New gestational diabetes mellitus guidelines and management

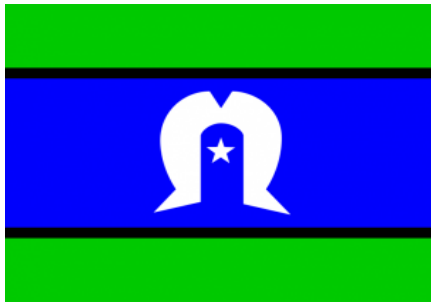
Monday 28th April 2025

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



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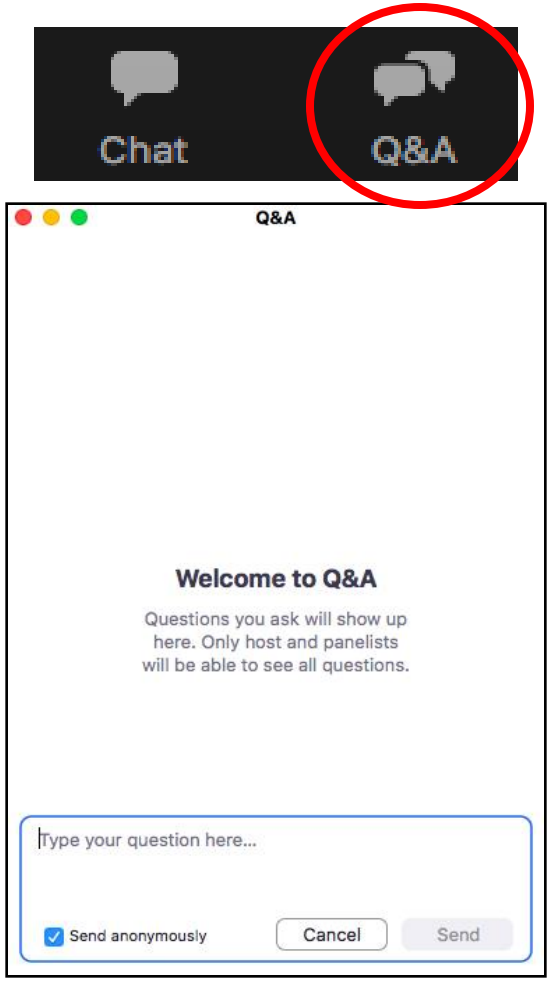
Q&A will be at the end of the presentation

This session is being recorded, you will receive a link to this recording and copy of slides in post session correspondence.

Questions will be asked anonymously to protect your privacy



Housekeeping – Zoom Webinar

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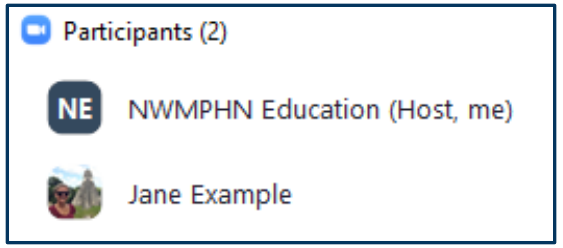


NWMPHN uses Zoom's participant list to mark attendance and certificates and CPD will not be issued if we cannot confirm your attendance.

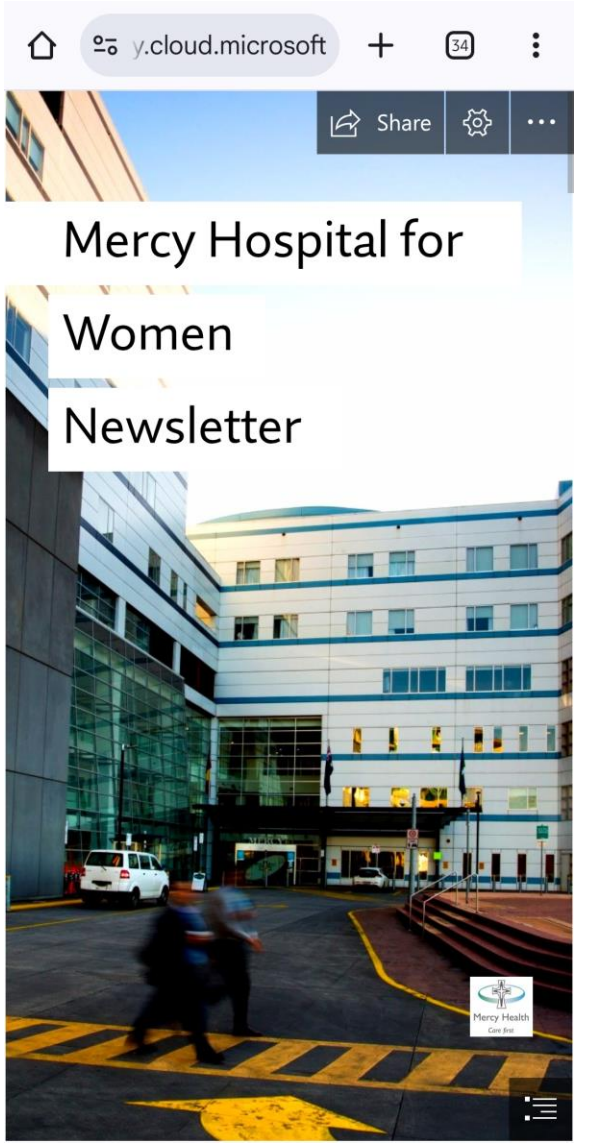
If you are not sure if your name matches, please send a Chat message to 'NWMPHN Education' to identify yourself.

Mercy Health update

Stay informed on everything happening in the hospital!

Sign up for our new and improved mobile-friendly **newsletter** to receive essential updates, clinical information, and valuable educational opportunities.

Ensure you register for the Primary Care Liaison newsletter on the Mercy Health, Primary Care Liaison webpage today!

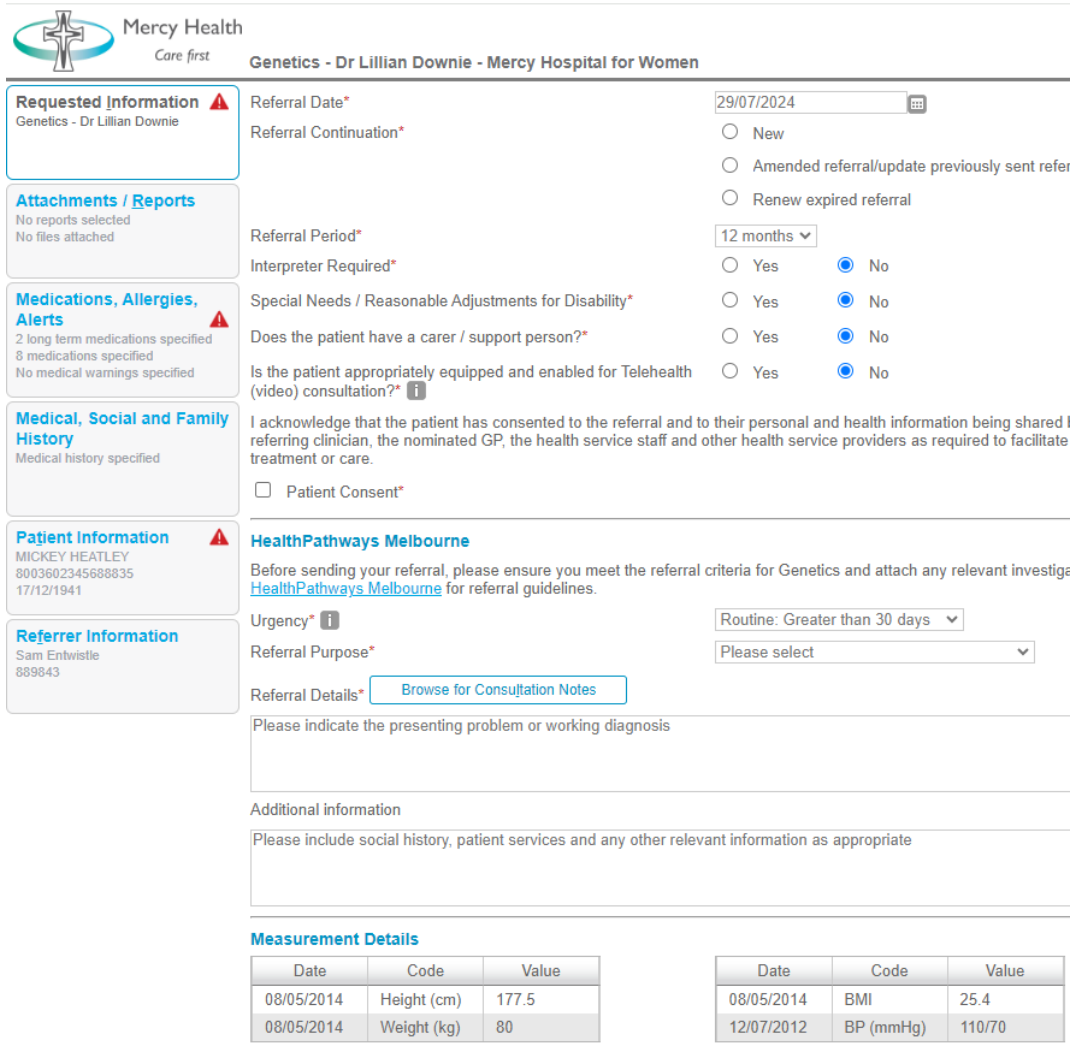


Mercy Health update

Mercy Health prefers that referrals to its Outpatient Specialist Clinics are submitted through eReferrals using HealthLink SmartForms.

