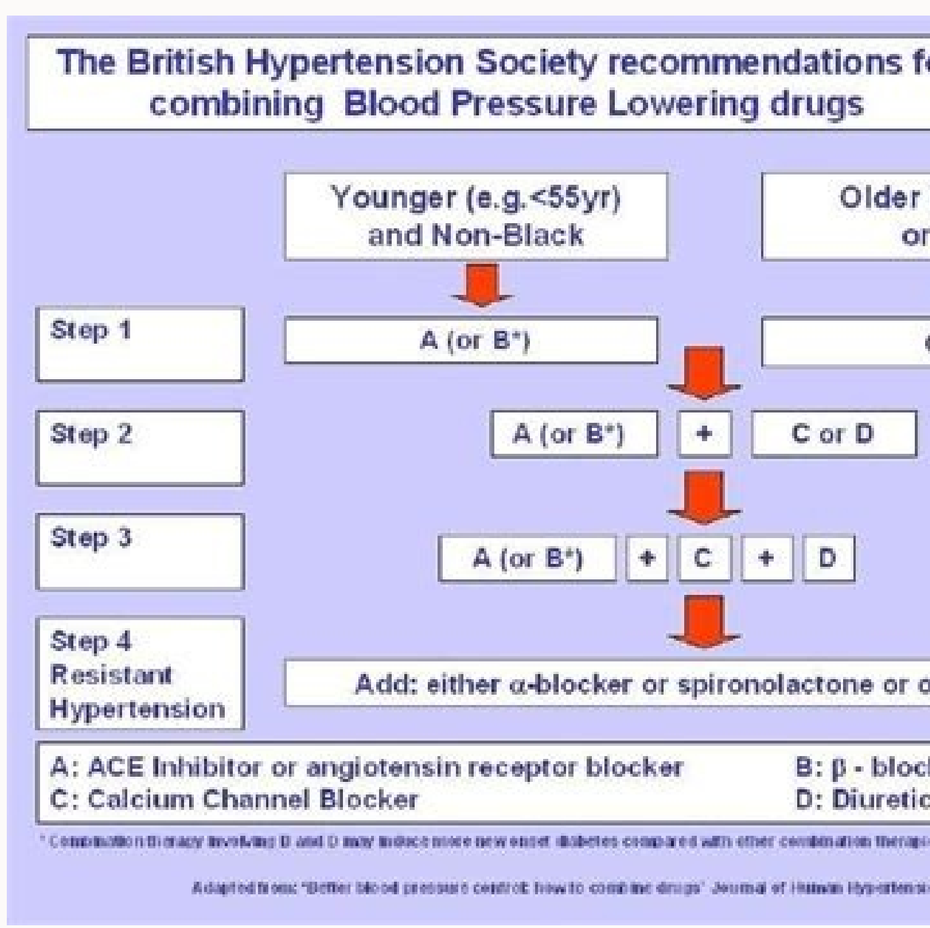
Nice guidelines diabetes in pregnancy 2017


healthy eating for gestational diabetes


The British Hypertension Society recommendations for combining Blood Pressure Lowering drugs
BHS
Younger (e.g.<55yr) and Non-Black
Older (e.g.≥55yr) or Black
Step 1
A (or B*)
C or D
Step 2
A (or B*)
+
C or D
Step 3
A (or B*)
+
C
+
D
Step 4 Resistant Hypertension
Add: either α-blocker or spironolactone or other diuretic
A: ACE Inhibitor or angiotensin receptor blocker
B: β - blocker
C: Calcium Channel Blocker
D: Diuretic (thiazide)

Gestational diabetes guidelines australia. Gestational diabetes guidelines australia 2020. Diabetes in pregnancy guidelines australia.

