested changes in management of GDM" (DPSG-NA 2009). Although the studies discussed clearly establish the importance of screening, diagnosis and treatment of women with GDM, including those with milder forms, the HAPO study raises additional questions. At what thresholds should treatment be initiated? If thresholds for diagnosis are lowered, what will be the impact on clinical and financial resources? Maternal/fetal risk increases on a continuum and identifying which patients should be treated will be a question for healthcare providers to examine on an ongoing basis.

Members of the American Association of Diabetes Educators (AADE) Pregnancy/Reproductive Health Specialty Practice Group (SPG) attended the meetings in Pasadena, Sorrento and Baltimore and participated in decision making regarding translating research findings into practice. Diabetes educators specializing in the care of women with GDM can be instrumental in the education of colleagues from various disciplines and advocate for patients regarding evidenced-based practice changes. The AADE's 36th Annual Meeting & Exhibition in Atlanta will give diabetes educators at the Pregnancy/Reproductive Health SPG meeting the opportunity to discuss these important studies and potential practice changes.

References available upon request.

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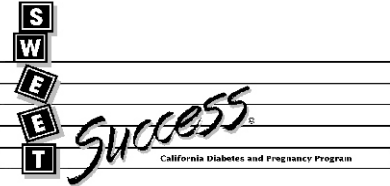
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