The East Anglia Centre for Fetal and Maternal Medicine

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Introduction to Gestational Diabetes

This booklet aims to explain what gestational diabetes is, what this means for you and your pregnancy, how you can manage it and outline the care you will receive until your baby is born. Feel free to discuss any aspect of your care with us at your clinic appointments.

The team that will look after you is made up of the Obstetrician, Physician (diabetes), Diabetes Specialist Midwife (DSM), Diabetes Specialist Nurse (DSN) and Diabetes Specialist Dietitian (DSD).

What is Gestational Diabetes?

Gestational Diabetes (GDM) is a condition that occurs in pregnancy when the body becomes less able to regulate the levels of sugar, called glucose, and levels can rise above normal.

It typically occurs during the second half of pregnancy although it can occur earlier and usually goes away once your baby is born (this will be confirmed with a test – see **page 3**).

Normally, the hormone insulin regulates blood glucose, within the normal range 3.5 – 6.0 mmol/L. During pregnancy the body becomes resistant to the action of insulin, so the body needs to produce more insulin to maintain blood glucose levels within the normal range.

Gestational Diabetes occurs when the body is unable to produce enough insulin to meet the extra needs of the pregnancy.

If they are deemed high risk, pregnant women are screened for Gestational Diabetes at around 28 weeks (or earlier in some cases, for example if you have had a previous pregnancy with GDM).

Gestational Diabetes more commonly occurs in women who are overweight, have a family history of diabetes and/or have had a large baby in a previous pregnancy. It is also more common in some ethnic groups such as Asian, Middle Eastern and Afro-Caribbean populations.

This leaflet will give you the information you need to manage your GDM through diet and exercise or with additional medication or insulin treatment. You will learn how to measure your blood glucose levels so that you can aim to keep your glucose levels in a healthy range.

The Antenatal/Diabetes care team will then see you every one to four weeks to give help and support. This clinic is held in the Ante Natal Clinic of the Norfolk and Norwich Hospital on a Wednesday (and sometimes Thursday) afternoon. You may also have a growth scan at some appointments, typically around 28, 32 and 36 weeks.

How will GDM affect my pregnancy?

Most women do not feel any different or unwell with gestational diabetes, however some things will happen differently as a result of having gestational diabetes:

- You need to be very careful with your diet throughout the rest of your pregnancy right up to and during delivery (see page 5)
- We encourage you to keep active, aiming for 30 minutes every day (see page 5)
- You need to monitor your blood sugar levels four times every day (see page 5)
- We will offer you extra scans to monitor the growth of your baby (as above)
- You will be seen more frequently in the ante natal clinic. The antenatal/diabetes team usually see you every 2-4 weeks to review your glucose levels and your scans.

- Having GDM means you will have your baby on the delivery floor where there are trained staff to meet any additional needs during delivery (see page 9)
- You may need to be induced before your due date. This depends on your glucose control and you will be able to discuss this with the diabetes and obstetric teams during your clinic appointments.

What does Having Gestational Diabetes Mean for my Baby?

By managing your GDM you can work toward having a healthy baby born close to term. However, having GDM increases the risk of some complications; the two main complications are explained below and we will happily discuss these with you at your clinic appointments.

Macrosomia – When the baby is born larger than expected
One of the major sources of food for your baby is the glucose in your blood. If your glucose levels run high these pass directly to your baby. This causes your baby to produce more insulin, lay down excess fat stores and grow bigger than it would otherwise do.

Having a big baby increases the risk of complications during labour and can influence when and how your baby is delivered. The growth of your baby will be monitored closely by extra scans, and we will discuss delivery choices with you towards the end of your pregnancy.

Increased insulin production and fat stores in the growing baby means that your baby will have an increased risk of obesity and Type 2 Diabetes as a child and adult. Keeping your blood sugar levels in the healthy range reduces these risks.

Neonatal Hypoglycaemia – when the baby's blood glucose levels fall too low after birth
If your glucose levels are too high this passes to the baby causing their pancreas to produce more insulin than normal. When this happens towards the end of pregnancy the baby's glucose levels can then fall too low after delivery – called neonatal hypoglycaemia.

