## Implications

Universal screening for GD is hampered by the out-of-pocket costs of the 75-g OGTT. It also requires a trip to the hospital or a stand-alone laboratory where this test is available. The diagnosis of GD makes prenatal care more expensive because of the need for specialized care, blood sugar monitoring and other lab tests. Possible use of insulin, the only approved medication for diabetes in pregnancy, and the necessity of delivering in the hospital entail higher costs.

Expertise for gestational diabetes care is lacking with qualified physicians concentrated in urban centers. The primary care pathway for gestational diabetes has not been established.

Many women do not return for the recommended repeat 75-g OGTT or monitoring after giving birth.

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## Recommendations

The government must pay for the 75-g OGTT to screen for GD in pregnant Filipino women. Glucometer strips, additional laboratory tests like $HbA_{1c}$ and urine ketones and insulin should be funded as well. Currently, insulin is only covered by the Philhealth for inpatient but not outpatient use.

The management of women with GD requires specialized care. Local government units must establish a primary care pathway where these women can get access to a 75-g OGTT in their locality, be referred to specialists as needed, and deliver their babies in a hospital. After delivery, these women must be monitored closely by their local health centers. Community health workers should encourage them to return for a repeat 75-g OGTT and their annual tests.

### References


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# Support Universal Screening & A Primary Care Pathway for Women with Gestational Diabetes

World Diabetes Day 2017: Women & Diabetes

# Executive Summary

**Gestational diabetes (GD) begets diabetes** with both mother and baby at risk of developing diabetes in later life. During the pregnancy, women with GD have an increased risk of hypertension and Cesarean section as their infants become too big for a normal delivery. A missed diagnosis of GD can lead to death of the fetus or stillbirth.

Screening for GD requires the woman to undergo a blood test (75-g oral glucose tolerance test), which is only available at stand-alone laboratories or hospitals. GD makes prenatal care more expensive because of specialized care, blood sugar monitoring and other lab tests. Possible use of insulin, the only approved medication for diabetes in pregnancy, and the need for delivery in the hospital entail higher costs. Expertise for GD care is lacking with qualified physicians concentrated in urban centers. The primary care pathway for GD has not been established, which is crucial as these women need a specialized care team. Many women do not return for the recommended blood tests or monitoring after giving birth.

The government must fund screening and management of these high-risk women and infants. Local government units must establish a primary care pathway for proper management of women with GD, during and after pregnancy. We need to break the cycle of diabetes begetting diabetes.

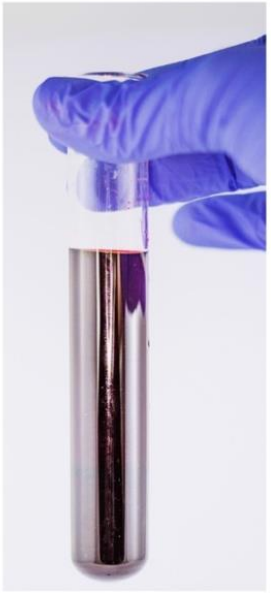
***Gestational diabetes refers to diabetes that is discovered while a woman is pregnant.***

# Introduction

Filipino women are at high risk to develop GD. The 1996 ASGODIP study[1] showed that 14% of pregnant Filipino women tested had GD, higher than 2010 prevalence estimate of 9.2% for the United States.[2]

Women with GD are likely to develop hypertension or preeclampsia. GD can recur in the next pregnancy. While GD can resolve after a woman delivers her baby, she still has a 35-60% risk of developing type 2 diabetes within ten years.[3] Later, these women may become overweight, hypertensive and have cholesterol problems. A missed diagnosis of GD can lead to death of the fetus or stillbirth. Infants of women with GD can weigh more than 8 lbs at term, putting them at risk for birth injuries and requiring Cesarean delivery. These infants may become overweight and develop diabetes themselves in later life.

**Screening and treatment of GD decreases risks for both mother and infant.** Women with GD should be followed up regularly after delivery.



# Approach

The 2011 clinical practice guideline of the UNITE for Diabetes Coalition recommends that **all Filipino women be screened for GD** during their pregnancy.[4] At the first prenatal visit, Filipino women should be evaluated for risk factors: GD in a prior pregnancy, presence of sugar in the urine, family history of diabetes, delivery of an infant weighing 8 lbs or more, age more than 25 years old, diagnosis of polycystic ovary syndrome, overweight before pregnancy, a big baby and too much amniotic fluid in the current pregnancy, and intake of drugs affecting blood sugar. Women with any of these risk factors are at high risk.

The **75-g oral glucose tolerance test** (OGTT) is the recommended screening test. High-risk women should undergo an OGTT at the soonest possible time. Low-risk women should undergo the OGTT at the 6th to 7th month of pregnancy. Testing for GD should still be done even beyond seven months, if missed.

Women with GD should be seen by a team of physicians (internal medicine/endocrinology/diabetology, pediatrics, obstetrics) experienced in their care. They will require biweekly to monthly follow up visits, self-monitoring of blood sugar with a glucometer and additional tests like $HbA_{1c}$ and urine ketones at intervals, on top of usual prenatal care. They may or may not require insulin to control their blood sugar levels. Delivery in a hospital is also necessary. After delivery, these women should undergo a repeat 75-g OGTT after 6-12 weeks to check if their blood sugar has gone back to normal. Another 75-g OGTT should be done after one year and at a minimum every three years thereafter. Their weight, blood pressure and cholesterol profile should also be monitored.