This method is integrated into most practice software, and you will receive an acknowledgment once we have received your referral.

For more information, visit our [HealthLink eReferral information website]



Speakers

Dr Alexis Shub
Mercy Hospital for Women

Associate Professor Dr Alexis Shub is a maternal foetal medicine subspecialist and obstetrician at Mercy Hospital for Women. She is head of the hospital's diabetes clinic, a board member of Australasian Diabetes in Pregnancy Society (ADIPS), and author of the latest ADIPS guidance on diagnosis of GDM. She has many years of experience in caring for pregnant women with diabetes.

Gestational diabetes
Alexis Shub

THE UNIVERSITY OF MELBOURNE

Mercy Health
Care first

Conflict of interest

Member of ADIPS board

What is new in GDM – early testing, diagnostic criteria

What should be new – metformin

What else matters – breastfeeding and expressing, body shame, stigmatism, long term outcomes, normalisation of care, perinatal mortality

Case: Amanpreet

1st visit at 5 weeks to confirm pregnancy

POH

2020 India NVD 3.2kg breastfeeding difficulty

More history?

Plan for the pregnancy?

Case: Amanpreet

1st visit at 5 weeks to confirm pregnancy

POH

2020 India NVD 3.2kg breastfeeding difficulty

Didn't have GTT in last pregnancy

BMI 29

FH – mother Type 2 DM age 50

Mother coming to stay from 20 weeks to make sure she eats correctly and doesn't over-exert herself in pregnancy

Early GTT

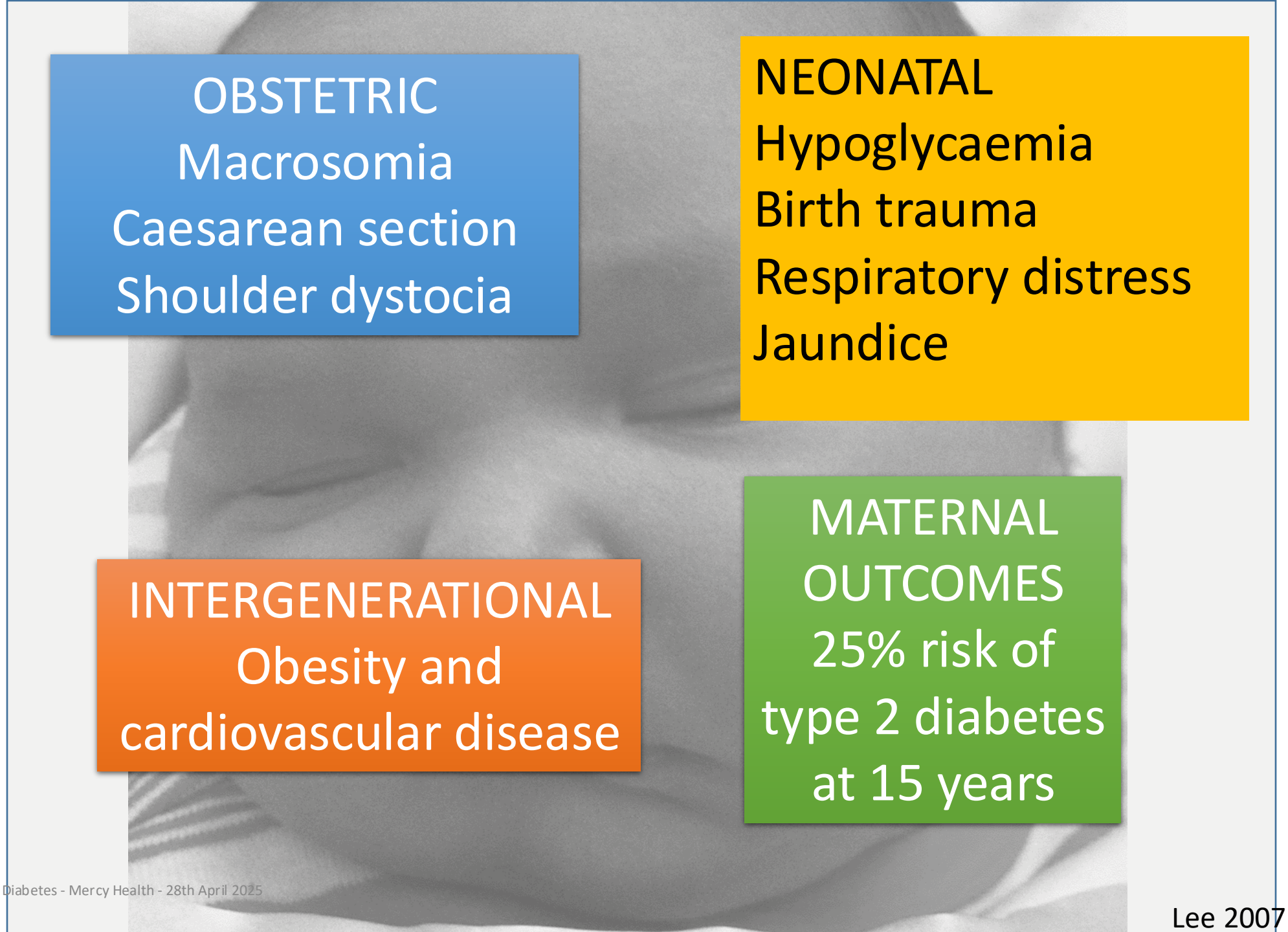
4.9/8.7/6.8

HbA1c 4.7

Advice??

Current ADIPS diagnostic pathway	Proposed ADIPS diagnostic pathway
	HbA1c for women with risk factors for diabetes to diagnose T2DM
Early GTT for women with risk factors for diabetes	Early GTT preferably 10-14 weeks for women with previous GDM or Hb A1c 6-6.4
75gm OGTT for everyone at 24-28 weeks	75gm OGTT for everyone at 24-28 weeks
Diagnose as GDM if 5.1/10.0/8.5	Diagnose as GDM if 5.3/10.5/9.0

What problems does gestational diabetes cause?



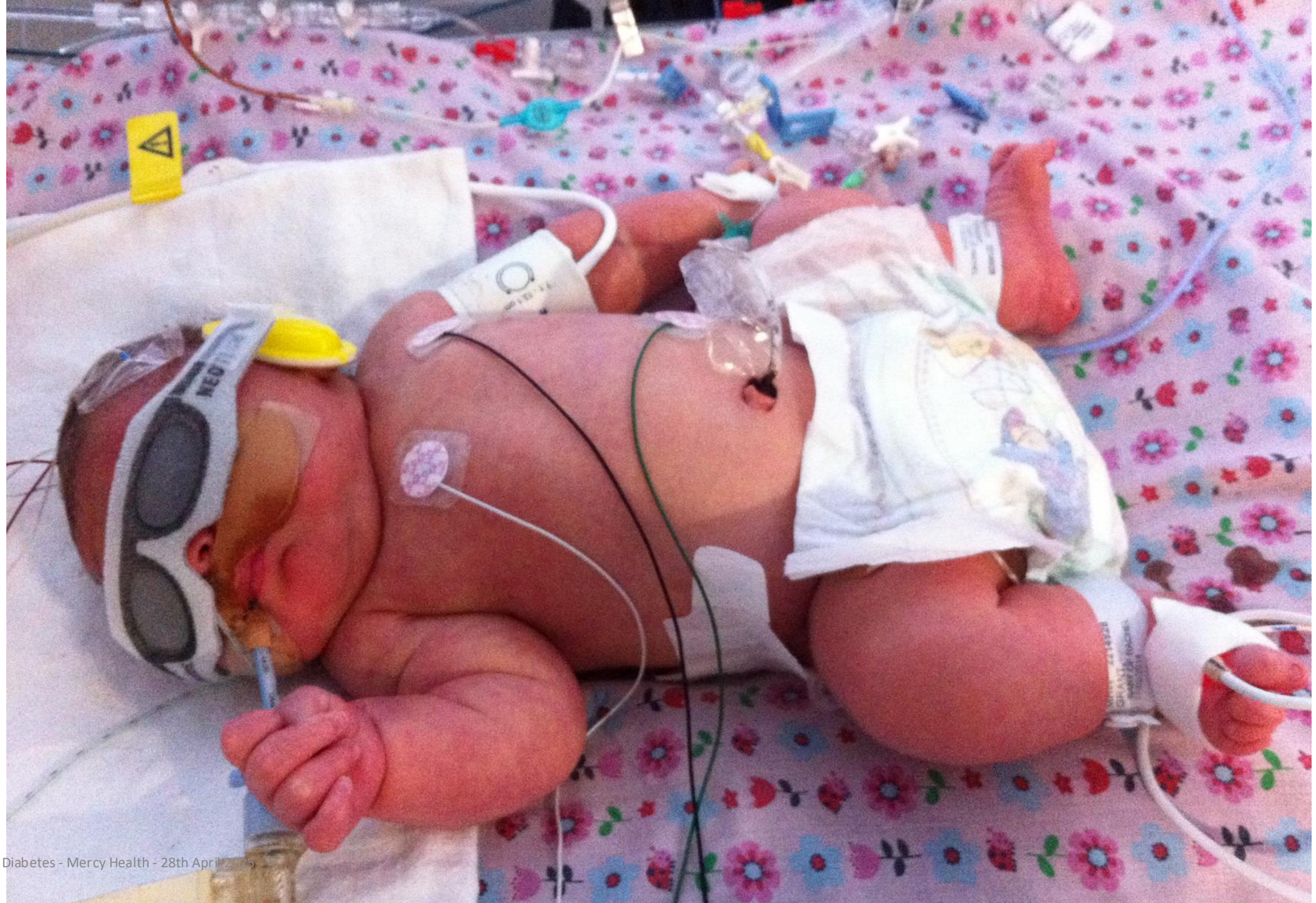
OBSTETRIC
Macrosomia
Caesarean section
Shoulder dystocia