Skip to Main Content Skip Nav Destination This Guidelines summary covers managing diabetes and its complications in women who are planning pregnancy or are already pregnant. It includes recommendations that are relevant to the primary care setting. Please refer to the full guideline for the complete set of recommendations. This summary is abridged for print. View the full summary at guidelines.co.uk/252595.article Provide information, advice, and support, to empower women to have a positive experience of pregnancy and to reduce the risks of adverse pregnancy outcomes for mother and baby Explain to women with diabetes who are planning a pregnancy that: if they have good blood glucose control before conception and throughout their pregnancy, this will reduce the risk of miscarriage, congenital malformation, stillbirth and neonatal death but the risks can be reduced but not eliminated When women with diabetes who are planning a pregnancy, provide them and their families with information about how diabetes affects pregnancy and how pregnancy affects diabetes. The information should cover: the role of diet, body weight and exercise the risks of hypoglycaemia and impaired awareness of hypoglycaemia during pregnancy how nausea and vomiting in pregnancy can affect blood glucose control the increased risk of having a baby who is large for gestational age, which increases the likelihood of birth trauma, induction of labour and caesarean section deliveries the need for diabetic retinopathy assessment before and during pregnancy the need for diabetic nephropathy assessment before pregnancy the importance of maternal blood glucose control during labour and birt, and the need for early feeding of the baby, in order to reduce the risk of neonatal hypoglycaemia the possibility that the baby may have temporary health problems in the first 28 days, and may need admitting to a neonatal unit the risk of the baby developing obesity, diabetes and/or other health problems in later life Emphasise the importance of planning for pregnancy, as part of diabetes education from adolescence for women with diabetes. Explain to women with diabetes that their choice of contraception should be based on their own preferences and any risk factors (covered in the Faculty of Sexual and Reproductive Healthcare UK medical eligibility criteria for contraceptive use) Advise women with diabetes that they can use oral contraceptives Advise women with diabetes who are planning to become pregnant: that the risks associated with diabetes in pregnancy will increase the longer they have had diabetes to use contraception until they have good blood glucose control (assessed by HbA1c levels) that blood glucose targets, glucose monitoring, medicines for treating diabetes (including insulin regimens) and medicines for complications of diabetes will need to be reviewed before and during pregnancy that extra time and effort is needed to manage diabetes during pregnancy, and that more frequent contact is needed with healthcare professionals For women with diabetes who are planning a pregnancy, provide information about the local arrangements for support, including emergency contact numbers Offer individualised dietary advice to women with diabetes who are planning a pregnancy For women with diabetes who are planning a pregnancy and who have a body mass index (BMI) above 27 kg/m2, offer advice on how to lose weight, in line with the NICE guideline on identifying, assessing and managing obesity. See the NICE guideline on BMI for guidance on using variations on the BMI cut-off, based on the risk for different ethnic groups Advise women with diabetes who are planning a pregnancy to take folic acid (5 mg/day) until 12 weeks of gestation to reduce the risk of having a baby with a neural tube defect Offer up to monthly measurement of HbA1c levels for women with diabetes who are planning a pregnancy Offer blood glucose meters for self-monitoring to women with diabetes who are planning a pregnancy If a woman with diabetes who is planning a pregnancy needs to intensify blood glucose-lowering therapy, advise her to monitor her blood glucose more often, to include fasting levels and a mixture of pre-meal and post-meal levels Offer blood ketone testing strips and a meter to women with type 1 diabetes who are planning a pregnancy, and advise them to test for ketonaemia if they become hyperglycaemic or unwell Agree individualised targets for self-monitoring of blood glucose with women who have diabetes and are planning a pregnancy, taking into account the risk of hypoglycaemia Advise women with type 1 diabetes who are planning a pregnancy to aim for the normal capillary plasma glucose target ranges: a fasting