

# Gestational Diabetes

## Discussion Group

### Topic: *Glucose Testing*

*May I suggest you read Anne Frye's book about lab work in the childbearing years.*

*The American Diabetes Association DOES NOT recommend, support or endorse routine glucose testing for pregnant women.*

*The 3-hour test is often administered incorrectly and sometimes the second reading (usually a very high reading) is 'taken' as the result-, instead of the third reading and without taking all results into account. The goal here is less about rooting out a potential/future diabetic, than getting the ever-popular 'high-risk' label attached to the women.*

*I have had many a pediatrician admit that with all the 'monitoring' done by the medical model for GD (absurd right there--how can being pregnant make you diabetic--it's a nutrition issue, AND I can tell you that when the protein is increased, walking everyday and finger-poking goes on many times a day, the woman NEVER has an out-of-range blood sugar reading again. Is she taken off the GD list? Is she now proclaimed un-high-risk?)*

*"The first intervention a woman does to herself in labor is leave her house." Marsden Wagner*

## Website reference:

<http://www2.cochrane.org/reviews/en/ab007222.html>

<http://www2.cochrane.org/reviews/en/ab003395.html>

## Treatments for Gestational Diabetes:

Treatments for gestational diabetes and impaired glucose tolerance in pregnancy  
The best way of identifying and treating women with abnormal blood glucose tests in pregnancy is not known.

Glucose in urine is abnormal outside pregnancy but is common in pregnancy. Blood glucose levels are needed to check glucose control in pregnancy. Elevations in pregnancy may return to normal afterwards. This is known as gestational diabetes or impaired glucose tolerance depending on the degree of abnormality. Diabetes has higher levels than impaired glucose tolerance. These abnormalities may be associated with bigger babies and more difficult birth. There are no good tests to identify these babies. The review has not found enough evidence on how to treat these women and their babies, even if identified correctly. More research is needed.

## Excerpt from Henci Goer...

Several organizational bodies that have looked critically at the GD research have come out against GD testing. A Guide to Effective Care in Pregnancy and Childbirth, the bible of evidence-based care, relegates screening for gestational diabetes to "Forms of Care Unlikely to be Beneficial (12)." The American College of Obstetricians and Gynecologists says no data support the benefits of screening

(1). The U.S. Preventative Services Task Force and the Canadian Task Force on the Periodic Health Examination both conclude that there is insufficient evidence to justify universal GD screening (4,11). <http://www.ivillage.com/gestational-diabetes-3/6-a-129187>

## **Gestational Diabetes: The Emperor Has No Clothes**

<http://gentlebirth.org/archives/gdhgoer.html>

by Henci Goer

Good medicine demands that diagnosis and treatment of any disease fulfill four criteria:

1. The condition has to pose a health risk;
2. Diagnosis must accurately distinguish between those who have the disease and those who don't;
3. Treatment should be effective; and
4. The benefits of diagnosis and treatment should outweigh the risks.

An entire medical industry has grown up around diagnosing and treating gestational diabetes (GD) in the belief that doing so prevents perinatal deaths, congenital anomalies, neonatal complications, macrosomic babies, and because of fetal macrosomia, birth injuries and excessive cesarean rates. However, diagnosis and treatment of gestational diabetes don't fulfill any of the above criteria.

## **New York Times Examines Increasing Prevalence of Gestational Diabetes Among Pregnant Women in the U.S. (Kaiser)**

[http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?DR\\_ID=35517](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=35517)

The New York Times on Saturday examined the increasing prevalence of gestational diabetes among pregnant women in the U.S. and the condition's impact on infants and women. Gestational diabetes -- which is similar to chronic forms of diabetes and is characterized by extremely high levels of sugar in the blood -- normally appears at 24 to 28 weeks' gestation, occurs in about 4% to 8% of pregnancies and usually disappears after the woman gives birth.

## **Diabetes Is Seen as a Rising Risk in Mothers-to-Be**

Click here to read the article:

<http://www.nytimes.com/2006/02/18/nyregion/nyregionspecial5/18diabetes.html? r=1&oref=slogin>.