This risk can also be reduced by keeping your blood sugar levels well controlled right up to and during delivery. If you wish to try to express some colostrum (the first milk) from 37 weeks to use for your baby, the Diabetes Specialist Midwife will show you how to do this and give you some syringes to store it.

It is also important for you to feed your baby within the first 1 hour of delivery, and to feed your baby every 2 – 3 hours for the next couple of days. (A normal feeding pattern for a baby is 8-12 times in 24 hours) Staff will be able to help you do this.

Your baby's blood glucose levels will be checked at around three to four hours after birth and then before the next few feeds to make sure they stay in the normal range.

Keeping your blood glucose levels in the normal range is important to allow your baby to grow at the correct rate and keep your baby's sugar levels stable after delivery.

What Does Having Gestational Diabetes Mean for Me?

Once your baby is born the GDM should go away. This will usually be checked with a fasting glucose test 6-8 weeks after delivery and we will write to you with the result. Most women can stop blood glucose monitoring (though some mother's are asked to continue) and return to a normal healthy diet.

Having had GDM means you are likely to develop GDM in any future pregnancy and more likely to develop Type 2 Diabetes.

Future Pregnancies: because you have had GDM in this pregnancy you should be screened for type 2 diabetes before you become pregnant again and be screened for GDM earlier in your next pregnancy. If you are overweight during this pregnancy, losing weight for your next pregnancy will reduce your risk for developing GDM.

Developing Type 2 Diabetes: Research studies show that women with GDM have a 50-70% increased chance of developing Type 2 Diabetes over the next 5-10 years.

How can I reduce my risk of developing Type 2 Diabetes

- **Healthy weight:** If you are overweight you should reduce your weight to a healthy range after your baby has been born. You can ask your GP to refer you to a dietitian or weight reducing program if you would find this helpful.
- **Physical activity** makes insulin work more effectively. Including some physical activity into your **daily** routine for 30 minutes will reduce the risk of developing diabetes. This needs to be additional to your normal daily activity and at a level that makes you breathe harder than normal; for example 30 minute brisk walk. This can be divided into smaller time slots if that fits into your routine better. Please ask a Physio or Nurse on the Ward for advice.
- **Eating a healthy diet** that is high in fibre, low in refined carbohydrate and fat will help keep your weight in a healthy range. It also reduces the risk of developing Type 2 diabetes.
- **Breast feeding:** Research shows that women with GDM who breast feed their babies delay the risk of developing Type 2 Diabetes by 10 years. Women who don't breast feed may develop diabetes as early as 2 years after delivery compared with 12 years later in women who do breast feed.

How can I manage gestational diabetes?

It is possible to manage your diabetes by doing the following:

- Regular blood glucose monitoring
- Making dietary changes
- Being physically active
- Avoid gaining excess weight
- Medication when necessary

1. Regular Blood glucose monitoring

You will be asked to monitor your blood glucose levels **four times every day**:

- ✓ Before breakfast
- ✓ One hour after breakfast, lunch and dinner (timed from start of meal)

It is important you always wash your hands before testing to avoid getting false high results. The blood glucose levels you are aiming for are listed below:

Time	Blood glucose level mmol/L
Fasting	less than **5.3**
One hour after meals (timed from start of meal)	less than **7.8**

If you get a reading above target range write down what and how much you ate at the meal before or if you were inactive or feeling unwell.

If you get three readings above these targets contact us on the numbers at the front of your diary.

2. Making dietary changes

Your blood sugar levels will be regulated by eating well and being physically active. Diet and activity are the first and often the only form of treatment required. Please see **page 11** for more dietary information. You will also be referred to a dietitian during your ante-natal appointment for individualised dietary advice.

3. Being Physically Active

Regular physical activity will improve your body's sensitivity to insulin and make it more effective; especially if this is done after meals.

You are recommended to walk or be active (see below) for at least 30 minutes daily – which can be done in two or three 10-15 minute bursts.

Types of activity can be - walking, swimming or cycling, being active around the house, moving the legs whilst sitting on a chair. If you are struggling with increasing activity discuss this with us in clinic.

4. Avoid gaining excess weight

If you were overweight prior to the pregnancy or have gained more than the recommended amounts of weight during your pregnancy, this can increase insulin resistance and make the blood glucose levels more difficult to control by diet alone.