plasma glucose level of 5–7 mmol/litre on waking and a plasma glucose level of 4–7 mmol/litre before meals at other times of the day Advise women with diabetes who are planning a pregnancy to aim to keep their HbA1c level below 48 mmol/mol (6.5%), if this is achievable without causing problematic hypoglycaemia Reassure women that any reduction in HbA1c level towards the target is likely to reduce the risk of congenital malformations in the baby Strongly advise women with diabetes whose HbA1c level is above 86 mmol/mol (10%) not to get pregnant until their HbA1c level is lower, because of the associated risks Women with diabetes may be advised to use metformin as an adjunct or alternative to insulin in the preconception period and during pregnancy, when the likely benefits from improved blood glucose control outweigh the potential for harm. Stop all other oral blood glucose-lowering agents before pregnancy, and use insulin instead[A] Be aware that the available evidence on rapid-acting insulin analogues (aspart and lispro) does not show an adverse effect on the pregnancy or the health of baby Use isophane insulin (also known as NPH insulin) as the first choice for long-acting insulin during pregnancy. Consider continuing treatment with long-acting insulin analogues (insulin detemir or insulin glargine) in women with diabetes who have established good blood glucose control before pregnancy[B] Stop angiotensin-converting enzyme inhibitors and angiotensin-II receptor antagonists before conception, or as soon as pregnancy is confirmed. Use alternative antihypertensive agents that are suitable for pregnant women Stop statins before pregnancy, or as soon as pregnancy is confirmed From adolescence onwards, at every contact with women with diabetes: healthcare professionals (including the diabetes care team) should explain the benefits of preconception blood glucose control the diabetes care team should record the plans women have for pregnancy and conception Provide preconception care for women with diabetes in a supportive environment, and encourage partners or other family members to attend For women with diabetes who are seeking preconception care, offer a retinal assessment at their first appointment (unless they have had a retinal assessment in the last 6 months) Advise women with diabetes who are planning a pregnancy to defer rapid optimisation of blood glucose control until after they have had retinal assessment and treatment Offer women with diabetes a renal assessment (including a measure of albuminuria), before stopping contraception Consider referring women with diabetes to a nephrologist before stopping contraception if: serum creatinine is 120 micromol/litre or more or the urinary albumin:creatinine ratio is greater than 30 mg/mmol or the estimated glomerular filtration rate (eGFR) is less than 45 ml/minute/1.73 m2. For recommendations on gestational diabetes, refer to the full summary online at guidelines.co.uk/252595.article Risk assessment, testing and diagnosis Risk assessment To help women make an informed decision about risk assessment and testing for gestational diabetes, explain that: some women find that gestational diabetes can be controlled with changes in diet and exercise most women with gestational diabetes will need oral blood glucose-lowering agents or insulin if gestational diabetes is not detected and controlled, there is a small increase in the risk of serious adverse birth complications such as shoulder dystocia women with gestational diabetes will need more monitoring, and may need more interventions during pregnancy and labour Assess risk of gestational diabetes using risk factors in a healthy population. At the booking appointment, check for the following risk factors: BMI above 30 kg/m2 previous macrosomic baby weighing 4.5 kg or above previous gestational diabetes family history of diabetes (first-degree relative with diabetes) an ethnicity with a high prevalence of diabetes Offer women with any one of these risk factors testing for gestational diabetes Do not use fasting plasma glucose, random blood glucose, HbA1c, glucose challenge test or urinalysis for glucose to assess risk of developing gestational diabetes Glycosuria detected by routine antenatal testing Consider further testing to exclude gestational diabetes in women who have the following reagent strip test results during routine antenatal care: glycosuria of 2+ or above on one occasion glycosuria of 1+ or above on two or more occasions Testing Use the 75-g 2-hour oral glucose tolerance test (OGTT) to test for gestational diabetes in women with risk factors For women who have had gestational diabetes in a previous pregnancy, offer: early