NEONATAL
Hypoglycaemia
Birth trauma
Respiratory distress
Jaundice

INTERGENERATIONAL
Obesity and cardiovascular disease

MATERNAL OUTCOMES
25% risk of type 2 diabetes at 15 years

Lee 2007

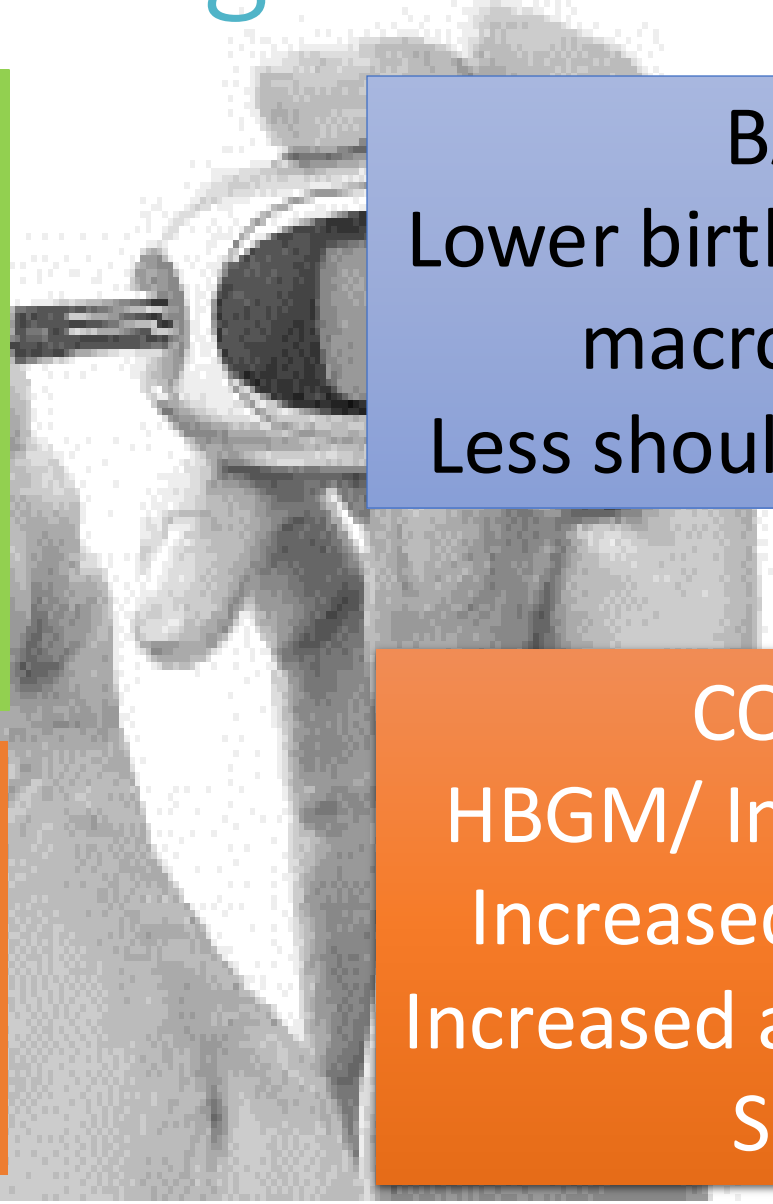


What problems are improved by treating gestational diabetes?

What problems are caused by treating gestational diabetes?

What problems are not caused by GDM?

Treating GDM



WOMAN
Less weight gain*
Lower preeclampsia rates *
Lower caesarean section rate

BABY
Lower birth weight/less macrosomia*
Less shoulder dystocia

NOT intergenerational outcomes
NOT miscarriage, congenital anomalies

COSTS
HBGM/ Insulin/visits
Increased induction
Increased admission to SCN

Treating GDM does not make a difference to long term outcome for the offspring

Mercy Health
Care first

GDM RCT

GEMS treated and untreated, or diagnostic criteria Fat mass at 6 months **No difference** Manerkar 2024 Diabetes Care

ACHOIS treated or non-treated GDM BMI at 5 years **No difference** Gillman Diabetes Care 2010

MFMU trial. Treated vs not treated GDM 5-10 yr BMI, waist circumference, triglycerides, HDL cholesterol, blood pressure, or insulin resistance. **No difference** Female offspring lower fasting glucose. Landon Diabetes Care 2015

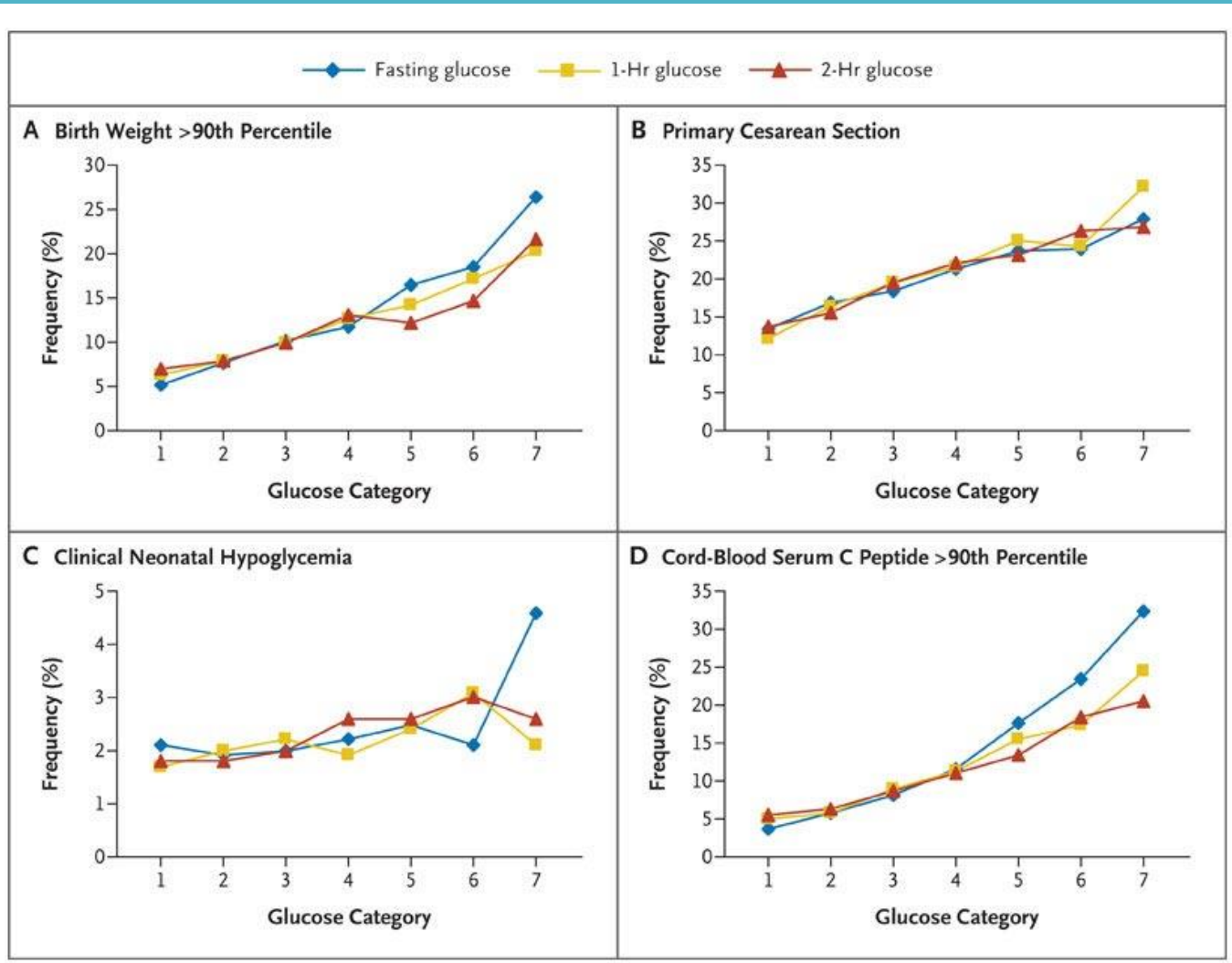
Metaanalysis GDM with or without lifestyle interventions , obesity in childhood **No difference** Gao Obesity Reviews 2022

Non GDM observational

GDM and obesity vs obesity vs GDM – overweight at age 16. Lowest risk for GDM. Pirkola Diabetes Care 2010

Childhood obesity is increased or reduced related to maternal lifestyle factors, corrected for demographics including GDM Dhana BMJ 2018

Definitions



Hyperglycaemia is a continuum

HAPO 1.75 5.1/10.0/8.5 mmol/L
HAPO 2.0 5.3/10.5/9.0 mmol/L

Early GDM
diagnosed before 20 weeks gestation
Late GDM/GDM
diagnosed at 24-28 weeks gestation

HAPO NEJM 2008

Early testing for GDM

If we treat disease earlier do we make more difference?

