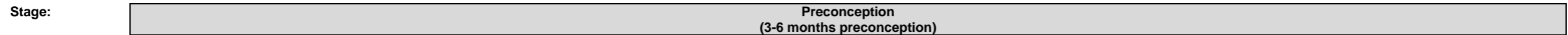


Waterloo-Wellington Diabetes and Pregnancy Clinical Pathway

This pathway was created to support a consistent standard of care for all women with diabetes and pregnancy throughout the region. It recognizes a multidisciplinary approach and offers details of care and education from preconception to post-partum, based on the 2018 CDA Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada. This pathway is to be used as a guideline and does not replace clinical judgment.



Preconception	<p>Activities: Referrals</p> <p>Referral to Waterloo Wellington Diabetes Central Intake* Ophthalmologic assessment (Retinal Eye Exam) Consider referral to nephrologist if:</p> <ul style="list-style-type: none"> serum creatinine ≥ 100 $\mu\text{mol/L}$ or eGFR < 60 mL/min or urine ACR ≥ 2.0 mg/mmol eGFR 60-100 mL/min requires close monitoring 	<p>Activities: Referrals</p> <p>Referral to Waterloo Wellington Diabetes Central Intake* Ophthalmologic assessment (Retinal Eye Exam) Consider referral to nephrologist if:</p> <ul style="list-style-type: none"> serum creatinine ≥ 100 $\mu\text{mol/L}$ or eGFR < 60 mL/min or urine ACR ≥ 2.0 mg/mmol eGFR 60-100 mL/min requires close monitoring 	<p>High Risk for Gestational Diabetes</p> <ul style="list-style-type: none"> Previous diagnosis of GDM Prediabetes Ethnicity (Aboriginal, Hispanic, South Asian, Asian, African) BMI ≥ 30 kg/m² Age ≥ 35 years PCOS Acanthosis nigricans Corticosteroid use History of macrosomic infant (> 9 lbs) 	<p>Activities: Referrals</p> <p>Referral to Waterloo Wellington Diabetes Central Intake* (if diagnosed with prediabetes, at risk for diabetes or previous gestational diabetes)</p>
	<p>Tests</p> <p>A1C, FBS, creatinine, eGFR, uric acid, ALT, AST, bilirubin, thiamine, vitamin B12, ferritin, CBC Urine ACR Thyroid Screening If abnormal thyroid, repeat tests every 4 weeks Lipid profile Lab/meter correlation SMBG ac meals and hs (more frequently if needed) Consider use of Continuous Glucose Monitor (CGM)/Flash glucose monitor</p>	<p>Tests</p> <p>A1C, FBS, creatinine, eGFR, uric acid, ALT, AST, bilirubin, thiamine, vitamin B12, ferritin, CBC Urine ACR Lipid profile SMBG ac meals and hs (more frequently if needed) Consider use of Continuous Glucose Monitor (CGM)/Flash glucose monitor</p>	<p>Tests</p> <p>A1C, FBS, creatinine, uric acid, ALT, AST, bilirubin, thiamine, vitamin B12, ferritin, CBC Thyroid Screening -If abnormal thyroid, repeat tests every 4 weeks Diabetes Screening- 2 hour 75 gm OGTT</p> <ul style="list-style-type: none"> Dx. of diabetes is confirmed if: <ul style="list-style-type: none"> FPG ≥ 7.0 mmol/L 2hPG ≥ 11.0 mmol/L A1c ≥ 6.5 	<p>Tests</p> <p>A1C, FBS, creatinine, uric acid, ALT, AST, bilirubin, thiamine, vitamin B12, ferritin, CBC Thyroid Screening -If abnormal thyroid, repeat tests every 4 weeks Diabetes Screening- 2 hour 75 gm OGTT</p> <ul style="list-style-type: none"> Dx. of diabetes is confirmed if: <ul style="list-style-type: none"> FPG ≥ 7.0 mmol/L 2hPG ≥ 11.0 mmol/L A1c ≥ 6.5
