Pre-existing Diabetes in Pregnancy

Complete baseline diabetes in pregnancy evaluation and nutrition assessment & education

Current insulin therapy

Fasting: 60-90 (<95)
Premeal: 60-105
1 hour post prandial < 140
2 hour post prandial < 120
2am-6am > 60

Review glucose log q 1-3 weeks
> 30% of values above upper range

Continue current medications, self blood glucose monitoring
Antenatal management of diabetes in pregnancy on medications

Insulin therapy

Convert oral medications to multiple daily dose insulin or initiate insulin if not well controlled

Initiate/continue insulin therapy and provide hypoglycemia education *
Multiple daily dosing superior to less frequent dosing; individualize dosing
- see Insulin/Medication Therapy Dosing

Adjust dose weekly
Typical dose adjustments are 10-20% of TDD
- if max oral agent dose achieved, convert to insulin
  - Antenatal management of diabetes in pregnancy on medications
  - continue SBGM

Hypoglycemia
- check blood glucose
- 15 gram CHO, repeat blood glucose in 15 minutes
- Unconscious
  - Glucagon 1 mg IM
  - repeat blood glucose in 15-20 min

Oral medications
No medications

Yes

Convert oral medications to multiple daily dose insulin or initiate insulin if not well controlled

* If well-controlled on metformin or glyburide, and unable or unwilling to utilize insulin, refer to Gestational Diabetes Medication Management Algorithm. Recommend conversion to insulin for all other oral hypoglycemic medications due to paucity of pregnancy-related data.

Suggested well controlled:
- Hgb A1c < 6.5 at conception
- >= 70% of self testing values in target range

No

Initiate/continue insulin therapy and provide hypoglycemia education *
Multiple daily dosing superior to less frequent dosing; individualize dosing
- see Insulin/Medication Therapy Dosing

No medications

Yes

Current insulin therapy

Remains on oral agents

Review glucose log q 1-3 weeks
> 30% of values above upper range

- Continue current medications, self blood glucose monitoring
- Antenatal management of diabetes in pregnancy on medications

No
These algorithms are designed to assist the primary care provider in the clinical management of a variety of problems that occur during pregnancy. They should not be interpreted as a standard of care, but instead represent guidelines for management. Variation in practices should take into account such factors as characteristics of the individual patient, health resources, and regional experience with diagnostic and therapeutic modalities.

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