### **Discussion Group**

**Question - Mom's situation:** *I just heard back the results of my glucose test -- I was 132 and the cutoff at my midwife/dr office is 130 -- even though from what I can find out online at PubMed and other places the cutoff for the WHO is 140 and even 150! They want me to do the 3 hour test and I feel frustrated by this -- especially since I wanted a low-intervention approach to this pregnancy. Anyhow, the response to gestational diabetes is to alter your diet and exercise daily -- no medical intervention. So, I'd rather just exercise more, make some diet changes, and skip the 3 hour test. I'm not sure if they'll let me go to the birth center without the test. I'm kind of upset about it -- I haven't gained more weight than I'm supposed to and my midwife always says the baby is measuring perfectly for the time. I am waiting to speak with my midwife -- but I was wondering about my options...*

- *Can she get around this test in any way by waiting and having her numbers checked after making some changes in her lifestyle?*
- *Is there something additional she can do to lower her glucose numbers (aside from diet & exercise)?*
- *Is this just a matter of needing to look into another midwife facility or is this a standard at all offices?*

**Responses:**

*What about her just refusing to take the test?! I am "high risk" for gestational diabetes (all my babies have weighed over 4.5kg), I know I just grow big babies (after taking the stupid test 3 times and having normal results - they \*still\* want me to take it this time), I'm not a diabetic - therefore I just refuse the GTT now. Her numbers are clearly fine according to WHO (and I would trust those over individual hospital numbers) - it's her body - just refuse it!*

*Incidentally Michel Odent is vehemently anti- testing for gestational diabetes - for just the very reasons you have described. What's the point in making somebody high risk, worrying them and testing them when it will be controlled by a healthy diet (which ALL pregnant women should follow) anyway?!*

[www.birthfriendly.co.uk](http://www.birthfriendly.co.uk)

*How about taking the WHO recommendations, along with the standard of care from other local medical professionals, and discussing it with the midwife? I'd look also for a "rate of false positive" list, and all the research I could find. And make sure she didn't eat prior to the test.*

*I also have a client who was diagnosed with GD; no-one told her not to eat before the test, so she had lunch before she went (raising her blood sugar) and then tested positive (154). She refused the 3 hour test, pending another trial without lunch first, a week later. She modified her diet, drank gallons of water, and meditated. Passed the test 2nd time with 132, and no need to take the 3 hour test.*

*So, it could just be a 'one-off'...if she has no other signs of GD.*

*The thing that I'd keep in mind here (and especially since she was so close to the "cutoff") is that one in three women "fails" their one hour glucose tolerance test. Expectant moms are shocked when I tell them that but it's the truth. So there is no reason to panic or assume that she has gestational diabetes - chances are 2 to 1 that she does not.*

*I had a mum recently who had the same thing: tested 9.2 when the cut-off was 9. She got herself a blood glucose test and tested herself daily - all her tests after that 1st one were normal. She kept the levels stable with diet and exercise. She researched GD and persuaded her midwives and consultants to 'allow' her to continue with her home birth when they realized she had done her research and was making an 'informed' choice. Had a great home birth, no problems with GD for her or baby.*

*Incidentally, she went into hospital immediately to test the baby as her midwives had been 'so great' - missed the bonding with baby, baby got cold, ended up taken away to be warmed, then wouldn't feed properly, breast feeding went wrong, now on bottle and a bit fussy: Great birth, messed up by agreeing to the hospital protocol.*

*Moms should stick to their guns regarding birth preferences. Recently, a mom caved in to pressure - ended up with a hospital birth - now suffering post-traumatic stress from a traumatic birth.*

*This is conservative, 130 when the commonly accepted cut off is 140. She could compromise and just do a fasting blood sugar and see what that is. Have her watch her diet for extra sugars, soda, and starchy carbohydrates. Also, is she overweight or of an average weight? If she is over 200 pounds, then the test is recommended. Many aren't doing the 3 hour now, though, it is the 'diagnostic test' for gestational diabetes.*

*Diet and regular exercise are the things to think about. She has a choice to refuse the test, but that needs to come from within her. The concern is elevated blood sugars and a large baby, which do happen.*

*Unfortunately, more and more birth centers (both outside and inside of hospitals) are getting stricter about having their clients "checked off" on all the little checklist items that the overseeing OB's want to see in the chart before the mom is approved for the birth center. I had my son at the XXXX Birth Center in 2003. He was 10lbs 2oz. It was a perfectly normal 5-hour labor and birth. He was big, but I am too, and we had no trouble fitting together. :-) Now I am pregnant with #3 and like you, do not want to take the GTT this time because I feel it is a silly test that has a risk of labeling me as having GD when I know I do not. (I have other issues with this test as well such as taking a large dose of glucose on an empty stomach. Why do that to a baby?!) Well, it turns out that if I refuse the GTT I will automatically be "risked out" of the birth center and have to go to the hospital. I also recently learned that they have a policy that requires AROM by 8cm if the water has not released on its own. I am not sure if this was the policy in 2003 but I find it curious that my midwife talked me into breaking the water to "speed things up" when I was right around 8cm. I now realize she wanted to be sure the water was clear. I guess they get into trouble if they have meconium births at the birth center.*