	<p>Targets</p> <p>A1C $\leq 7\%$ ($\leq 6.5\%$ if can safely be achieved) BP $< 130/85$ BG: 4-7 mmol/L FPG or preprandial PG 5-10 mmol/L 2 hours postprandial PG</p>	<p>Targets</p> <p>A1C ≤ 7.0 ($\leq 6.5\%$ if can safely be achieved) BP $< 130/85$ BG: 4-7 mmol/L FPG or preprandial PG 5-10 mmol/L 2 hours postprandial PG</p>	<p>Targets</p> <p>A1C $< 5.5\%$ Normal BP FBS < 5.6 mmol/L 2hr BG < 7.8 mmol/L</p>	<p>Targets</p> <p>A1C $< 5.5\%$ Normal BP FBS < 5.6 mmol/L 2hr BG < 7.8 mmol/L</p>
	<p>Treatment</p> <p>Encourage reliable contraception until optimal glycemic control Ensure appropriate vaccinations have occurred Basal bolus insulin injections or insulin pump Prenatal Multivitamin (MV) containing 1.0 mg Folic Acid & 400-4000 IU Vitamin D Measurement of RBC Folate may be useful to guide dosage of folic acid in women with obesity or who have had bariatric surgery</p> <p>Stop ACE inhibitors and ARBs (continuation may be considered in case of significant diabetic nephropathy to prevent progression, but must be stopped at dx of pregnancy) Consider CCBs, BB, labetalol, and methyldopa Stop Statins, Fibrates and Niacin</p>	<p>Treatment</p> <p>Encourage reliable contraception until optimal glycemic control Ensure appropriate vaccinations have occurred Prenatal Multivitamin (MV) containing 1.0 mg Folic Acid & 400-4000 IU Vitamin D Measurement of RBC Folate may be useful to guide dosage of folic acid in women with obesity or who have had bariatric surgery</p> <p>Stop oral diabetes agents Initiate insulin therapy Calculate Total Daily Dose 0.3-0.5 units/kg 40% Basal (Detemir, Glargine, NPH) at bedtime 60% Bolus divided between 3 meals (Aspart, Lispro, Glulisine) <i>*this is a starting dose, increase aggressively to reach target</i> Maintain Metformin if PCOS Stop ACE inhibitors and ARBs Consider CCBs, BB, labetalol, and methyldopa Stop Statins, Fibrates and Niacin</p>	<p>Treatment</p> <p>Ensure appropriate vaccinations have occurred Prenatal Multivitamin (MV) containing 0.4 mg Folic Acid & 400-4000 IU VD Measurement of RBC Folate may be useful to guide dosage of folic acid in women with obesity or who have had bariatric surgery</p>	<p>Treatment</p> <p>Ensure appropriate vaccinations have occurred Prenatal Multivitamin (MV) containing 0.4 mg Folic Acid & 400-4000 IU VD Measurement of RBC Folate may be useful to guide dosage of folic acid in women with obesity or who have had bariatric surgery</p>

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Preconception	Teach	<p>Identify hypoglycemia unawareness and Rx for Glucagon/Baqsimi</p> <p>Encourage optimal control 3 months prior to conception Reinforce healthy lifestyle including nutrition and exercise Review self-care practices Assess carb/insulin ratio knowledge and ability Discuss:</p> <ul style="list-style-type: none"> • Self-monitoring of BG QID (ac meals and hs) • Importance of maintaining glycemic targets • Importance of regular visits • Avoiding DKA (low level ketosis is normal in pregnancy) <p>Assess the need for social/financial support during pregnancy</p>	<p>Encourage optimal control 3 months prior to conception Encourage healthy weight reduction if BMI >29 Reinforce healthy lifestyle including nutrition and importance of exercise in reducing insulin resistance Discuss:</p> <ul style="list-style-type: none"> • Importance of maintaining glycemic targets • Importance of regular visits <p>Review current therapy and reason for switching to insulin therapy for the duration of their pregnancy Teach insulin administration Assess the need for social/financial support during pregnancy</p>	<p>Reinforce healthy lifestyle including nutrition and importance of exercise in reducing insulin resistance Encourage healthy weight reduction if BMI >29 Risks for Type 2 diabetes</p>