self-monitoring of blood glucose or a 75-g 2-hour OGTT as soon as possible after booking (whether in the first or second trimester), and a further 75-g 2-hour OGTT at 24–28 weeks if the results of the first OGTT are normal Offer women with any of the other risk factors for gestational diabetes a 75-g 2-hour OGTT at 24–28 weeks Diagnosis Diagnose gestational diabetes if the woman has either: a fasting plasma glucose level of 5.6 mmol/litre or above or a 2-hour plasma glucose level of 7.8 mmol/litre or above When women are diagnosed with gestational diabetes: offer a review with the joint diabetes and antenatal clinic within 1 week tell their primary healthcare team Interventions Explain to women with gestational diabetes: about the implications (both short and long term) of the diagnosis for her and her baby that good blood glucose control throughout pregnancy will reduce the risk of foetal macrosomia, trauma during birth (for her and her baby), induction of labour and/or caesarean section, neonatal hypoglycaemia, and perinatal death that treatment includes changes in diet and exercise, and could involve medicines Teach women with gestational diabetes how to self-monitor their blood glucose Use the same capillary plasma glucose target levels for women with gestational diabetes as for women with pre-existing diabetes Tailor blood glucose-lowering therapy to the blood glucose profile and personal preferences of the woman with gestational diabetes When women are diagnosied with gestational diabetes, offer advice about changes in diet and exercise Advise women with gestational diabetes to eat a healthy diet during pregnancy, and to switch from high to low glycaemic index foods Refer all women with gestational diabetes to a dietitian Advise women with gestational diabetes to exercise regularly (for example, walking for 30 minutes after a meal) For women with gestational diabetes who have a fasting plasma glucose level below 7 mmol/litre at diagnosis, offer a trial of diet and exercise changes If blood glucose targets are not met with diet and exercise changes within 1 to 2 weeks, offer metformin[A] If metformin is contraindicated or unacceptable to the woman, offer insulin If blood glucose targets are not met with diet and exercise changes plus metformin,[A] offer insulin as well For women with gestational diabetes who have a fasting plasma glucose level of 7.0 mmol/litre or above at diagnosis, offer: immediate treatment with insulin, with or without metformin[A]and diet and exercise changes For women with gestational diabetes who have a fasting plasma glucose level of between 6.0 and 6.9 mmol/litre and complications such as macrosomia or hydramnios, consider: immediate treatment with insulin, with or without metformin[A]and diet and exercise changes Monitoring blood glucose Advise pregnant women with type 1 diabetes to test their fasting, pre-meal, 1-hour post-meal and bedtime blood glucose levels daily Advise pregnant women with type 2 diabetes or gestational diabetes who are on a multiple daily insulin injection regimen to test their fasting, pre-meal, 1-hour post-meal and bedtime blood glucose levels daily Advise pregnant women with type 2 diabetes or gestational diabetes to test their fasting and 1-hour post-meal blood glucose levels daily if they are: managing their diabetes with diet and exercise changes alone or taking oral therapy (with or without diet and exercise changes) or single-dose intermediate-acting or long-acting insulin Target blood glucose levels Agree individualised targets for self-monitoring of blood glucose with pregnant women with diabetes, taking into account the risk of hypoglycaemia Advise pregnant women with any form of diabetes to maintain their capillary plasma glucose below the following target levels, if these are achievable without causing problematic hypoglycaemia: fasting: 5.3 mmol/litre and 1 hour after meals: 7.8 mmol/litre or 2 hours after meals: 6.4 mmol/litre Advise pregnant women with diabetes who are taking insulin to maintain their capillary plasma glucose level above 4 mmol/litre Monitoring HbA1c Measure HbA1c levels at the booking appointment for all pregnant women with pre-existing diabetes, to determine the level of risk for the pregnancy Consider measuring HbA1c levels in the second and third trimesters of pregnancy for women with pre-existing diabetes, to assess the level of risk for the pregnancy Be aware that level of risk for the pregnancy for women with pre-existing diabetes increases with an HbA1c level above 48 mmol/mol (6.5%) Measure HbA1c levels when women are diagnosed with gestational diabetes, to identify women who may have pre-existing type 2 diabetes Do not routinely use HbA1c levels