

Gestational diabetes

- **Intro:**
 - One of the most **common** conditions of pregnancy, which can have serious complications for the parent and baby if not identified and managed
 - Usually goes away again after giving birth
 - It's usually diagnosed from a **blood test 24 to 28 weeks** into pregnancy
 - Less common than Type 1 & 2 diabetes (increasing prevalence tho)
 - Affects 4-5 in 100 women during pregnancy, or 1 in 20 pregnancies in the UK
- **Causes:**
 - Hormonal difficulty to use insulin (increased risk of insulin resistance)
 - Cells don't respond properly to insulin by not producing enough, making it difficult to use glucose properly for energy (stays in body & blood sugar level rises), leads to gestational diabetes
- **Risk factors:**
 - Living with overweight or obesity
 - Having had it before in a previous pregnancy
 - Having had a very large baby in a previous pregnancy (4.5kg / 10lbs or more)
 - Having a fHx of diabetes (at least one parent or sibling)
 - Having a South Asian, Black or African Caribbean or Middle Eastern background
 - Increasing age (NHS recommends screening if pregnant and over 40yrs or older)
- **Prevention:**
 - Some people can't prevent it{{nl}}- Get support to manage weight, healthy diet and keeping active before and during pregnancy
- **What after diagnosis?**
 - Care team informs GP
 - Within **1 week** you should be referred to a joint diabetes and antenatal clinic
 - Team will work on targeting blood sugar levels with you (will reduce risks of complications)
- **What happens if mom has GD?**
 - Can affect how well the placenta works
 - Can make baby unwell and affect their movements
 - If baby movements have slowed, stopped or are different to normal, **contact midwife or maternity unit immediately**



Gestational diabetes (cont)

- **Complications:**
 - Baby growing larger than normal (more painful or difficult birth & possible distress)
 - Neonatal hypoglycaemia (baby has low blood sugar after birth)As well as the above, continuous high blood sugar levels can also lead to:
 - Induced labour
 - Caesarean section
 - Baby having higher risk of being overweight or obesity & developing Type 2 diabetes
 - Baby having yellow skin & eyes (jaundice) after birth

- **Symptoms:**
 - Going for a wee a lot, especially at night
 - Being really thirsty
 - Feeling more tired than usual
 - Genital itching or thrush
 - Blurred eyesight

Many women have no noticeable symptoms

- **Tests:**
 - Oral glucose tolerance test (OGTT)**

Doesn't harm mom or baby

 1. You'll need to fast (no food or drinks) for 8-10 hours the night before & the morning of the test
 2. Blood test to measure blood glucose level
 3. Will be given a glucose drink
 4. Rest for 2 hours, another blood test to see how the body is dealing with the glucose

Results: Diagnosed with GD if fasting blood sugar level is **5.6mmol/l or above**, or if your 2hr post glucose blood sugar level is **7.8mmol/l or above**

 - GD can develop at any time during pregnancy, if you develop any symptoms (despite -ve OGTT), talk to midwife

- **Treatments:**
 - Checking blood sugar levels regularly (pricking w/ lancet)
 - Levels outside targets discuss with healthcare team, can cause problems for mom and baby
 - Very common to need **glucose lowering medication**, including **insulin**
 - Regular physical activity
 - Healthy diet



Gestational diabetes (cont)

- **Medications:**
 - **Metformin:** tablet that helps to reduce the amount of glucose produced by the liver, & to make insulin work more effectively; taken with, or after, a meal
 - **Insulin:** Allows glucose to enter the cells and to be used for energy; injection that goes in just underneath skin (can't be taken orally because the stomach will digest it)
- **What should I aim for?**
 - Going for regular walks after lunch or dinner
 - Pregnancy yoga
 - Swimming or water aerobics
 - Dancing in the kitchen
 - Try not to sit after a meal (being active for 15-20min within 30 min of a meal)
- **Blood sugar level aims:**
 - Fasting: below 5.3mmol/l
 - 1hr after meals: below 7.8mmol/l
 - If not able to check until 2hr after a meal: below 6.4mmol/l

<https://www.diabetes.org.uk/diabetes-the-basics/gestational-diabetes>

Gestational hypertension

- **Intro:**
 - BP readings of **≥140/90 mmHg on 2 occasions at least 4hr apart after 20 weeks' gestation** in a previously normotensive woman
 - Must be **w/o** the presence of **proteinuria** (<300mg in 24hr) or **other clinical features** (thrombocytopenia, impaired renal or kidney function, pulmonary oedema, or new-onset headache) **suggestive of pre-eclampsia**
- **Key diagnostic factors:**
 - Presence of risk factors
 - Previously normotensive
 - BP **≥140/90 mmHg**
 - **<20 weeks' gestation**
 - Absence of Ssx that suggest pre-eclampsia
- **Risk factors:**
 - Nulliparous (hasn't given birth before)
 - Black or Hispanic ethnicity
 - Obesity



