Gestational Diabetes and Polycose Test

The number of people diagnosed with Type 2 Diabetes Mellitus in New Zealand is increasing every year. People with diabetes have high blood sugar (glucose) levels. Insulin is needed for the transfer of glucose from the blood into the cells where it can be used for energy and growth or stored as fat. They will often have sugar in their urine as the body tries to lower the blood sugar levels by excreting it from the kidneys. Some women become diabetic in pregnancy (gestational diabetes), and this can have an effect on the mother and the baby.

Pregnancy hormones inhibit the effect of insulin to enable the mother's blood sugar to stay higher for a longer period, so that the baby gets glucose which they use to grow. Insulin requirements increase 1.5 – 2 times in pregnancy. Some women are not able to increase the amount of insulin they secrete, so their blood sugar takes longer to return to normal. This gives the baby an increased amount of glucose which enables it to grow larger than it otherwise would. Babies produce their own insulin to enable the glucose to transfer to their cells where it can be used.

The risk factors for developing gestational diabetes are:
Family history of Diabetes – type I and type II
Maternal Obesity – BMI over 30
Age- over 30 years
Sugar in the urine (glycosuria) on two or more occasions in current pregnancy
Previous gestational diabetes, large baby, unexplained still birth or Neonatal death
Multiple pregnancy
Smoking
History of Polycystic ovarian syndrome
Ethnicity: People of Maori, Pacific Island, Asian and Indian descent all have increased risk.

Most women do not show any symptoms of having gestational diabetes. Some of the symptoms that a woman may exhibit include: increased thirst, increased urination, fatigue, nausea, vomiting, bladder infection, thrush, and blurred vision.

At booking as part of your antenatal blood screen we check your HbA1c level and this tells us if your blood sugars have been raised in the previous three months and would alert us that you may have undiagnosed diabetes prior to becoming pregnant. If within normal levels we then offer a Polycose test which is a screening test at around 28 weeks gestation. It involves going to the lab, having a drink of glucose and waiting an hour before a blood test is taken to measure the blood glucose (sugar). If the level is above 7.8 mmol/l it is recommended that a Glucose Tolerance Test (GTT) be done. If a woman has an increased risk of becoming diabetic (see above) she may be asked to have a GTT without first having a polycose screening test. The GTT is a diagnostic test it checks your fasting blood sugar and the blood sugar 2 hours after the glucose drink and if either are high the diagnosis of gestational diabetes is made. Your midwife will then refer you to the Diabetic Educators who will arrange for you to test your blood sugars and make a plan.

So you have Gestational Diabetes

Once you have been diagnosed as having gestational diabetes, you LMC will refer you to the Diabetic educator and the Dietician. Most women are able to control their blood sugars using diet and exercise. Occasionally some women will have to use insulin to control their blood sugars.

The Diabetic educator will discuss your diet with you and will teach you how and when to measure your blood sugars and keep a record of them. You will have regular visits with the educator to check your blood sugars and she will refer you on to see the medical consultant if necessary.

The Dietician will discuss your diet and give you some advice on what and how to eat to keep your blood sugars within the normal range.

Once the baby is born your blood sugars will most likely return to normal. A repeat Hba1c is done around three months after the baby is born to check it is normal again.

Having gestational diabetes does increase your risk of getting type II Diabetes in later life.

It is recommended that you have an Hba1c done annually for the rest of your life following a diagnosis of gestational diabetes.