routinely to assess a woman's blood glucose control in the second and third trimesters of pregnancy Managing diabetes during pregnancy Insulin treatment and risks of hypoglycaemia A 2020 Medicines and Healthcare products Regulatory Agency drug safety update highlights the need to rotate insulin injection sites within the same body area to avoid cutaneous amyloidosis Consider rapid-acting insulin analogues (aspart and lispro) for pregnant women with diabetes. Be aware that these insulin analogues have advantages over soluble human insulin during pregnancy. Advise women with insulin-treated diabetes of the risks of hypoglycaemia and impaired awareness of hypoglycaemia in pregnancy, particularly in the first trimester Advise pregnant women with insulin-treated diabetes to always have available a fast-acting form of glucose (for example, dextrose tablets or glucose-containing drinks) Provide glucagon to pregnant women with type 1 diabetes for use if needed. Explain to the woman and her partner or other family members how to use it Offer continuous subcutaneous insulin infusion (CSII; also known as insulin pump therapy) to pregnant women with insulin-treated diabetes who: are using multiple daily injections of insulin and do not achieve blood glucose control without significant disabling hypoglycaemia Intermittently scanned CGM and continuous glucose monitoring Offer continuous glucose monitoring (CGM) to all pregnant women with type 1 diabetes to help them meet their pregnancy blood glucose targets and improve neonatal outcomes Offer intermittently scanned CGM (isCGM, commonly referred to as flash) to pregnant women with type 1 diabetes who are unable to use continuous glucose monitoring or express a clear preference for it Consider CGM for pregnant women who are on insulin therapy but do not have type 1 diabetes, if: they have problematic severe hypoglycaemia (with or without impaired awareness of hypoglycaemia) or they have unstable blood glucose levels that are causing concern despite efforts to optimise glycaemic control For pregnant women who are using isCGM or CGM, a member of the joint diabetes and antenatal care team with expertise in these systems should provide education and support (including advising women about sources of out-of-hours support) Ketone testing and diabetic ketoacidosis Offer blood ketone testing strips and a meter to women with type 1 diabetes. Advise them to test for ketonaemia and to seek urgent medical advice if they become hyperglycaemic or unwell Advise pregnant women with type 2 diabetes or gestational diabetes to seek urgent medical advice if they become hyperglycaemic or unwell Test urgently for ketonaemia if a pregnant woman with any form of diabetes presents with hyperglycaemia or is unwell Immediately admit women withsuspected diabetic ketoacidosis for level 2 critical care, where they can receive both medical and obstetric care Retinal assessment during pregnancy After pregnant women with pre-existing diabetes have had their first antenatal clinic appointment: offer retinal assessment by digital imaging with mydriasis using tropicamide (unless they have had a retinal assessment in the last 3 months) if they have diabetic retinopathy, offer an additional retinal assessment at 16 to 20 weeks offer another retinal assessment at 28 weeks Diabetic retinopathy should not be considered a contraindication to rapid optimisation of blood glucose control in women who present with a high HbA1c in early pregnancy Diabetic retinopathy should not be considered a contraindication to vaginal birth Renal assessment during pregnancy Arrange a renal assessment at first contact during the pregnancy for women with pre-existing diabetes, if they have not had 1 in the last 3 months Consider referring pregnant women with diabetes to a nephrologist if: their serum creatinine is 120 micromol/litre or more or the urinary albumin:creatinine ratio is greater than 30 mg/mmol or total protein excretion exceeds 0.5 g/day Do not use eGFR to measure kidney function in pregnant women Consider thromboprophylaxis for pregnant women with nephrotic range proteinuria above 5 g/day (albumin:creatinine ratio greater than 220 mg/mmol) Preventing pre-eclampsia Detecting congenital malformations Offer women with diabetes an ultrasound scan at 20 weeks to detect foetal structural abnormalities, including examination of the fetal heart (4 chambers, outflow tracts and 3 vessels) Organisation of antenatal care Offer immediate contact with a joint diabetes and antenatal clinic to pregnant women with diabetes Joint diabetes and antenatal clinics should be in contact with women with diabetes every 1 to 2 weeks throughout pregnancy, for blood glucose control