*All of this has seriously put me off to submitting to their care. And these are some of the most progressive, kind, caring CNM's I think there are available. Sadly, it seems that CNM's now have to bend to the will of the medical model even when they have done years of work to establish their own places for birthing. The CNM's in Cambridge opened the birth center 10 years ago. Many things about the center are right on, including NO EFM, no IVs, few vaginal exams during labor, tubs for birthing, etc. Unfortunately, it seems that as the years go by more and more restrictions are being placed on these midwives and for whatever reason (probably pressure from insurance companies and overseeing OB's) they are agreeing to become more conservative.*

*In my mind the only safe place to give birth now is at home (even in the Boston area, which has TONS of choices for hospitals and care providers). That is, if you do not want to be at the mercy of "policy" interventions that are passed off as standard of care, your only choice is a home birth midwife. Unfortunately, this option is only available to those who can afford it (roughly \$3000) because most insurance companies will not cover a home birth. I am in that unlucky group and am now working overtime to scrape together the money to pay my homebirth midwife.*

*Sorry to go on and on about my personal situation, but I think it is important for those of us in the birth community to see where prenatal care is headed in this country. Even places that masquerade as "alternative" and supportive of natural birth, really are just places with the same policies covered in pretty wallpaper.*

*You are not supposed to fast (not eat) before the one hour screening glucose test. You need to eat a normal diet. It's the three hour GTT, or the fasting and two hour post a meal test that needs a fasting. The standard for the test is to drink the liquid (or eat jelly beans !) and then have the blood drawn in an hour.*

*Women who are heavier are at more risk for gestational diabetes, as the insulin and glucose levels are higher in pregnancy. I do think we are heading for over kill on GDM, but these tests are considered standard of care. If not done and a large baby or bad outcome is the result, this is concerning. If moms refuse the test, they need true informed consent.*

*I agree with the recommendations...watch for extra sugars, starchy carbohydrates, pops, and things that will naturally raise the sugar levels.....and I too agree....labels are awful...*

*Wow - I never fail to be stunned by the maternity "care" in the US.*

*My babies were 9lb 12, 10lbs and 11lb 3oz (I'm 5ft 1 "tall") - this one is expected to be the biggest yet - I am currently measuring 7wks ahead at 35wks -(though my instinct tells me more mid 10lb range than a 12lber but we'll see!) - nobody batted an eyelid when I refused the GTT (and growth scans and consultant/obstetrician appointments, and vaginal examinations etc...), I can't believe the hoops you have to jump through in the US to be considered "normal" (all of which have far more danger of labeling you as abnormal it seems).*

*I'm booked in for a homebirth, thankfully we have a legal right to it (with attendance from midwives) here. I guess us women in England should consider ourselves lucky!*

**Question:**

*I have a couple that I am working with now and mom has borderline gestational diabetes. Is there anything she can do besides with diet to handle this. ...they took her blood pressure and it was "high" 130/90. They have told her that she may have preeclampsia. I have told her that before her next blood pressure to do some relaxation. Any other suggestions??*

**Response:**

*I had an email from one of my moms I was checking up on. She said at her last check-up her BP was high. She said she focused on being relaxed, and they retook her BP 5 minutes later in the other arm it was normal again. Things like stressing to get to the Dr.'s office in time or just fear of medical practices (all those smells of medicines and disinfectants can trigger it) can cause increase in pressure too. Encourage her to allow herself enough time to "settle" when she goes to her appointments.*

**Question:**

*A mother is facing induction at 39 or 40 weeks at the latest, due to Gestational Diabetes. Does anyone have any research that can support waiting for labor to start naturally? I've had plenty of mothers who were diagnosed with GD and went on to have wonderful births without intervention. Is there a circumstance when intervention is the only alternative for a GD diagnosis? I don't want to have her advocate for birth to start naturally if there is a special circumstance that I am missing. She has been eating well and exercising, is in great health and not overweight at all.*

**Responses:**

*The question is...are her blood sugars within a normal range...is she 'in control'? There is a trend for inductions after 39 weeks for gestational diabetes....not sure it is necessary, but I believe it is what is recommended by some. So, caught between a rock and a hard place.*

<http://www.ahrq.gov/clinic/uspstf08/gestdiab/gdrs.htm>

*Exercise!! Get her body moving, especially after eating. This will help lower her glucose levels and also decrease her stress. Also, she should check out Henci Goer's articles on gestational diabetes. They are available at [www.hencigoer.com](http://www.hencigoer.com).*

## **Research Article:**

**Importance:** *Pregestational diabetes* refers to diabetes diagnosed before pregnancy. *Gestational diabetes* refers to any degree of glucose intolerance with onset or first recognition during pregnancy. Pregnant women with pregestational diabetes are at increased risk for multiple complications affecting both the mother and the fetus. The degree to which pregnant women with gestational diabetes are at increased risk for maternal or fetal complications is less certain.