Gestational hypertension (cont)

• 1.3 Management of chronic hypertension in pregnancy:

Referral & discussion:

- Offer referral to a specialist in hypertensive disorders for women with chronic hypertension to **discuss treatment risks & benefits**
- For those taking **ACE inhibitors or ARBs**, highlight the increased risk of congenital abnormalities during pregnancy
- Emphasise discussing **alternative antihypertensive treatment** with healthcare professionals if planning pregnancy or taking these medications for other conditions

Medication safety update:

- Note the MHRA's drug safety update on ACE inhibitors and angiotensin II receptor antagonists, advising against use in pregnancy **unless absolutely necessary**

Antihypertensive treatment adjustment:

- Promptly discontinue ACE inhibitors or ARBs if pregnancy is confirmed, preferably **within 2 working days**, & provide alternative options
- For thiazide or thiazide-like diuretics, **inform about potential risks of congenital abnormalities & neonatal complications** during pregnancy
- **Encourage discussion of alternative antihypertensive treatment** with healthcare professionals for those planning pregnancy

Limited risk with other antihypertensive treatments:

- **Assure** women taking antihypertensive treatments other than ACE inhibitors, ARBs, thiazide, or thiazide-like diuretics that limited evidence **suggests not increased risk of congenital malformation**



Gestational hypertension (cont)

- 1.4
- Management of gestational hypertension:**
- Assessment & risk factors:**
- Full assessment in 2° care by a trained healthcare professional
 - Consider additional risk factors: nulliparity, age >40 or older, pregnancy interval >10 yrs, fHx of pre-eclampsia, multi-feral pregnancy, BMI 35kg/m² or more, gestational age at presentation, previous Hx of pre-eclampsia or gestational hypertension, pre-existing vascular disease, pre-existing kidney disease
- Tests & treatment:**
- Hypertension (BP 140/90 - 159/109 mmHg): offer pharmacological treatment if BP remains above 140/90 mmHg
 - Severe hypertension (BP 160/110 mmHg or more): admit to hospital; if BP falls below 160/110 mmHg, manage as for hypertension
 - Antihypertensive treatment: offer to all women; target BP of 135/85 mmHg or less
 - BP measurement: 1 or 2x / week until BP is 135/85 mmHg or less
 - Dipstick proteinuria testing: 1 or 2x /week (w/ BP measurements)
 - Blood tests: measure full blood count, liver function, & renal function at presentation & then weekly
 - Placental growth factor (PLGF)-based testing: if suspicion of pre-eclampsia
 - Fetal assessment: offer fetal heart auscultation at every antenatal appointment; ultrasound assessment at diagnosis & repeat every 2-4 weeks if normal; cardiotocography (CTG) if clinically indicated
- Additional fetal monitoring (severe hypertension):**
- Ultrasound assessment every 2 weeks if severe hypertension persists
 - CTG at diagnosis & then only if clinically indicated

<https://www.nice.org.uk/guidance/ng133/chapter/Recommendations#management-of-gestational-hypertension>



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Pelvic girdle pain (PGP) in pregnancy

- **Intro:**
 - Pelvis has 3 joints that normally move slightly & work together
 - PGP is caused by **uneven movement** of these joints, resulting in **less stability & pain**
 - Factors contributing to PGP include **changes in weight & posture** during pregnancy
- **Signs & symptoms:**
 - Px in pubic region, lower back, hips groin, thighs or kness
 - Clicking or grinding in the pelvic area
 - Pain made worse by movement: walking on uneven surfaces / rough ground or for long distances; moving your knees apart (getting in/out of the car); standing on one leg (climbing the stairs, dressing, getting in/out of bath); rolling over in bed; during sexual intercourse
- **Risk factors:**
 - Hx of back problems
 - Hx of pelvic injuries
 - Hypermobility syndrome
- **Management options:**
 - Avoiding aggravating movements / changing positions
 - Exercises for pain relief & mobility: focus on strengthening abdominal & pelvic floor muscles for improved balance, posture, & spine stability; incorporate routines that facilitate easier movement while minimising strain
 - Mobs, drops, SMT
 - Warm baths, or heat, or ice packs
 - Hydrotherapy
 - Acupuncture / dry needling
 - Support belt or crutches

<https://www.rcog.org.uk/for-the-public/browse-our-patient-information/pelvic-girdle-pain-and-pregnancy/#::text=PGP%20is%20common%2C%20affecting%201,stage%20during%20or%20after%20pregnancy.>



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