	Frequency of Visits to DEP team	Monthly	Monthly	As needed
	Supporting Documents	"A Record of my Journey with Pregnancy and Diabetes"	"A Record of my Journey with Pregnancy and Diabetes"	"A Record of my Journey with Pregnancy and Diabetes"

Stage: 1st Trimester (1-12 weeks)

1st Trimester	Activities: Referrals	<p>If not already done: Referral to Waterloo Wellington Diabetes Central Intake* Ophthalmologic assessment (Retinal Eye Exam) Obstetrician Consider referral to nephrologist if:</p> <ul style="list-style-type: none"> • serum creatinine \geq100 umol/L or • urine ACR \geq2.0 mg/mmol • Pre-conception eGFR <60 mL/min 	<p>If not already done: Referral to Waterloo Wellington Diabetes Central Intake* Ophthalmologic assessment (Retinal Eye Exam) Obstetrician Consider referral to nephrologist if:</p> <ul style="list-style-type: none"> • serum creatinine \geq100 umol/L • urine ACR \geq2.0 mg/mmol • Pre-conception eGFR <60 mL/min 	<p>Referral to Waterloo Wellington Diabetes Central Intake* at 10 to 12 weeks' gestation for women with previous gestational diabetes</p>
	Tests	<p>Confirm viability of pregnancy and gestational age A1C (more often if there is concern), FBS, creatinine, uric acid, ALT, AST, bilirubin, triglycerides, thiamine, vitamin B12, ferritin, CBC Urine ACR Thyroid Screening - If abnormal, repeat tests every 4 weeks Repeat retinal eye exam Self-monitoring of blood glucose: 4-7x/day, ac and 1 hr pc meals, hs and occasionally during night CGM should be offered</p>	<p>Confirm viability of pregnancy and gestational age A1C (more often if there is concern), FBS, creatinine, uric acid, ALT, AST, bilirubin, triglycerides, thiamine, vitamin B12, ferritin, CBC Urine ACR Thyroid Screening - If abnormal, repeat tests every 4 weeks Repeat retinal eye exam Self-monitoring of blood glucose 4-7x/day, ac and 1 hr pc meals, hs and occasionally during night (if on insulin) CGM should be offered</p>	<p>2-hour 75g OGTT if high risk and not previously done</p> <ul style="list-style-type: none"> • Dx. of GDM with one elevated value <ul style="list-style-type: none"> FPG \geq5.1 mmol/L 1hPG \geq10.0 mmol/L 2hPG \geq8.5 mmol/L <p>A1C, FBS, creatinine, uric acid, ALT, AST, bilirubin, triglycerides, thiamine, vitamin B12, ferritin, CBC Thyroid Screening- If abnormal, repeat tests every 4 weeks Start self-monitoring of blood glucose fasting and 1 hr pc meals 2 to 3 days/week</p>