What we know about blood sugar in pregnancy

What are the changing demographics of our population that impact on patterns of diabetes

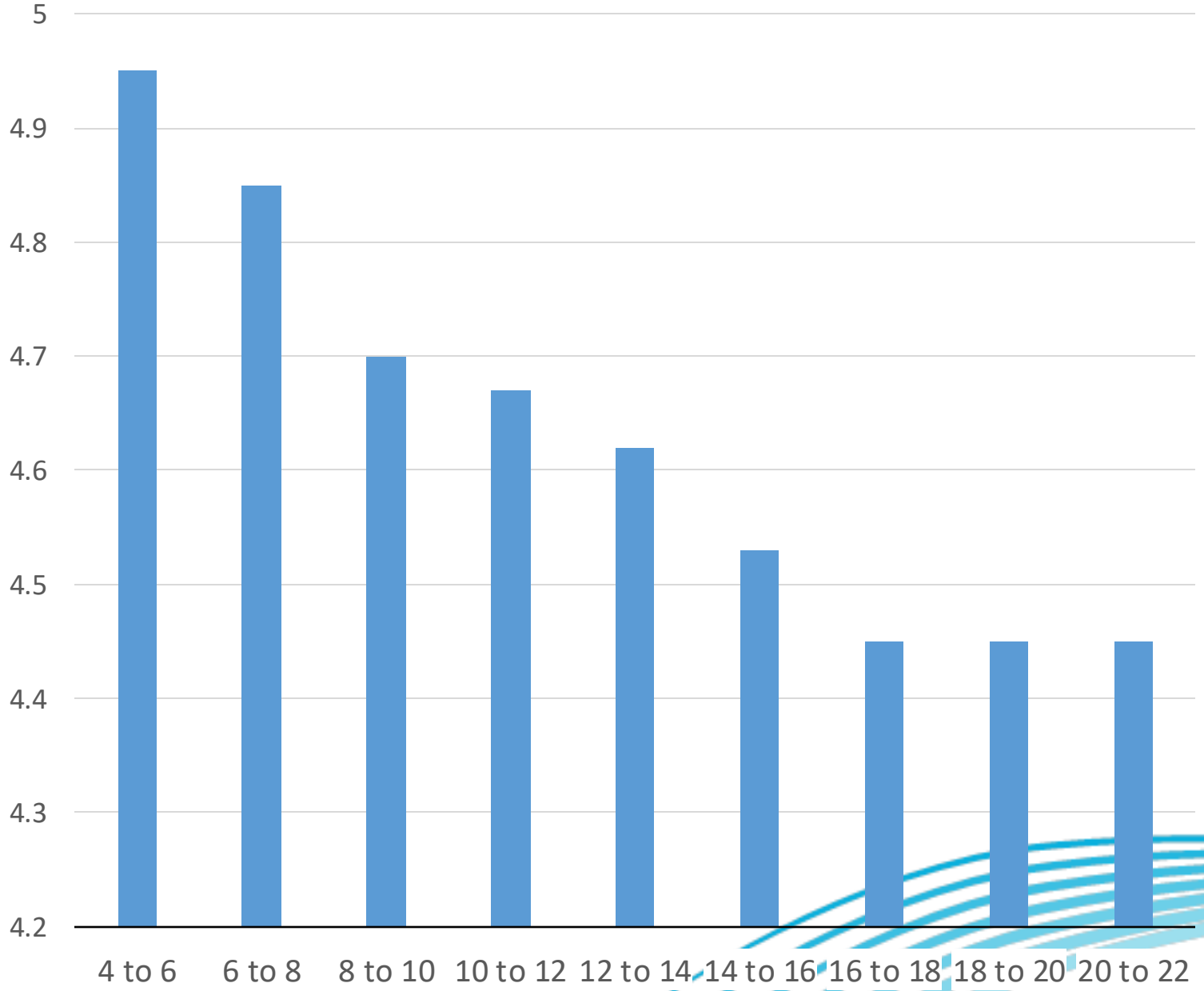
T2DM

Well demonstrated risks in pregnancy

Increasing in Australia with changing demographics

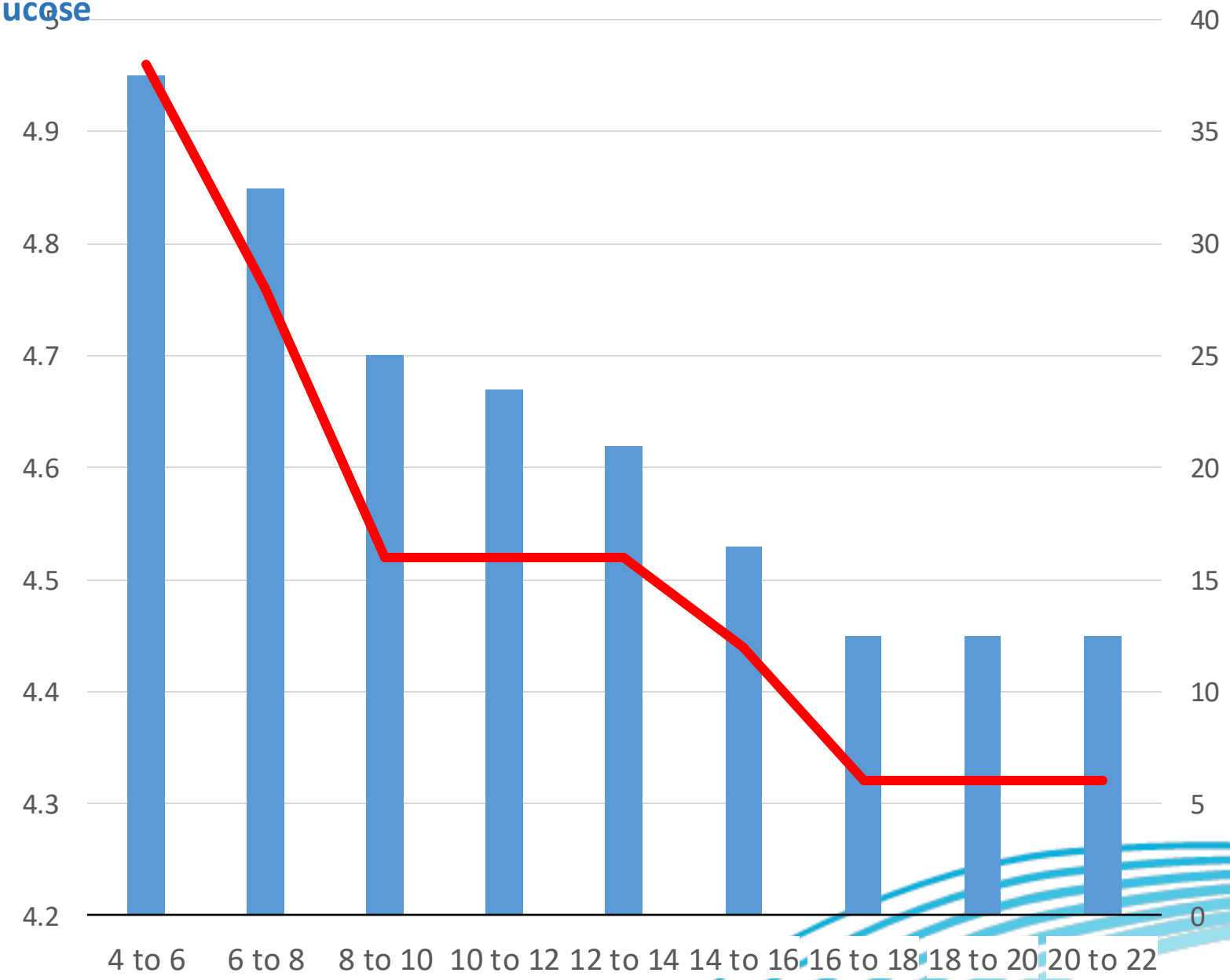
Screen with HbA1c

Mean fasting blood glucose



Zhu Diabetes Care 2013

Mercy Health
Care first



Zhu Diabetes Care 2013

Blood sugar in pregnancy in women without GDM

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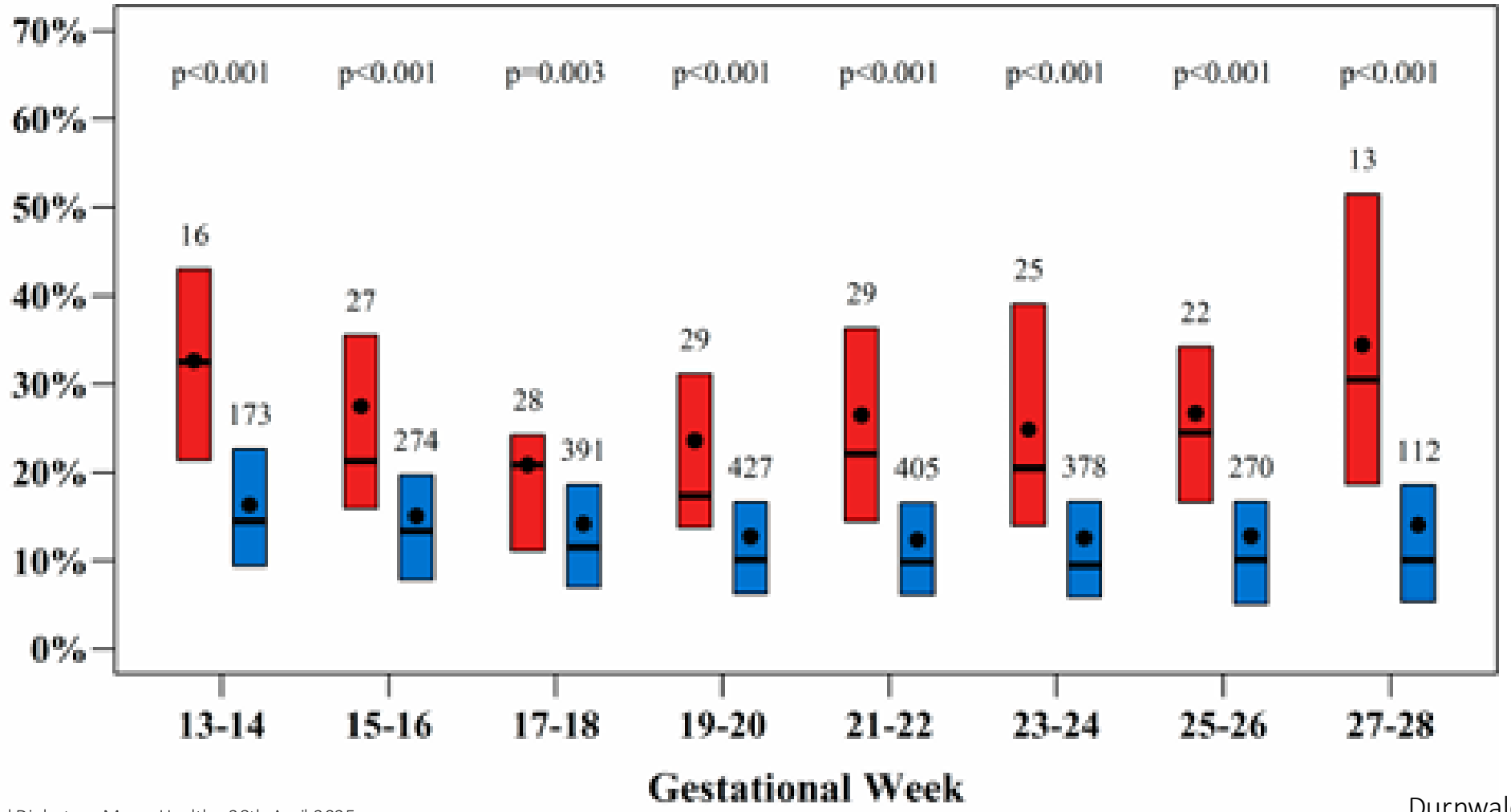
