
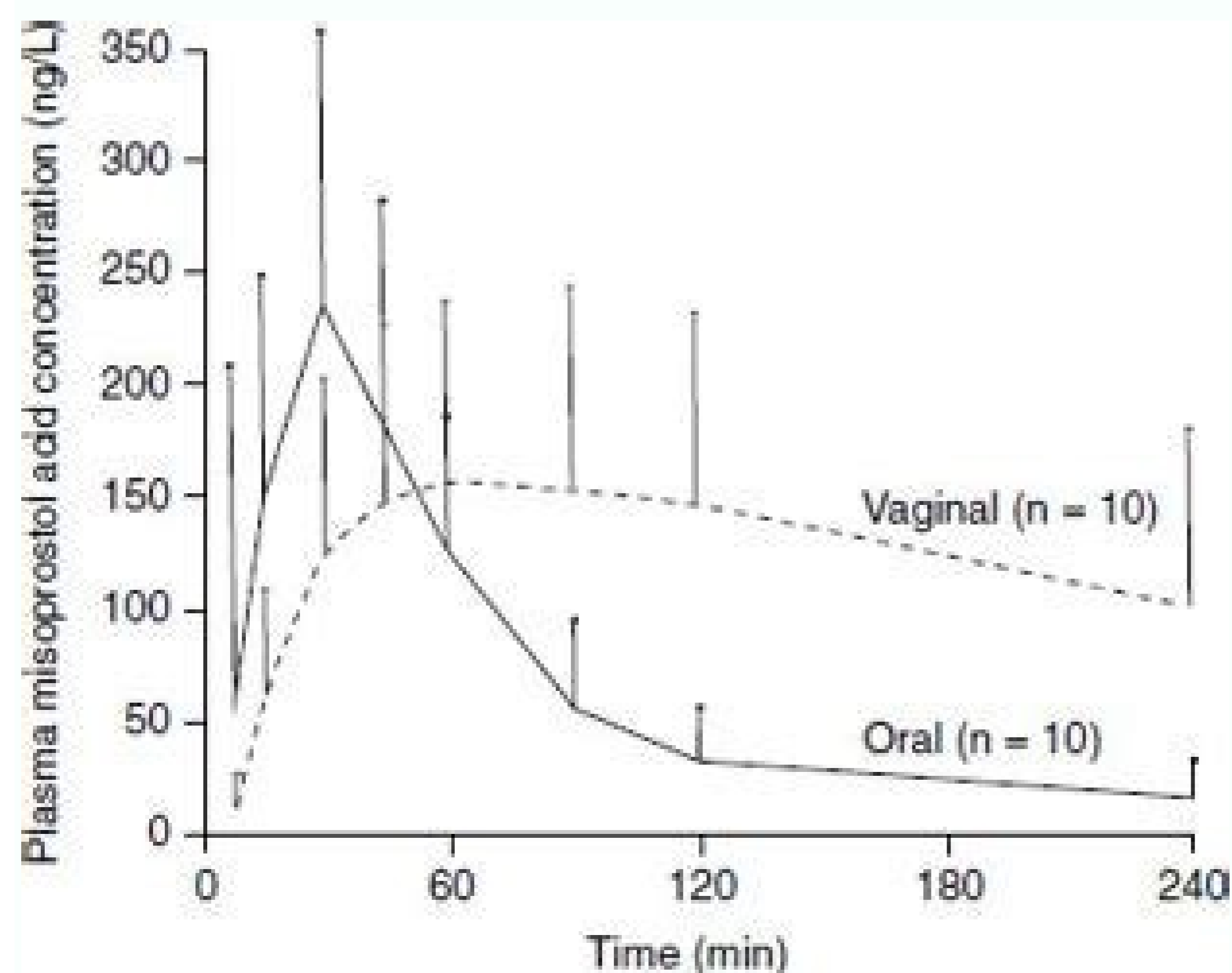


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INTERIM UPDATE

# ACOG PRACTICE BULLETIN

Clinical Management Guidelines for Obstetrician–Gynecologists

NUMBER 190, FEBRUARY 2018

(Replaces Practice Bulletin Number 180, July 2017)

Committee on Practice Bulletins—Obstetrics. This Practice Bulletin was developed by the American College of Obstetricians and Gynecologists Committee on Practice Bulletins—Obstetrics with the assistance of Aaron B. Caughey, MD, PhD, and Mark Turrentine, MD.

INTERIM UPDATE: This Practice Bulletin is updated as highlighted to reflect a limited, focused change to clarify and provide additional information on the pharmacologic treatment of gestational diabetes mellitus.