If your Body Mass Index was greater than 30 at booking (this is recorded with your height and weight in your hand held notes) or you have gained more weight than recommended, see below, you should aim to keep your weight stable for the rest of your pregnancy.

BMI pre-pregnancy	Total weight gain recommended by Institute Of Medicine
Less than 20	12.7 -18 kg
20 -25	11.4 -15.9kg
26 – 30	7.0 -11.4kg
More than 30	Max 7 kg

If you are concerned that you are gaining too much weight during your pregnancy discuss this with us in clinic and keep to the following guidelines.

- Grill, bake, boil, braise, microwave or steam food instead of frying or roasting in fat or oil
- Trim the visible fat from meat and remove skin from chicken before cooking.
- Use low fat products such as semi-skimmed milk, low fat spreads, lower fat cheeses, low fat or diet yoghurt, low fat or fat free salad dressings.
- Avoid fatty foods such as crisps, nuts, pastry, chips, roast potatoes, cake, biscuits, cream, tinned meats, etc.

5. Medication

Not all women with gestational diabetes will need to take medication. Many women are able to regulate their blood glucose levels by being careful with their diet and being physically active.

However, some women do not produce enough insulin to manage what they need to eat to support a healthy pregnancy and in spite of their best efforts need to start some medication to keep blood glucose levels in the normal range.

There are two treatment options:

Insulin injections to “top up” the limited amount of insulin you are able to produce. This may be before bed and / or before meals.
Or
Metformin is a tablet that enables the insulin you produce to work more effectively.

Which is the best choice for you will be discussed with you in clinic.

Gestational Diabetes - Treatment options

For many women careful attention to diet and increased physical activity are enough to keep glucose levels in the target range, however for about one in three women, additional treatment options need to be considered.

Sometimes glucose levels remain above target even if you are very carefully following the recommended diet and being more physically active. This means your body is not able to produce enough insulin to cope with the extra demands of the pregnancy.

It is important that you do not over-restrict carbohydrates to keep your blood glucose levels down. Restricting the diet too much can lead to excessive weight loss, which is not recommended in pregnancy.

Moderate weight loss (up to 5kg or 11-12 pounds) is not harmful as long as you are eating a healthy balanced diet. Indeed most women, especially if they are overweight, can expect to lose weight after cutting out refined carbohydrates. However sometimes as well as a healthy diet and regular physical activity, medication is still needed.

Insulin Option
When the glucose levels are rising above target your own insulin production can be 'topped up' with an injection of insulin to keep your glucose levels within the target range. Needing to do an injection may sound a bit daunting but the injection itself is simple. It is given with a short needle into the fatty tissue just under the skin and is much less painful than the finger pricks you are already doing. This will be explained to you by a diabetes nurse or diabetes midwife.

The insulin you inject does not pass across the placenta to your baby.

There are two times for giving insulin:
1. If your glucose levels are too high first thing in the morning you may be advised to give an injection of slow release also known as background insulin before bed (e.g. Insulatard, Humulin I, Levemir)

2. If your glucose levels are above target after meals you may be advised to give an injection of quick acting insulin 10-15 minutes before eating. This may be at one, two or all of your breakfast, lunch and evening meals (e.g. Novorapid, Humalog)

Balancing the insulin dose with the food you eat and your activity levels will help to keep your glucose levels in the normal range.

The dose of insulin will go up as your pregnancy progresses. Daily glucose monitoring is very important as it shows when a change is needed to keep you and your babies glucose levels in the target range.

During labour, you will continue giving your usual doses of insulin whilst you are eating normally. If glucose levels rise above 7mmol/L you may be changed to a constant infusion of insulin through a drip.

Once your baby is born you will stop taking the insulin but continue to check blood glucose levels for 24 hours.

Metformin Option
Metformin is a tablet that has been used successfully for almost 40 years to treat diabetes outside of pregnancy. It is increasingly being used during pregnancy as an alternative to or in addition to insulin. It is most commonly used for women with higher body mass index (BMI>30kg/m^2) in early pregnancy.

Metformin works by allowing insulin to work more effectively, so that a smaller amount of insulin will work better. This can mean that your own limited insulin production may be enough to regulate your glucose levels with metformin to boost its action.