% time over 6.7



Durnwald Diabetes Care 2024

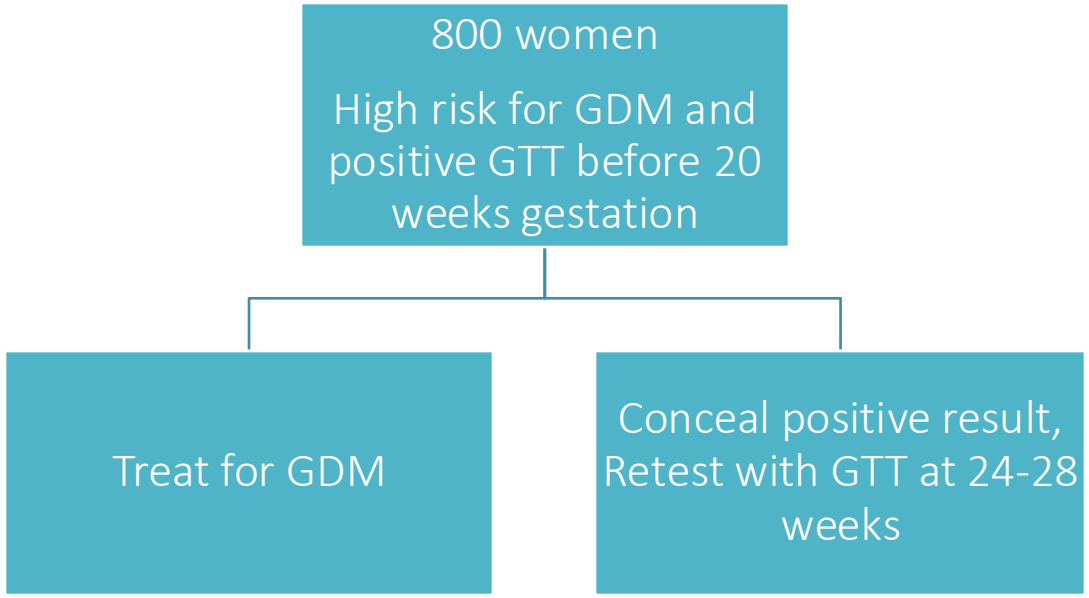
TOBOGM

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Treatment of Gestational Diabetes Mellitus Diagnosed Early in Pregnancy

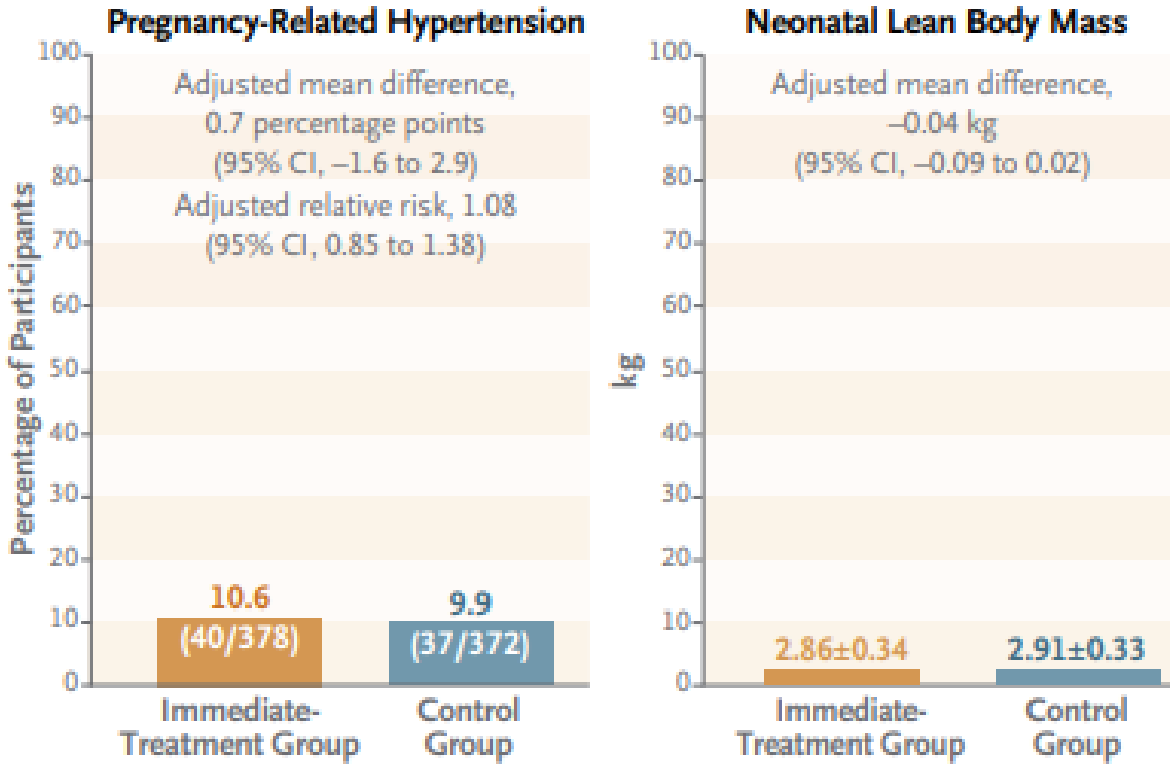
D. Simmons, J. Immanuel, W.M. Hague, H. Teede, C.J. Nolan, M.J. Peek, J.R. Flack, M. McLean, V. Wong, E. Hibbert, A. Kautzky-Willer, J. Harreiter, H. Backman, E. Gianatti, A. Sweeting, V. Mohan, J. Enticott, and N.W. Cheung, for the TOBOGM Research Group*