	Targets	<p>A1C <6.5% (ideally <6.1% if can safely be achieved) Time in Range (TIR) >70%, Time Below Range (TBR) <4%, Time Above Range (TAR) <25% BP <130/85 FBS and Preprandial BG: <5.3 mmol/L 1 hr postprandial BG: <7.8 mmol/L 2 hr postprandial BG: <6.7 mmol/L (Be prepared to raise these targets if needed because of the increased risk of severe hypoglycemia) Manage gestational weight gain as per Institute of Medicine (IOM) guidelines</p>	<p>A1C <6.5% (ideally <6.1% if can safely be achieved) BP <130/85 FBS and Preprandial BG: <5.3 mmol/L 1 hr postprandial BG: <7.8 mmol/L 2 hr postprandial BG: <6.7 mmol/L Manage gestational weight gain as per Institute of Medicine (IOM) guidelines</p>	<p>A1C <5.5% Normal BP FBS and Preprandial BG: <5.3 mmol/L 1 hr postprandial BG: <7.8 mmol/L 2 hr postprandial BG: <6.7 mmol/L Manage gestational weight gain as per Institute of Medicine (IOM) guidelines</p>
	Treatment	Prenatal MV containing: 1mg Folic acid & 400-4000 IU VD	Prenatal MV containing 1 mg Folic & 400-4000 IU VD Basal Bolus Insulin injections or Insulin Pump	Prenatal MV containing 0.4mg folic acid & 400-4000 IU VD

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1 st Trimester	<p>Teach</p> <p>Basal Bolus Insulin injections or Insulin Pump (Aspart, lispro, glulisine, detemir/glargine)</p> <p>Explain changing insulin requirements during pregnancy and high risk of hypoglycemia during 1st trimester Identify possible hypoglycemia unawareness Teach partner glucagon/Baqsimi Ketone testing Assess the need for social/financial support during pregnancy</p>	<p>Initiate insulin therapy if not previously done: Calculate Total Daily Dose 0.3-0.5 units/kg 40% Basal (Detemir, Glargine, NPH) 60% Bolus divided between 3 meals (Aspart, Lispro, glulisine) <i>*this is a starting dose, increase aggressively to reach target</i></p> <p>Explain increasing insulin resistance during pregnancy requiring frequent adjustments Reinforce healthy lifestyle including nutrition and exercise Importance of maintaining glycemic targets Importance of regular visits Review current therapy and initiate insulin therapy if not already done Assess the need for social/financial support during pregnancy</p>	<p>Explain risk of developing GDM if previously diagnosed Review increasing insulin resistance during pregnancy and importance of occasional monitoring early in pregnancy Reinforce healthy lifestyle including nutrition and exercise Assess the need for social/financial support during pregnancy</p>	
	<p>Frequency of Visits</p> <p>Monthly</p>	<p>Monthly</p>	<p>As required</p>	
1 st Trimester	<p>Supporting Documents</p> <p>“A Record of My Journey with Pregnancy and Diabetes”</p>	<p>“A Record of My Journey with Pregnancy and Diabetes”</p>	<p>“A Record of My Journey with Pregnancy and Diabetes”</p>	
Stage	2 nd Trimester (13-27 weeks)			
2 nd Trimester	<p>Activities: Referrals</p> <p>Consider referral to nephrologist if:</p> <ul style="list-style-type: none"> serum creatinine \geq 100 μmol/L or urine ACR \geq2.0 mg/mmol 	<p>Obstetrician if not already done Consider referral to nephrologist if:</p> <ul style="list-style-type: none"> serum creatinine \geq 100 μmol/L or urine ACR \geq2.0 mg/mmol 	<p>If diagnosed with GDM: Referral to Waterloo Wellington Diabetes Central Intake*</p>	<p>If not already done, referral to Waterloo Wellington Diabetes Central Intake*</p>