**Detection:** Several different methods are used to screen for GDM; many women with positive screening test results do not meet current diagnostic criteria for GDM.

## **Benefits of Detection and Early Treatment:**

**Screening before 24 weeks gestation:** The evidence is poor to determine whether there are benefits to screening women at this time in pregnancy.

**Screening after 24 weeks gestation:** Although screening and early treatment of GDM reduces macrosomia, and although 1 trial suggests the possibility of other health benefits, the overall evidence is poor to determine whether maternal or fetal complications are reduced by screening.

**Harms of Detection and Early Treatment:** There is fair evidence that short-term anxiety occurs in some women with positive screening results; longer term psychological or other harms have not been documented. The majority of positive screening test results are probably false positives. Consequently, it is likely that many women and medical practices are being inconvenienced unnecessarily by screening.

**USPSTF Assessment:** The USPSTF concludes that the current evidence is insufficient to assess the balance between the benefits and harms of screening women for GDM either before or after 24 weeks gestation.

**Potential Harms of Screening and/or Treatment:** There are 2 potential domains of harms of screening and treatment for GDM: the psychological and the physical. The primary adverse effects associated with screening would be the psychological impact of screening on the mother with GDM, and potentially on the mother who does not have GDM but has the added time, cost, physical discomfort and psychological burden of screening and confirmatory diagnostic testing. A review of the literature revealed mixed available evidence on the initial psychological impact of GDM screening. In the first few weeks after screening, women who screened positive for GDM may report higher anxiety, more psychological distress, and poorer perceptions of their general health than women who screened negative. Available evidence, however, suggests that these differences, even if present shortly after diagnosis, do not persist into the late third trimester or postpartum period.[14-16](#)

Further, ACHOIS found, in a subgroup that responded to the questionnaire, that treatment was

potentially associated with overall improved self-reported health status and reduced postpartum depression at 3 months postpartum compared with no treatment.<sup>11</sup> Alternative explanations for the reduced postpartum depression and improved quality-of-life responses in the treated group could include unblinding prior to the 3-months postpartum period before the questionnaire was completed or what is sometimes termed the Hawthorne effect, in which the additional attention given to the treatment group, rather than the treatment itself, could improve perceptions. Finally, a prospective study found that mood did not differ in women treated for GDM compared with controls.<sup>17</sup>

For the mother, hypoglycemia is the potentially most serious physical harm. Not all studies monitored or reported maternal hypoglycemia, but in those that did the rates are low with treatment and no worse with alternate therapies.

With regard to potential fetal or newborn risks, the potential teratogenicity of certain newer treatments for GDM (oral hypoglycemic agents or insulin analogues) presents a potential physical harm to the fetus that clearly could relate to GDM treatment; however, most treatments for GDM start in the second trimester, after the period of major organogenesis. Thus, data are very limited to assess potential teratogenicity of newer agents for treatment.

One potential issue is the number of false-positive screening test results. Given the lack of evidence to determine the accuracy of screening tests, it is difficult to estimate how often this occurs. However, studies show that fewer than 1 in 5 women with a positive GCT will meet criteria for GDM on a full OGTT.<sup>13</sup> This result indicates that many women are being inconvenienced, that health care services are being used unnecessarily, and that time is wasted evaluating false-positive test results.

**Estimate of the Magnitude of Net Benefit:** The USPSTF was unable to estimate the magnitude of net benefit, or indeed the existence of a benefit, of screening or treatment for GDM. This was due to a lack of studies of screening with a sufficient number of participants to permit evaluation of important health outcomes such as mortality, brachial plexus injury, clavicular fracture, and admission to neonatal intensive care units for hypoglycemia, hyperbilirubinemia, or respiratory distress syndrome. In addition, because of the lack of an accepted gold standard for screening, there is limited evidence on the accuracy of available screening strategies. There is also insufficient evidence on the benefits of treating GDM in improving health outcomes.