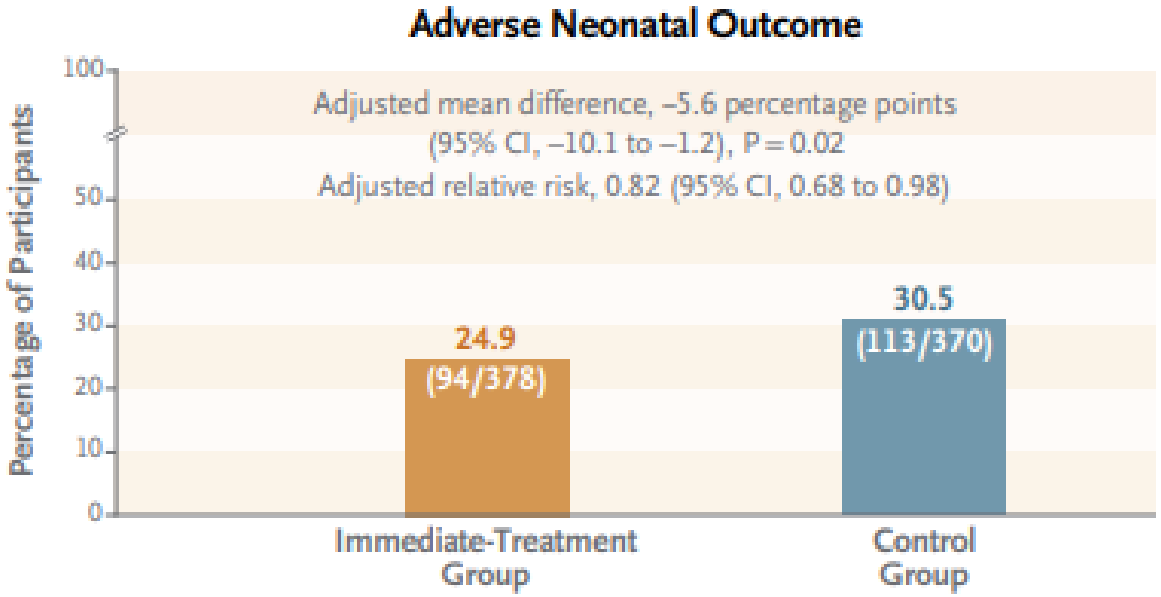


TOBOGM

3 Primary outcomes

- Hypertension/preeclampsia – no difference
- Neonatal lean mass – no difference
- Composite neonatal outcome – reduced in early intervention group



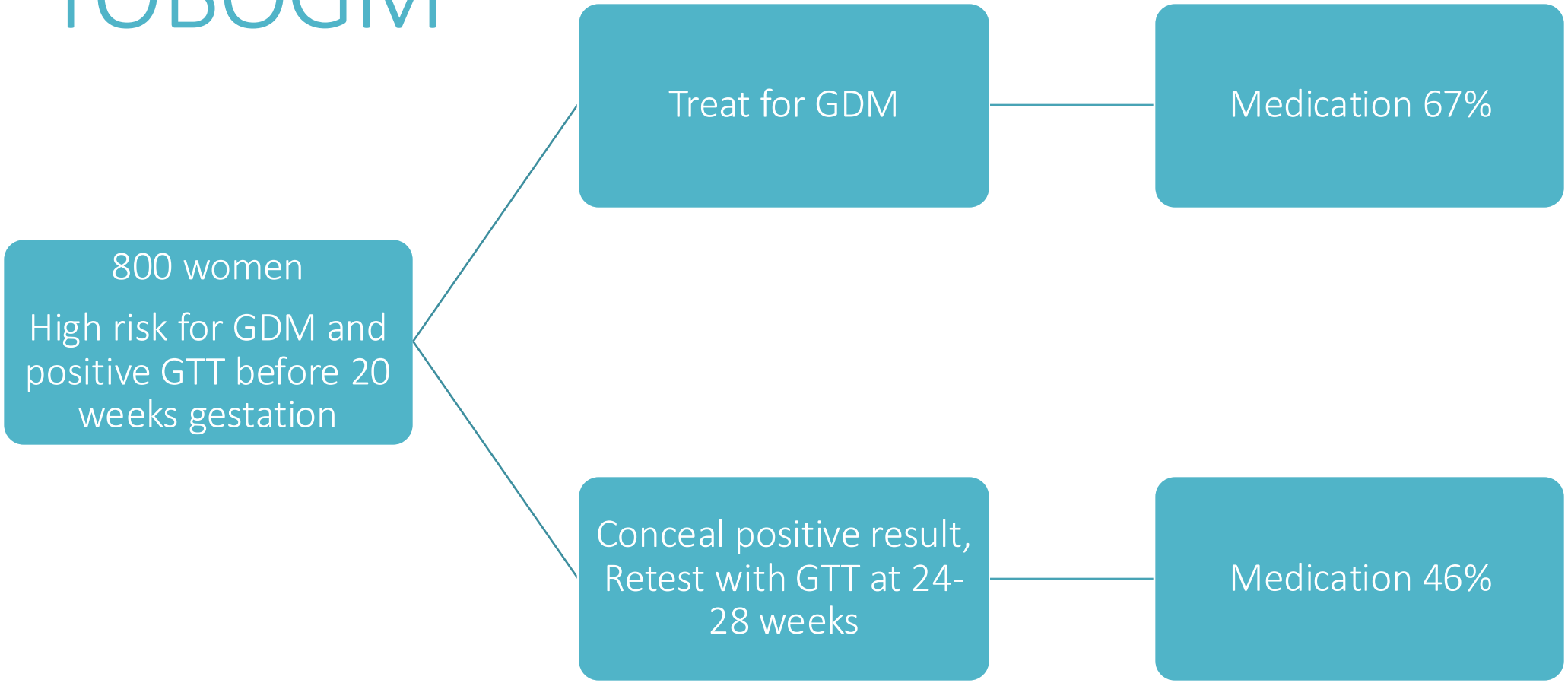


TOBOGM

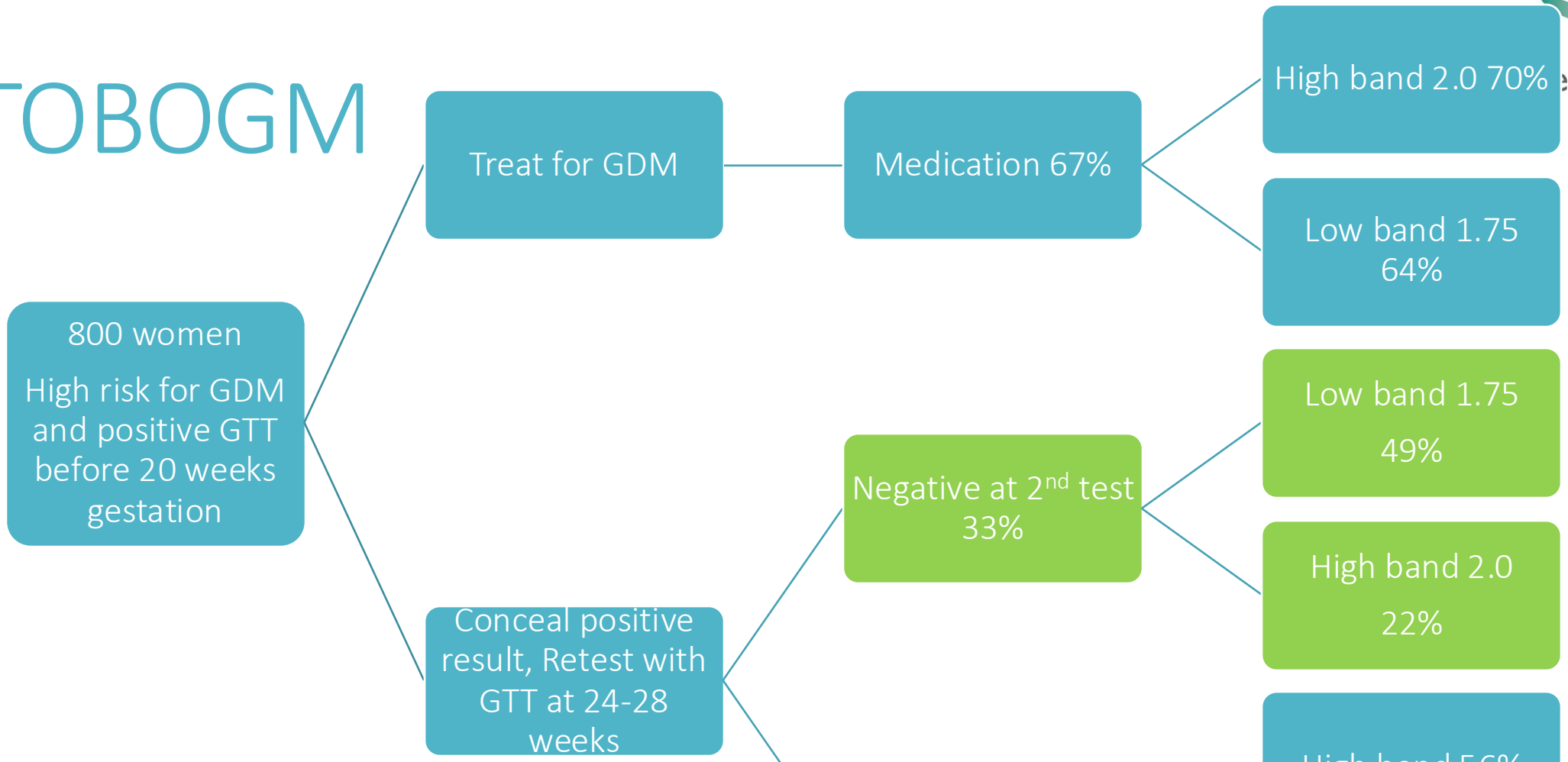
Outcome	Immediate Treatment (N=400)	Control (N=393)	Adjusted Treatment Effect†	
			Difference in Value (95% CI)	Relative Risk (95% CI)
Components of Primary Adverse Neonatal Outcome				
Preterm birth — no./total no. (%)‡	28/377 (7.4)	31/369 (8.4)	−1 (−4 to 2)	0.89 (0.63 to 1.26)
Birth weight ≥4500 g — no./total no. (%)	2/377 (0.5)	6/369 (1.6)	NR	NR
Birth trauma — no./total no. (%)§	3/374 (0.8)	5/367 (1.4)	−0.4 (−1 to 0.2)	0.59 (0.24 to 1.43)
Neonatal respiratory distress — no./total no. (%)	37/376 (9.8)	62/365 (17.0)	−7 (−12 to −3)	0.57 (0.41 to 0.79)
Phototherapy — no./total no. (%)	44/374 (11.8)	42/358 (11.7)	0 (−1 to 1)	0.99 (0.87 to 1.13)
		2/370 (0.5)	NR	NR
		11/367 (3.0)	−1 (−2 to 1)	0.77 (0.40 to 1.48)
		74/368 (20.1)	1 (−4 to 5)	1.04 (0.86 to 1.27)
		72/368 (19.6)	−0.5 (−6 to 5)	0.98 (0.76 to 1.25)
		9/371 (2.4)	1 (−0 to 2)	1.32 (0.90 to 1.94)
		30/372 (8.1)	0.2 (−1 to 1)	1.03 (0.85 to 1.24)
unit — mm Hg				
Systolic	121±15	121±14	1.0 (−1.0 to 2.9)	NA
Diastolic	75±10	75±10	0.5 (−1.1 to 2.1)	NA
Other Neonatal outcomes**				
Female sex — no./total no. (%)	179/377 (47.5)	180/368 (48.9)		NA
Weeks of gestation at birth	38.2±1.8	38.3±2.0	−0.1 (−0.3 to 0.2)	NA
Median birth-weight percentile (IQR)††	52 (27 to 81)	55 (30 to 85)	−3.0 (−7.9 to 0.1)	NA
Median no. of bed days in neonatal special care nursery or neonatal ICU‡‡	2.0 (0.3 to 4.8)	2.0 (1.0 to 6.0)	−0.8 (−1.3 to −0.3)	0.60 (0.41 to 0.89)