## Gestational Diabetes Mellitus

*Gestational diabetes mellitus (GDM) is one of the most common medical complications of pregnancy. However, debate continues to surround the diagnosis and treatment of GDM despite several recent large-scale studies addressing these issues. The purposes of this document are the following: 1) provide a brief overview of the understanding of GDM, 2) review management guidelines that have been validated by appropriately conducted clinical research, and 3) identify gaps in current knowledge toward which future research can be directed.*

### Background

#### Definition and Prevalence

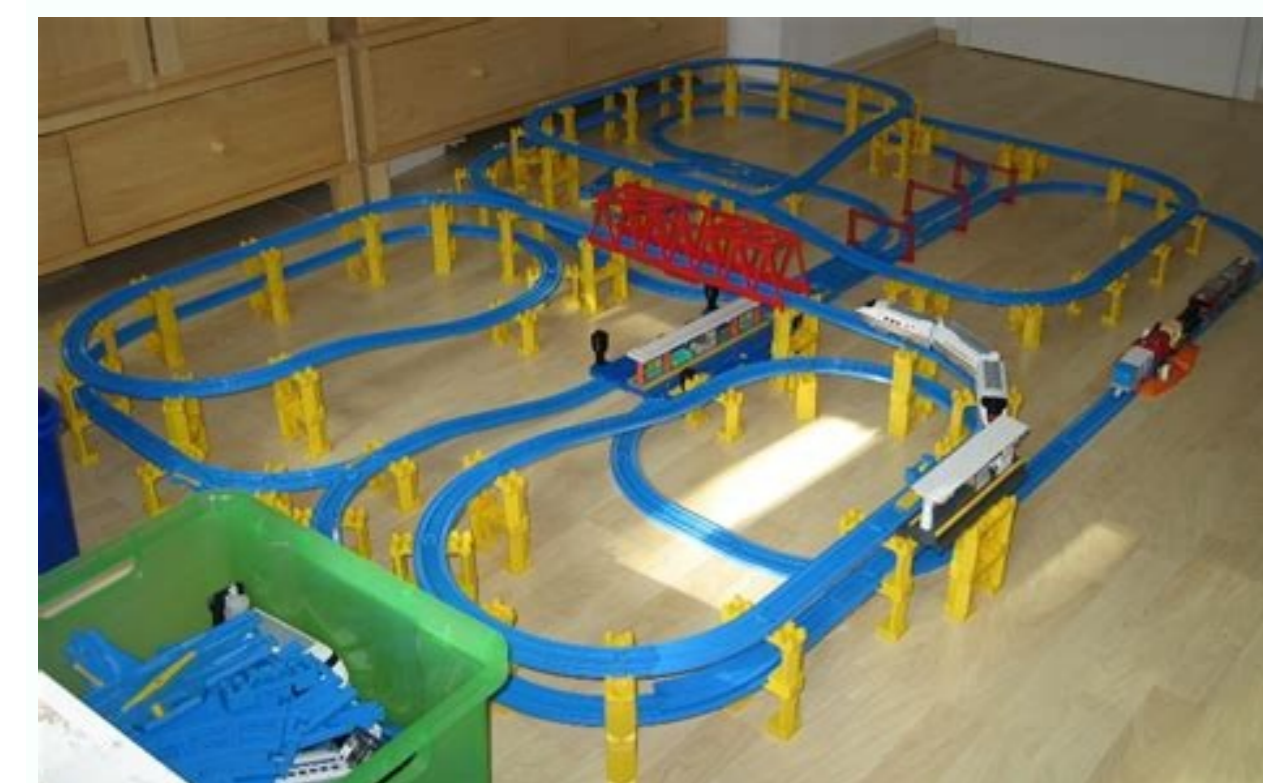
Gestational diabetes mellitus is a condition in which carbohydrate intolerance develops during pregnancy. Gestational diabetes that is adequately controlled without medication is often termed diet-controlled GDM or class A1GDM. Gestational diabetes mellitus that requires medication to achieve euglycemia is often termed class A2GDM. Because many women do not receive screening for diabetes mellitus before pregnancy, it can be challenging to distinguish GDM from preexisting diabetes. However, it has been estimated that in 2009, 7% of pregnancies were complicated by any type of diabetes and that approximately 86% of these cases represented women with GDM (1). Additionally, the prevalence of GDM varies in direct proportion to the prevalence of type 2 diabetes in a given population or racial or ethnic group. Caucasian women generally have the lowest rates of GDM. There is an increased prevalence of GDM among Hispanic, African American, Native American, and Asian or Pacific Islander women (2). Gestational diabetes also increases with the same risk factors seen for type 2 diabetes such as obesity and increased age (3). With a greater prevalence of obe-

sity and sedentary lifestyles, the prevalence of GDM among reproductive-aged women is increasing globally.

#### Maternal and Fetal Complications

Women with GDM have a higher risk of developing preeclampsia (9.8% in those with a fasting glucose less than 115 mg/dL and 18% in those with a fasting glucose greater than or equal to 115 mg/dL) and undergoing a cesarean delivery (25% of women with GDM who require medication and 17% of women with diet-controlled GDM underwent cesarean delivery versus 9.5% of controls) (4, 5). Furthermore, women with GDM have an increased risk of developing diabetes (predominantly type 2 diabetes) later in life. It is estimated that up to 70% of women with GDM will develop diabetes within 22–28 years after pregnancy (6–8). The progression to diabetes also is influenced by race, ethnicity, and obesity. For example, 60% of Latin American women with GDM may develop type 2 diabetes within 5 years of their index pregnancy (9).

The offspring of women with GDM are at increased risk of macrosomia, neonatal hypoglycemia, hyperbilirubinemia, shoulder dystocia, and birth trauma. There also is an increased risk of stillbirth, although how much this





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