Metformin can also be useful as an addition to insulin injections. Using them together can keep insulin doses lower. This can help prevent excessive pregnancy weight gain.

Unlike insulin, **Metformin does pass across the placenta to your baby**. There have been a number of studies to look at the safety of Metformin in late pregnancy and your diabetes team will be happy to discuss this with you.

Metformin is not a good choice for everyone. There are medical conditions or pregnancy complications that may mean insulin would be a better choice.

Some people (2 out of every 10) experience side effects from taking Metformin, such as stomach upsets. These can be minimised by starting on a low dose, and by building the dose up slowly every 3-4 days and by taking the tablet with or immediately after food.

Typical starter regime for Metformin: follow the steps indicated by a ticked box

Days 1, 2 & 3- Take one tablet with breakfast **or** evening meal o

Days 4, 5 & 6 - If this is tolerated take one tablet with breakfast **and** evening meal o

Days 7, 8 & 9 - If this is tolerated take two tablets with breakfast **or** evening meal and continue with one tablet at the other meal o

Day 10 - Take two tablets with breakfast **and** evening meal o

If you develop side effects after a dose increase – go back to the previous dose
It is very important to maintain blood glucose levels in the normal range for pregnancy. If you are unable to do this by following a healthy diet and staying active, insulin and/or metformin can help you reach your target blood glucose level. Your diabetes team will advise you on the best treatment for you and your baby.

Obstetric/Maternity Care

The first appointment after you have been diagnosed with GDM will be with the Diabetes Specialist Midwife and the Diabetes Specialist Dietitian. At this visit you will be able to discuss the results and ask any questions you may have.

During this visit, you will be able to talk to the Specialist Dietitian about your diet, and there will be an opportunity to discuss any changes to this. The Specialist Midwife will also show you how to use a home use blood sugar meter and tell you the ranges to aim for.

Once you are confident with this information, and what to do, you will be able to go home, with contact numbers for the Specialist Midwives and Nurses.

If your care was previously community-based you will now be allocated a consultant obstetrician lead to help plan your care for the remainder of your pregnancy.

1 week after seeing the Specialist Midwife/Dietician

If you are over 26 weeks pregnant, and there has been 4 weeks or more since you last had a scan, you can expect to have a scan of your baby.

You will then see the doctors to discuss the results of your blood sugars and possibly start treatment if the results are over the target ranges you have been given.

Subsequent visits
You will be offered diabetes appointments every 2-4 weeks, and obstetric appointments every 4 weeks (usually at 28, 32 and 36 weeks gestation) when you can expect to have a scan to monitor the growth of your baby and a check to make sure your blood sugars are in target range.

Birth

Most women will have had their baby by 40 weeks and if this has not happened naturally you may need to be induced as the delivery date and plan are likely to be affected by having Gestational Diabetes. You will have the opportunity to discuss this with the Obstetric Team and the specialist midwife between 32 and 36 weeks. If you were on insulin or metformin treatment or your glucose control was above the recommended targets the birth of your baby may be around 38 or 39 weeks.

You may have already written a birth plan, so you will be able to discuss this, along with any questions you may have about induction of labour. As mentioned above (page 2/3) you will be able to talk about expressing some antenatal colostrum for your baby. This is recommended for all pregnant women from 37 weeks onwards. You can also discuss the benefits of perineal massage in the few weeks prior to birth, to try to help reduce the chance of a tear.

Your baby will be born in the Labour Ward of the Norfolk and Norwich Hospital where they have the staff and resources to give you the care you and your baby need during labour, although you may find that the induction (if needed) will start on the antenatal ward.

The care during established labour includes continuous monitoring of your baby's heart beat and hourly blood sugar tests. If your blood sugar level rises during labour, you may need an infusion to keep the levels normal for your baby.

Diet during birth – you will be able to eat and drink normally (and continue to take any medications you have been given for your blood sugars) in the early stages of induction (or if you go into labour yourself).

Once you are in active labour, or if you need an intravenous infusion (drip) with a hormone to help contractions, you will be advised to have only clear fluids (water, sugar free squash, tea or coffee without milk) until after the birth of your baby.