assessment Blood glucose control, medicines and breastfeeding Women with insulin-treated pre-existing diabetes should reduce their insulin immediately after birth and monitor their blood glucose levels carefully to establish the appropriate dose Explain to women with insulin-treated pre-existing diabetes that they are at increased risk of hypoglycaemia in the postnatal period (especially when breastfeeding), and advise them to have a meal or snack available before or during feeds Women who have been diagnosed with gestational diabetes should stop blood glucose-lowering therapy immediately after birth Women with pre-existing type 2 diabetes who are breastfeeding can resume or continue metformin[A] immediately after birth, but should avoid other oral blood glucose-lowering agents while breastfeeding Women with diabetes who are breastfeeding should continue to avoid any medicines for the treatment of diabetes complications that were stopped for safety reasons when they started planning the pregnancy Women with pre-existing diabetes Refer women with pre-existing diabetes back to their routine diabetes care arrangements Remind women with diabetes of the importance of contraception and the need for preconception care when planning future pregnancies Women diagnosed with gestational diabetes Before women who were diagnosed with gestational diabetes are transferred to community care, test their blood glucose to exclude persisting hyperglycaemia Remind women who were diagnosed with gestational diabetes of the symptoms of hyperglycaemia Explain to women who were diagnosed with gestational diabetes about the risks of recurrence in future pregnancies, and offer them diabetes testing when planning future pregnancies For women who were diagnosed with gestational diabetes and whose blood glucose levels returned to normal after the birth: offer lifestyle advice (including weight control, diet and exercise) offer a fasting plasma glucose test 6–13 weeks after the birth to exclude diabetes (for practical reasons this might take place at the 6-week postnatal check) after 13 weeks offer a fasting plasma glucose test if this has not been done earlier, or an HbA1c test if a fasting plasma glucose test is not possible do not routinely offer a 75-g 2-hour OGTT offer a referral into the NHS Diabetes Prevention Programme if eligible based on the results of the fasting plasma glucose test or HbA1c test For women having a fasting plasma glucose test as the postnatal test: advise women with a fasting plasma glucose level below 6.0 mmol/litre that: they have a low probability of having diabetes at the moment they should continue to follow the lifestyle advice (including weight control, diet and exercise) given after the birth they will need an annual test to check that their blood glucose levels are normal they have a moderate risk of developing type 2 diabetes, and offer them advice and guidance in line with the NICE guideline on preventing type 2 diabetes Advise women with a fasting plasma glucose level between 6.0 and 6.9 mmol/litre that they are at high risk of developing type 2 diabetes, and offer them advice, guidance and interventions in line with the NICE guideline on preventing type 2 diabetes Advise women with a fasting plasma glucose level of 7.0 mmol/litre or above that they are likely to have type 2 diabetes, and offer them a test to confirm this For women having an HbA1c test as the postnatal test: advise women with an HbA1c level below 39 mmol/mol (5.7%) that: they have a low probability of having diabetes at the moment they should continue to follow the lifestyle advice (including weight control, diet and exercise) given after the birth they will need an annual test to check that their blood glucose levels are normal they have a moderate risk of developing type 2 diabetes, and offer them advice and guidance in line with the NICE guideline on preventing type 2 diabetes Advise women with an HbA1c level between 39 and 47 mmol/mol (5.7% and 6.4%) that they are at high risk of developing type 2 diabetes, and offer them advice, guidance and interventions in line with the NICE guideline on preventing type 2 diabetes Advise women with an HbA1c level of 48 mmol/mol (6.5%) or above that they have type 2 diabetes and refer them for further care Offer an annual HbA1c test to women with gestational diabetes who have a negative postnatal test for diabetes Offer women with gestational diabetes early self-monitoring of blood glucose or an OGTT in future pregnancies. Offer a subsequent OGTT if the first OGTT results in early pregnancy are normal   Published date: 25 February 2015. Last update: 16 December 2020.

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