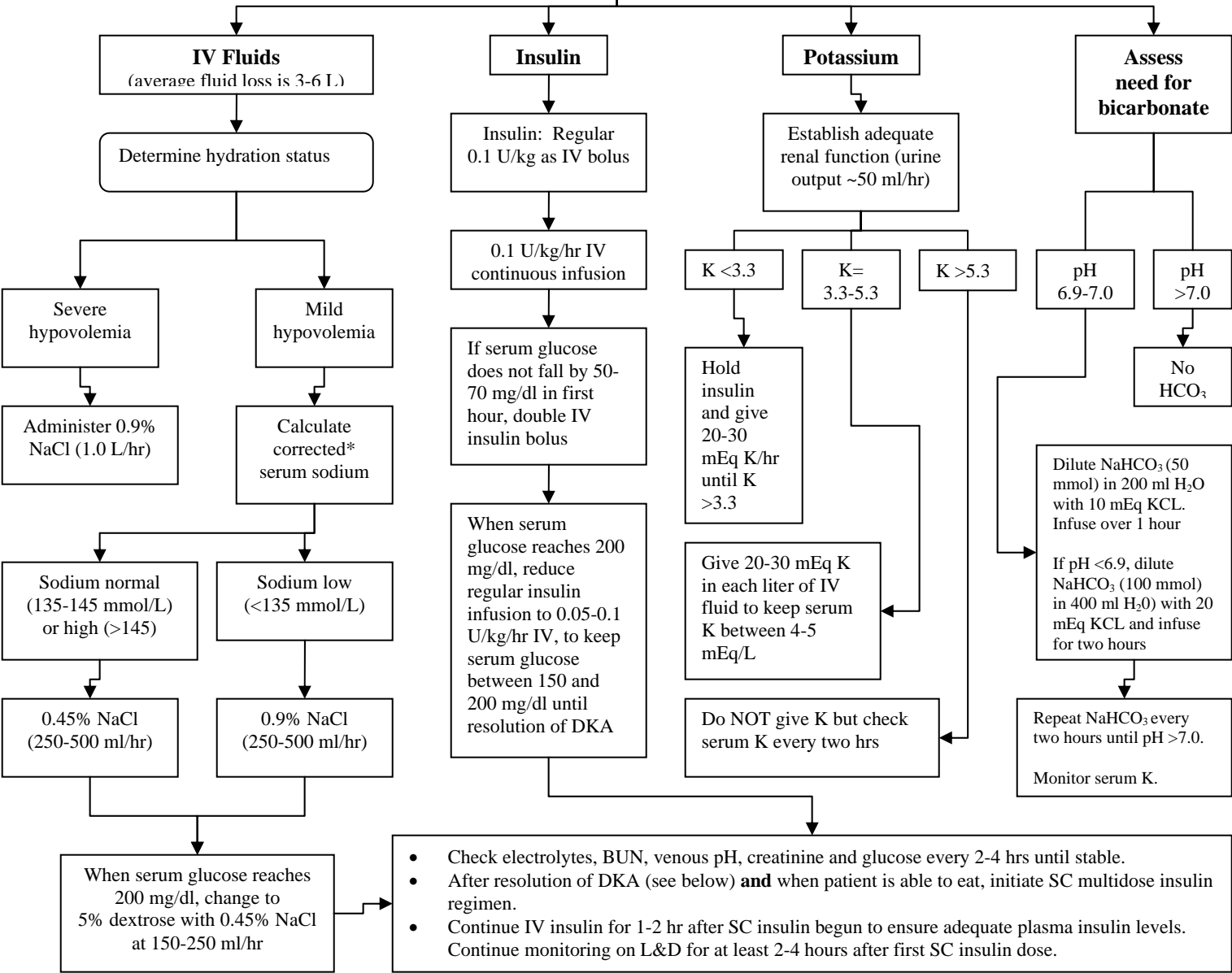


## Management of Diabetic Ketoacidosis in Pregnancy

Check capillary glucose and serum/urine ketones to confirm hyperglycemia and ketonemia/ketonuria.  
**Start IV fluids:** 1.0 L of 0.9% NaCl per hour. **Keep patient NPO.**  
**Use BETAMETHASONE WITH CAUTION and only with attending approval. AVOID Terbutaline.**

Continuous fetal monitoring until resolution of DKA as defined below.  
 DKA alone is generally NOT an indication for delivery. While fetal testing may be abnormal during acute DKA, fetal status should improve as the mother is treated

**STAT labs:** Arterial blood gas, CBC with diff, urinalysis, serum glucose, Na, Cl, K, HCO<sub>3</sub>, serum ketones, plasma osmolality, BUN, creatinine, and EKG. (Additional testing to search for precipitating event should be individualized and may include: cultures of urine and blood, serum lipase, and CXR).



**DKA diagnostic criteria:** Serum glucose >250 mg/dl, Arterial pH <7.3, Serum bicarbonate <18 mEq/l, and moderate ketonuria or ketonemia. DKA has been documented to occur at lower blood glucose levels during pregnancy (Cullen, 1996).

**Resolution of DKA:** Glucose <200 mg/dL, Anion gap <12 meq/L\*\*, Serum bicarb ≥18 meq/L, and Venous pH >7.3

\*Corrected serum sodium= Sodium + [ (glucose -100) / 100 ]

\*\*Anion gap= (Na + K) – (Cl + HCO<sub>3</sub>) (all units mmol/L)

## References

Adapted from UpToDate®. Kitabchi AE et al: Treatment of diabetic ketoacidosis and hyperosmolar hyperglycemic state in adults. Accessed 11/03/2008.

Cullen MT et al. Am J Perinatol 1996 Oct; 13(7): 449-51.

*Eleven episodes of DKA were diagnosed during the 10-year study period. Plasma glucose levels of less than 200 mg/dL were present in 4 of 11 patients (36%), 10 (90%) of whom presented with nausea, vomiting, and decreased caloric intake.*

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