Infant feeding and skin to skin contact
No matter how you choose to feed your baby, having your baby skin to skin is beneficial for you both. After the experience of birth for the baby, there is evidence to suggest that this unrushed time of skin to skin may help to calm the baby and stabilize their breathing and heart rate. Being close to you will also help the baby pick up friendly bacteria from your skin, which can help with fighting infections.

Skin to skin contact is not just for the first hour after birth, you will find it helps in any situation when you or your baby need help in calming down, such as when the baby is hungry and you may not have been able to see the early cues for feeding.

It may also help with the initiation of feeding your baby.

Breast feeding is best for you and your baby and is recommended to stabilise sugar levels in both mother and baby after birth, although you will be supported with whichever way you choose to feed.

You will need to feed your baby ideally within the first half hour but certainly within the first hour. If you have decided to breastfeed and have been able to express some antenatal colostrum, you can use this as well. You will also need to feed your baby every 2-3 hours for the first day, and can expect the midwives to check that the baby is maintaining normal blood sugar levels just before these feeds. (see above)

After a day or so, you will find that the baby will lead the frequency of feeding (or also called baby led feeding), and a usual pattern is 8-12 times in a 24 hour period. If your baby feeds more or less than this, then you will need a midwife to check that you have an effective milk transfer.

Your midwife will be happy to discuss all of this with you.

DIET INFORMATION

What and how much you eat have a direct effect on your blood glucose. For many women with gestational diabetes, diet and exercise are the only treatment for managing blood glucose.

All food will directly or indirectly affect your blood glucose but carbohydrate foods affect your blood glucose most and are the main focus of the dietary treatment.

Ordinarily when carbohydrates are eaten blood sugar levels rise and the body produces just the right amount of insulin to cover it, bringing the glucose levels back into the healthy normal range.

However in gestational diabetes your body is not able to produce enough insulin and the insulin that your body does produce may not work as effectively. Therefore being aware of your portions of carbohydrate is very important to keep your blood glucose levels within the normal range.

Carbohydrate foods can be divided into two main categories:

- **Starchy foods** include potato, bread, rice, pasta, plain breakfast cereals, crisp-bread and foods containing flour such as pastries or battered products
- **Sugary foods (naturally occurring and added sugars)** include fruit, milk, yoghurt, cakes, biscuits, sweets, chocolate, sugary breakfast cereals and table sugar.

You still need to eat good quality carbohydrates to provide you with energy, fibre, vitamins and minerals but you need to be aware of the **type of carbohydrates** you consume and your **portion** size. Some carbohydrate food are best avoided.

Carbohydrate Type
The more processed the carbohydrate is the faster the rise in blood sugars.

Avoid all refined forms of carbohydrate and choose high fibre, unrefined forms instead, as shown in the table on the next page.

Refined carbohydrates to avoid	Try instead
White breads: Sliced, rolls, pitta, naan, baguette, croissant, chapattis, paninis	**High fiber slow release breads:** Whole-wheat, granary and multi-grain varieties of breads, Oat bread
Rice and pasta: No types need to be avoided but be aware of portion size	Some people find their blood glucose is better when they use basmati or brown rice and whole wheat pasta instead of white
Breakfast cereals Best to avoid all types	Alternative to cereal such as plain yoghurt, wholegrain bread, oatcakes.
Potato: Mash, instant or jacket potato, oven chips, French Fries, Smiley faces, waffles, Croquettes, frozen roast potatoes, ready meals with instant potato e.g. Shepherd's Pie	Boiled new potatoes
Processed/white flour based foods: Cakes, biscuits, Cream crackers, water biscuits, Ritz, Tuc, Digestives, Hobnobs Yorkshire pudding, dumplings, pizza, pastry e.g. pies, pasties, quiche, sausage rolls, spring rolls. Breaded and battered foods e.g. fish fingers, battered fish	Oatcakes
Processed savoury snacks: Hula Hoops, Quavers, Pringles, Monster Munch, French Fries, Skips, baked crisps, potato crisps	One or two oat oatcakes or unsweetened, unsalted nuts and seeds
Cold drinks: Fruit juices and smoothies Full sugar squash and fizzy drinks Lucozade	Water, sugar free squash, sugar free carbonated drinks
Sugar: Sugar, glucose, maltose, dextrose	Splenda, Sweetex, Hermesetas, Nutrasweet, Candarel, Stevia
Preserves: Jam, marmalade, honey, lemon curd, maple syrup, chocolate spread, treacle and syrup	Marmite, no added sugar peanut butter
Sweets / Desserts: Dried fruit Sweets, chocolates, mints Sweet puddings and ice cream, Sweetened yoghurt / "fromage frais", tinned fruit in syrup Condensed, evaporated milk	Fresh fruit, tinned fruit in natural juice (juice drained off), sugar free jelly, small portion of sugar free Angel Delight Low fat Greek or natural yoghurt/diet fruit yoghurts / "fromage frais" (no more than 10-15g total carbohydrate / pot) Low fat Crème Fraiche
Refined carbohydrates to avoid	**Try instead**

