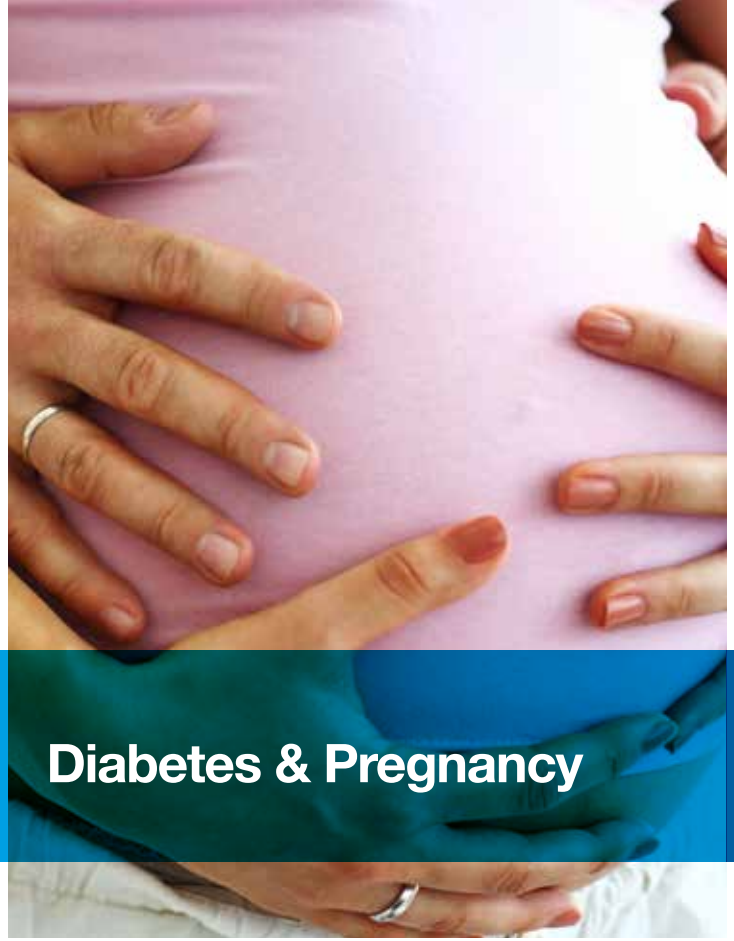

Diabetes & Pregnancy

If you are a woman with diabetes (Type 1, Type 2 and gestational), more thought and planning is required with your diabetes care team for a good pregnancy and healthy baby.

It is helpful to know what tests and treatment to expect, and be referred to a pre-conception clinic usually run by the diabetes midwife and diabetes specialist nurse.

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Tips for a healthy pregnancy

- Stop smoking, avoid alcohol, eat a balanced diet and keep active.
- You can increase your chances of delivering a healthy baby by keeping your blood glucose in control before conception and throughout pregnancy.
- Pregnancy can place extra pressure on the small vessels in your eyes, so if you have retinopathy that has not been checked, have this treated before becoming pregnant.
- Some medicines used in diabetes management should NOT be taken by pregnant women. You may need to switch to insulin injections to control your blood glucose, but you can usually return to tablets after pregnancy. If you are on blood pressure tablets, tell your doctor if planning a pregnancy as these may harm your baby. Start taking 5mg folic acid (prescribed by your doctor) until the end of the twelfth week of pregnancy to help prevent neural tube defects.

During pregnancy

You will be offered extra monitoring appointments and scans to help control your blood glucose and check your baby's growth and development. You should have contact with your diabetes team every one or two weeks to agree personal target levels. You may find you are more at risk of hypos and should be given a glucagon kit for treatment. You may also be offered an induction of labour or caesarean section if this is the best option for you.

After the birth

- All babies' blood glucose levels drop after separation from the mother; regular breastfeeding soon after delivery and blood glucose monitoring on them usually resolves this.
- Your insulin needs will significantly drop after delivery. You may need an intravenous insulin/glucose drip for a few hours thereafter and your insulin dose adjusted accordingly. Your blood glucose will be checked regularly until levels stabilise. When you resume your normal diet, you should also return to your pre-pregnancy insulin dose. If you were taking insulin for gestational diabetes, the insulin can usually be stopped immediately after giving birth.
- Most women who deliver by caesarean section are given antibiotics after delivery to decrease risk of infection at the wound site.

Breastfeeding and diabetes

You may have some early difficulties - for example if your baby needs extra feeds, or if you were initially separated from your baby due to caesarean section or baby's treatment in the neonatal unit - but with patience and practice you should be able to establish a good breastfeeding pattern.

- Breastfeeding may lower your insulin needs by up to 25%. Breast milk contains sugar called lactose. Every time you feed your baby, you will lose that sugar and your blood glucose will drop, which may cause a hypo. To help avoid hypos, you may need to eat more starchy foods daily while still breastfeeding.
- Even though you will be eating more, breastfeeding may help you lose weight.
- If you take metformin or glibenclamide for Type 2 diabetes, you can usually resume or continue taking these while breastfeeding if your doctor agrees.

Gestational diabetes

Gestational diabetes (GDM) is hyperglycaemia (abnormally high blood glucose) that arises usually during the second or third trimester of pregnancy, and usually disappears after the baby is born. In some women, GDM occurs because the body cannot produce enough insulin to meet the extra needs of pregnancy. In other women, GDM may be found during the first trimester and most likely existed before pregnancy. If GDM is not detected and treated, it can increase the risk of birth complications for both mother and baby.

GDM often does not cause any symptoms. This means you may be screened for the condition at your first antenatal appointment by a venous glucose sample at around weeks 8-12 of pregnancy. An oral glucose tolerance test (OGTT) is used to diagnose GDM. If you are at increased risk of GDM (from having GDM before, being obese, previously given birth to a large baby, or family origin/history of diabetes), you will be offered an OGTT during weeks 24-28 of pregnancy. This involves a blood test before breakfast, then again two hours after a glucose drink.

Hyperglycaemia can cause the following symptoms:

- a dry mouth with increased thirst
- needing to urinate frequently, especially at night
- tiredness
- recurrent infections, such as thrush (a yeast infection)
- blurred vision.

GDM can be treated by eating healthily, exercising regularly, controlling weight gain and with taking insulin/certain medications. Women who develop GDM are more likely to develop type 2 diabetes later in life.