	<p>Tests</p> <p>Repeat retinal eye exam if required A1C, creatinine Urine ACR Thyroid Screening - If abnormal, repeat tests every 4 weeks Self-monitoring of blood glucose ac and 1 hr pc meals, hs and occasionally during night Continuous glucose monitoring should be offered</p>	<p>Repeat retinal eye exam if required A1C, creatinine Urine ACR Thyroid Screening - If abnormal, repeat tests every 4 weeks Self-monitoring of blood glucose ac and 1 hr pc meals and hs and occasionally during night (if on insulin) Continuous glucose monitoring should be offered</p>	<p>75 gm OGTT test at 24-28 week Dx. of GDM with one elevated value FPG \geq5.1 mmol/L 1hPG \geq10.0 mmol/L 2hPG \geq8.5 mmol/L Self-monitoring of blood glucose fasting and 1 hr pc meals If on insulin, self-monitoring of blood glucose ac and 1 hr pc meals Thyroid Screening - If abnormal, repeat tests every 4 weeks</p>	<p>If 1st trimester OGTT is normal, repeat 75 gm OGTT @ 24-28 weeks Dx. of GDM with one elevated value FPG \geq5.1 mmol/L 1hPG \geq10.0 mmol/L 2hPG \geq8.5 mmol/L Self-monitoring of blood glucose fasting and 1 hr pc meals If on insulin, self-monitoring of blood glucose ac and 1 hr pc meals Thyroid Screening - If abnormal, repeat tests every 4 weeks</p>
	<p>Targets</p> <p>A1C \leq6.5% (ideally \leq6.1% if can safely be achieved) TIR $>$70%, TBR $<$4%, TAR $<$25% BP $<$130/85 FBS and Preprandial BG: $<$5.3 mmol/L 1 hr postprandial BG: $<$7.8 mmol/L 2 hr postprandial BG: $<$6.7 mmol/L (Be prepared to raise these targets if needed because of the increased risk of severe hypoglycemia) Manage gestational weight gain as per IOM guidelines</p>	<p>A1C \leq6.5% (ideally \leq6.1% if can safely be achieved) BP $<$130/85 FBS and Preprandial BG: $<$5.3 mmol/L 1 hr postprandial BG: $<$7.8 mmol/L 2 hr postprandial BG: $<$6.7 mmol/L Manage gestational weight gain as per IOM guidelines</p>	<p>BP $<$130/80 FBS and Preprandial BG: $<$5.3 mmol/L 1 hr postprandial BG: $<$7.8 mmol/L 2 hr postprandial BG: $<$6.7 mmol/L Manage gestational weight gain as per IOM guidelines</p>	<p>BP $<$130/80 FBS and Preprandial BG: $<$5.3 mmol/L 1 hr postprandial BG: $<$7.8 mmol/L 2 hr postprandial BG: $<$6.7 mmol/L Manage gestational weight gain as per IOM guidelines</p>
	<p>Treatment</p> <p>Prenatal MV with 0.4 to 1.0 mg Folic Acid & 400-4000 IU VD Basal Bolus Insulin injections or Insulin Pump Aspirin 81 mg for the prevention of preeclampsia</p>	<p>Prenatal MV with 0.4 to 1.0 mg Folic Acid & 400-4000 IU VD Basal Bolus Insulin injections or Insulin Pump Aspirin 81 mg for the prevention of preeclampsia</p>	<p>Prenatal MV with 0.4mg Folic Acid & 400-4000 IU VD Ensure appropriate vaccinations have occurred Initiate Insulin therapy if:</p> <ul style="list-style-type: none"> Fasting Blood glucose above target Initiate 4-5 units basal insulin at bedtime (NPH, Detemir, Glargine) Postprandial blood glucose above target Initiate 2-4 units bolus insulin (Lispro, Aspart, glulisine) before the meal <p>If insulin therapy refused, consider 2nd line- Metformin, 3rd Line- Glyburide</p>	<p>Prenatal MV with 0.4mg Folic Acid & 400-4000 IU VD Ensure appropriate vaccinations have occurred Initiate Insulin therapy if:</p> <ul style="list-style-type: none"> Fasting Blood glucose above target Initiate 4-5 units basal insulin at bedtime (NPH, Detemir, Glargine) Postprandial blood glucose above target Initiate 2-4 units bolus insulin (Lispro, Aspart, glulisine) before the meal <p>If insulin therapy refused, consider 2nd line- Metformin, 3rd Line- Glyburide</p>