Ready meals/stir in sauces/take away: Some ready meals and sauces contain significant amounts of sugar, for example sweet and sour sauces, jar or packet Chinese sauces. Chinese takeaway. Tomato soup, Baked Beans, tinned spaghetti	Tomato-based pasta sauces Tomato-based/dry curries Reduced sugar baked beans
Bed-time and malted drinks such as Ovaltine, Horlicks, drinking chocolate	Cadbury's Highlight, Ovaltine Options, cocoa powder

Carbohydrate Portion

The larger the portion of carbohydrate food eaten, the higher the blood sugar levels rise and the more insulin the body needs to cover it. When you have GDM the body is not able to produce large amounts of insulin at any one time and so may not be able to cover your usual portions of carbohydrate foods.

An important part of the dietary management is to eat small amounts of slow acting (low Glycaemic Index) carbohydrate and spread it out over the day.

Your dietitian will review your carbohydrate intake and suggest portion sizes for carbohydrate foods.

- You may be asked to eat smaller meals and have additional snacks in between meals.
- Avoid doubling up on carbohydrate foods in one meal, for example don't have bread **and** potatoes or bread **and** pasta together.
- It is important that some carbohydrates are included in each meal. They should not be avoided completely or overly limited.

Snacks

If you are advised to have carbohydrate snacks between meals the following is a list of suitable snacks:

- 1-2 pieces fruit
- 2 oatcakes with low fat cream cheese
- Small pot of yoghurt
- 1 slice of wholemeal bread sandwich or toast
- Vegetable sticks with hummus/cream cheese/cottage cheese/salsa dips/pesto
- Glass of milk
- Pickles such as gherkins

The following foods have little impact on blood glucose levels and some could be used to bulk out meals or eaten as a snack. Filling up on more vegetables / salad and protein foods may help with hunger:

- Pulses and beans
- Meat, fish, chicken, eggs, cheese, tofu, Quorn®
- Plain nuts and seeds
- Peanut/Cashew/Almond butter if no added sugar
- Olives
- Avocado
- Sun blushed or sun dried tomatoes
- All vegetables (except for potatoes and sweet potatoes)
- Salad leaves such as lettuce, spinach and watercress
- Marmite, Vegemite, Bovril, Oxo
- Salt, pepper, herbs, spices, vinegar and mustard
- 1 cup cherries or berry fruits
- Sugar free jelly
- 2 squares 70% coco solids chocolate

Breakfast
Carbohydrate is often not well tolerated at breakfast and many women need to split what they would normally eat over breakfast and a mid-morning snack e.g. 2 slices toast would become 1 slice toast at breakfast with some added protein or healthy fats such as egg, avocado, no-added sugar peanut butter.
All types of breakfast cereals tend to cause too much of a blood glucose rise and best avoided all together.

Suggested breakfasts:

- 1 slice granary bread toasted with poached or scrambled eggs / mushrooms / tomato / cheese/avocado/no-added sugar peanut butter or
- 1 small pot of natural / full fat or diet / Greek yoghurt with a chopped fruit (small banana, apple) or cup of berries

You do not need to eat any special "Diabetic Foods" as part of your diet.

Keeping your blood glucose levels in the normal range is important to allow your baby to grow at the correct rate and keep your baby's sugar levels stable after delivery.

Suggested actions:

1.

2.

3.

4.