No difference need for SCN/NICU admission
No difference birthweight, IOL, Cesarean section
Reduction severe perineal tear
More insulin
More health care utilisation

TOBOGM


800 women
High risk for GDM and positive GTT before 20 weeks gestation
Treat for GDM
Medication 67%
Conceal positive result, Retest with GTT at 24-28 weeks
Medication 46%

TOBOGM


800 women
High risk for GDM and positive GTT before 20 weeks gestation
Treat for GDM
Medication 67%
High band 2.0 70%
Low band 1.75 64%
Conceal positive result, Retest with GTT at 24-28 weeks
Negative at 2nd test 33%
Low band 1.75 49%
High band 2.0 22%
Medication 46%
High band 56%
Low band 31%

Other options to early testing for GDM

	OR for diabetes diagnosed at 24- 28 weeks	Absolute risk
Previous GDM	8-21	50%
Age	2-5	
Ethnicity*	2	
FH GDM	2-3	
BMI	5	
Previous macrosomia	2-4	
PCOS	2-3	

Sweeting Lancet 2024
*AIHW Diabetes 2024

Current ADIPS diagnostic pathway	Proposed ADIPS diagnostic pathway
	HbA1c for women with risk factors for diabetes to diagnose T2DM
Early GTT for women with risk factors for diabetes	Early GTT preferably 10-14 weeks for women with previous GDM or Hb A1c 6-6.4
75gm OGTT for everyone at 24-28 weeks	75gm OGTT for everyone at 24-28 weeks
Diagnose as GDM if 5.1/10.0/8.5	Diagnose as GDM if 5.3/10.5/9.0

Other guidelines

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Country	Early for GDM	Early for T2DM	24-28	reference
USA	No	Consider OGTT or Hba1c if risk factors	2 step with 50gm non fasting GCT and then 100gm 3 hour GTT	ACOG Obs & Gyn July 2024
UK	If prev GDM, OGTT 5.6/7.8 or HBGM		For risk factors only, OGTT 5.6/7.8	Diabetes in pregnancy: management from preconception to the postnatal period NICE 2020
India	Non fasting 2 hour 75gm – 7.8	Non fasting 2 hour 75gm – 7.8	Non fasting 2 hour 75gm – 7.8	Seshiah Int J Diabetes in Developing Countries 2023
Scotland	HbA1c	HbA1c	75gm OGTT 5.3/10.6/9	
Canada	If multiple risk factors, 2 step GCT then 75gm GTT 5.3/10.6/9/0		2 step GCT then 75gm GTT 5.3/10.6/9/0	Guideline No. 393-Diabetes in Pregnancy Berger. JOGC ,2020; 41; 1814
New Zealand	*Universal HbA1c*		*75gm GTT 5.3/??*	*NZSSD*

Other options to early testing for GDM

HbA1c

STRiDE/PRiDE
India/Kenya/UK
rule in rule out test for late GDM
- FPG and HbA1c before 16 weeks
- GTT at 24-28 weeks
- reduce number having GTT by 50%

Diagnose Type 2
Convenient
Medicare rebate in Australia, long term use in NZ
Not useful for diagnosing GDM

Early pregnancy HbA_{1c} as the first screening test for gestational diabetes: results from three prospective cohorts

Ponnusamy Saravanan, Mohan Deepa, Zain Ahmed, Uma Ram, Tarakeswari Surapaneni*, Sailaja Devi Kallur, Papa Desari*, Seshadri Suresh, Ranjit Mohan Anjana, Wesley Hannah, Chockalingam Shivashri, Saite Hemavathy, Nithya Sukumar, Wycliffe K Kosgei, Astrid Christoffersen-Deb*, Vincent Kibet, John N Hector, Gertrude Anusu, Nigel Stallard, Yonas Ghebremichael-Weldeselassie, Norman Waugh, Sonak D Pastakia*, Viswanathan Mohan**

Saravanan Lancet Diab End 2024

CGM

no data on intervention, costs, resource equity

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JUNE 16, 2005 VOL. 352 NO. 24

Effect of Treatment of Gestational Diabetes Mellitus on Pregnancy Outcomes

Caroline A. Crowther, F.R.A.N.Z.C.O.G., Janet E. Hiller, Ph.D., John R. Moss, F.C.H.S.E., Andrew J. McPhee, F.R.A.C.P., William S. Jeffries, F.R.A.C.P., and Jeffrey S. Robinson, F.R.A.N.Z.C.O.G., for the Australian Carbohydrate Intolerance Study in Pregnant Women (ACHOIS) Trial Group*

ABSTRACT

GDM defined as GTT in women with risk factors or GCT
GDM if Fasting <7.8 or 2 hour 7.8-11
Insulin if 2> 5.5/7.0 (8 after 35 weeks)
20% on insulin

ORIGINAL ARTICLE

A Multicenter, Randomized Trial of Treatment for Mild Gestational Diabetes

Mark B. Landon, M.D., Catherine Y. Spong, M.D., Elizabeth Thom, Ph.D., Marshall W. Carpenter, M.D., Susan M. Ramin, M.D., Brian Casey, M.D., Ronald J. Wapner, M.D., Michael W. Varner, M.D., Dwight J. Rouse, M.D., John M. Thorp, Jr., M.D., Anthony Sciscione, D.O., Patrick Catalano, M.D., Margaret Harper, M.D., George Saade, M.D., Kristine Y. Lain, M.D., Yoram Sorokin, M.D., Alan M. Peaceman, M.D., Jorge E. Tolosa, M.D., M.S.C.E., and Garland B. Anderson, M.D., for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal–Fetal Medicine Units Network*

ABSTRACT

GDM defined as abnormal GCT
Then 5.3/10/8.6/7.8 after 100gm OGTT
Insulin if majority values were elevated
fasting 5.3 or
2-hour postprandial ≥6.7 mmol per liter
8% on insulin

Mercy Health
Care first

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GDM defined as GTT in women with risk factors or GCT
GDM if Fasting <7.8 or 2 hour 7.8-11
Insulin if 2> 5.5/7.0 (8 after 35 weeks)
20% on insulin

Less LGA, serious perinatal complications
More IOL, more SCN
No difference CS

The NEW ENGLAND JOURNAL of MEDICINE

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Insulin if majority values were elevated
fasting 5.3 or
2-hour postprandial ≥6.7 mmol per liter
8% on insulin

Less LGA
Less weight gain
No difference CS or IOL
No difference perinatal composite

Mercy Health
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The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 AUGUST 18, 2022 VOL. 387 NO. 7

Lower versus Higher Glycemic Criteria for Diagnosis of Gestational Diabetes

Caroline A. Crowther, M.D., Deborah Samuel, B.Ed., Lesley M.E. McCowan, M.D., Richard Edlin, Ph.D., Thach Tran, Ph.D., and Christopher J. McKinlay, Ph.D., for the GEMS Trial Group*

AB

BACKGROUND

Treatment of gestational diabetes improves maternal a
diagnostic criteria remain unclear.

METHODS

We randomly assigned women at 24 to 32 weeks' ge
evaluated for gestational diabetes with the use of lowe
for diagnosis. The lower glycemic criterion was a fast
at least 92 mg per deciliter (≥5.1 mmol per liter), a 1-h

	Lower cohort	Higher cohort
Rate of GDM	15.3%	6.1%
LGA	8.8%	8.9%
IOL, medication, use of health services, neonatal hypoglycaemia	higher	lower
C section, preeclampsia	No difference	

4000 women randomised to diagnostic criteria for GDM after 75g GTT of >=5.1/>=8.5 or >=5.5/>=9.0

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 AUGUST 18, 2022 VOL. 387 NO. 7

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Mercy Health

Care first

Subgroup analysis – women with blood sugars between lower (195 women) and higher range (175 women)

	Treated	Not treated
LGA*	12 (6.2)	32 (18.0)
Composite perinatal outcome*	1 (0.5%)	7 (3.9%)
SGA customised	26 (13.3)	16 (9.0)
SGA uncustomised*	19 (9.7)	7 (3.9)
preeclampsia	1 (0.5)	10 (5.6)
Caesarean section	77 (39.5)	86 (48.3)
insulin/metformin*	124 (63.6)	4 (2.3)
Gestational age*	38.8 ±1.0	39.1 ±1.6

4000 women randomised to diagnostic criteria for GDM after 75g GTT of >=5.1/>=8.5 or >=5.5/>=9.0

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 MARCH 11, 2021 VOL. 384 NO. 10

A Pragmatic, Randomized Clinical Trial of Gestational Diabetes Screening

Teresa A. Hillier, M.D., Kathryn L. Pedula, M.S., Keith K. Ogasawara, M.D., Kimberly K. Vesco, M.D., M.P.H., Caryn E.S. Oshiro, Ph.D., Suzanne L. Lubarsky, M.D., and Jan Van Marter, M.P.A., R.N.

ABSTRACT

BACKGROUND

Gestational diabetes mellitus is common and is associated with an increased risk of adverse maternal and perinatal outcomes. Although experts recommend universal screening for gestational diabetes, consensus is lacking about which of two recommended screening approaches should be used.

METHODS

We performed a pragmatic, randomized trial comparing one-step screening (i.e., a glucose-tolerance test in which the blood glucose level was obtained after the oral administration of a 75-g glucose load in the fasting state) with two-step screening (a glucose challenge test in which the blood glucose level was obtained after the oral administration of a 50-g glucose load in the nonfasting state, followed.

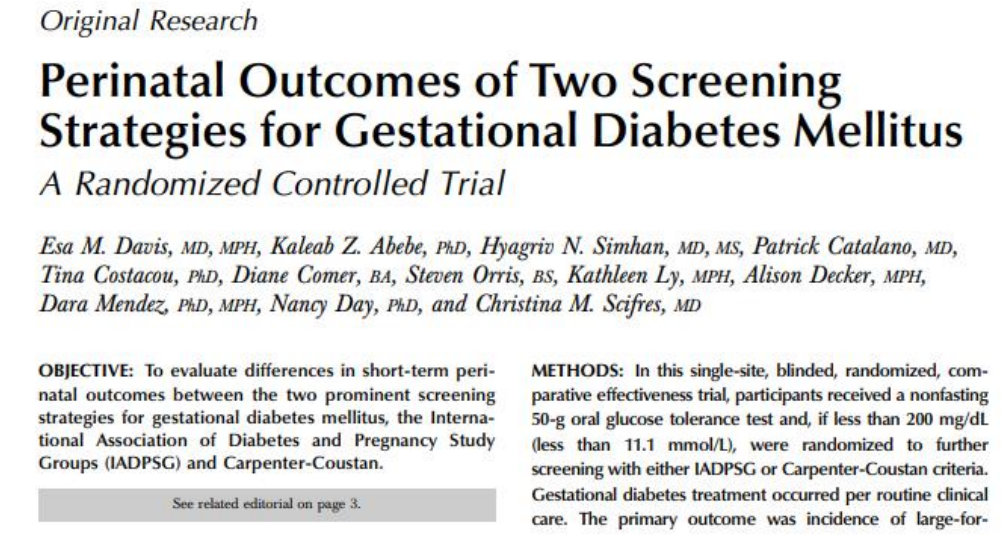
From the Center for Health Research, Kaiser Permanente Northwest (T.A.H., K.L.P., K.K.V., J.V.M.), and the Division of Perinatology, Department of Obstetrics and Gynecology, Northwest Permanente, Kaiser Permanente (S.L.L.), Portland, Oregon; and the Center for Integrated Health Care Research (T.A.H., C.E.S.O.) and the Division of Perinatology, Department of Obstetrics and Gynecology (K.K.O.), Hawaii Permanente Medical Group (K.L.P., K.K.O.), Kaiser Permanente Hawaii, Honolulu. Address reprint requests to Dr. Hillier

1016 women randomised to 1 step or 2 step
GDM 14% vs 4.5%
No difference in LGA, SGA, caesarean section
Increase neonatal composite in 1 step
Davis Obs Gyn 2021

Mercy Health
Care first

23,792 women randomised to
1 step (2 hour 75gm OGTT 5.1/10/8.5)
or
2 step GCT (>=7.2) and 3 hr 100gm OGTT screening (5.3/10/8.6/8.3 (any 2))
Hillier NEJM 2021

GDM 16.5% vs 8.5%
No difference LGA, perinatal composite, preeclampsia, primary caesarean section



Original Research

Perinatal Outcomes of Two Screening Strategies for Gestational Diabetes Mellitus

A Randomized Controlled Trial

Esa M. Davis, MD, MPH, Kaleab Z. Abebe, PhD, Hyagriv N. Simhan, MD, MS, Patrick Catalano, MD, Tina Costacou, PhD, Diane Comer, BA, Steven Orris, BS, Kathleen Ly, MPH, Alison Decker, MPH, Dara Mendez, PhD, MPH, Nancy Day, PhD, and Christina M. Scifres, MD

OBJECTIVE: To evaluate differences in short-term perinatal outcomes between the two prominent screening strategies for gestational diabetes mellitus, the International Association of Diabetes and Pregnancy Study Groups (IADPSG) and Carpenter-Coustan.

METHODS: In this single-site, blinded, randomized, comparative effectiveness trial, participants received a nonfasting 50-g oral glucose tolerance test and, if less than 200 mg/dL (less than 11.1 mmol/L), were randomized to further screening with either IADPSG or Carpenter-Coustan criteria. Gestational diabetes treatment occurred per routine clinical care. The primary outcome was incidence of large-for-

See related editorial on page 3.

Rademaker et al.
BMC Pregnancy and Childbirth (2025) 25:173
https://doi.org/10.1186/s12884-025-07230-x

BMC Pregnancy and Childbirth

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STUDY PROTOCOL Open Access

The TANGO-DM randomized controlled trial study protocol: treatment outcomes for gestational diabetes diagnosed according to WHO 2013 or WHO 1999 thresholds

Doortje Rademaker[1,2*†], Leon de Wit[3†], Anne van der Wel[1,2], Eline van den Akker[4], Babette Braams-Lisman[5], Remke Dullemond[6], Inge Evers[7], Sander Galjaard[8], Brenda Hermsen[5], Marion van Hoorn[9], Anjoke Huisjes[10], Joepe Kaandorp[3], Annemiek Lub[11], Simone Lunshof[12], Flip van der Made[13], Remco Nijman[14], Judith van Laar[15], Karlijn Vollebregt[16], Joost Velzel[17], Floortje Vlemmix[18], Michelle Westerhuis[19], Lia Wijnberger[20], Maurice Wouters[21], Joost Zwart[22], Judith Bosmans[23], Patrick Bossuyt[24], Ruben Duijnhoven[1], Enrico Lopriore[25], Esteriek de Miranda[1], Corine Verhoeven[1,15,26,27,28,29,30], Ben Willem Mol[31,32], Arie Franx[7], J. Hans DeVries[33], Bas van Rijn[15] and Rebecca Painter[8,21]

	WHO 2013	WHO 1999
Fasting glucose	≥ 5.1 mmol/l	< 7.0 mmol/l
1-hour glucose	≥ 10 mmol/l	
2-hour glucose	< 8.5 mmol/l	≥ 7.8 mmol/l

Summary

Blood glucose levels in pregnancy are on a continuum with outcomes

Treatment of GDM improves outcomes

Early diagnosis is of limited benefit

More inclusive strategies have higher rates of GDM and no *overall* benefit

More inclusive strategies may have both benefits and harms for women in lower glucose subgroups

Current ADIPS diagnostic pathway	Proposed ADIPS diagnostic pathway
	HbA1c for women with risk factors for diabetes to diagnose T2DM
Early GTT for women with risk factors for diabetes	Early GTT preferably 10-14 weeks for women with previous GDM or Hb A1c 6-6.4
75gm OGTT for everyone at 24-28 weeks	75gm OGTT for everyone at 24-28 weeks
Diagnose as GDM if 5.1/10.0/8.5	Diagnose as GDM if 5.3/10.5/9.0

Q&A

Dr Alexis Shub will now answer the questions placed in the Q&A box.

HealthPathways

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Session Conclusion

We value your feedback, let us know your thoughts.

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