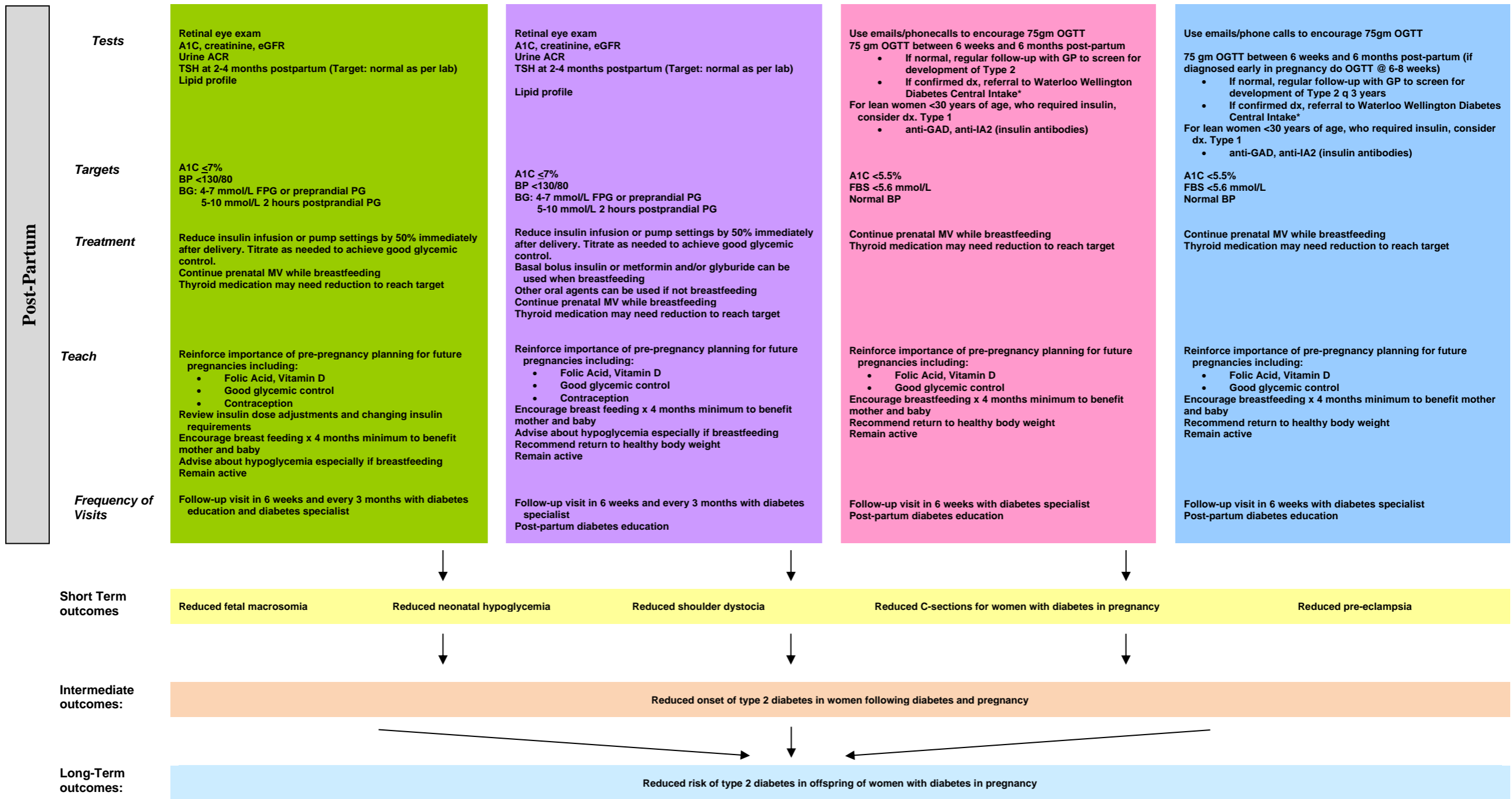
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		3 rd Trimester (28-42 weeks)			
2 nd Trimester	Teach	Review changing insulin requirements Review hypoglycemia treatment Advice on where to have birth e.g. Level 2 or 3 nursery	Review and explain increasing insulin requirements Review hypoglycemia treatment Advice on where to have birth e.g. Level 2 or 3 nursery	Pathophysiology of GDM Importance of nutrition, exercise, monitoring Review changing insulin requirements Review hypoglycemia treatment if on insulin	Pathophysiology of GDM Review nutrition and exercise guidelines Review changing insulin requirements Review hypoglycemia treatment if on insulin
	Frequency of Visits	Every 2 weeks Consider more frequent visits for those with poor glycemic control and/or hypertension	Every 2 weeks Consider more frequent visits for those with poor glycemic control, and/or hypertension	Every 2 weeks Consider more frequent in those with poor glycemic control, and/or hypertension	Every 2 weeks Consider more frequent in those with poor glycemic control, and/or hypertension
	Supporting Documents	"A Record of My Journey with Pregnancy and Diabetes"	"A Record of My Journey with Pregnancy and Diabetes"	"A Record of My Journey with Pregnancy and Diabetes"	"A Record of My Journey with Pregnancy and Diabetes"
Stage					
3 rd Trimester	Activities: Referrals	Consider referral to nephrologist if: <ul style="list-style-type: none"> serum creatinine ≥ 100 umol/L or urine ACR ≥ 2.0 mg/mmol 	Obstetrician (if not already done) Consider referral to nephrologist if: <ul style="list-style-type: none"> serum creatinine ≥ 100 umol/L or urine ACR ≥ 2.0 mg/mmol 	If not already done: referral to Waterloo Wellington Diabetes Central Intake*	If not already done: referral to Waterloo Wellington Diabetes Central Intake*
	Tests	Self-monitoring of blood glucose ac and 1 hr pc meals, hs and occasionally during night or CGM Repeat retinal eye exam if required A1C, creatinine Urine ACR Thyroid Screening If abnormal thyroid test repeat every 4 weeks Start fetal surveillance at 30-32 weeks, and weekly from 34-36 weeks through delivery for fetal growth	Self-monitoring of blood glucose ac and 1 hr pc meals and hs and occasionally during night (if on insulin) or CGM Repeat retinal eye exam if required A1C, creatinine Urine ACR Thyroid Screening If abnormal thyroid test repeat every 4 weeks Consider ultrasound at 36-38 weeks for fetal growth Start fetal surveillance at 30-32 weeks, and weekly from 34-36 weeks through delivery for fetal growth	Self-monitoring of blood glucose fasting and 1 hr pc meals or CGM If on insulin, self-monitoring of blood glucose ac and 1 hr pc meals Provide requisition for 3-month post-partum OGTT Thyroid Screening Consider ultrasound at 36-38 weeks for fetal growth	Self-monitoring of blood glucose fasting and 1 hr pc meals or CGM If on insulin, self-monitoring of blood glucose ac and 1 hr pc meals Provide requisition for 3-month post-partum OGTT Thyroid Screening Consider ultrasound at 36-38 weeks for fetal growth
	Targets	A1C $\leq 6.1\%$ (increased risk of still birth with A1c > 6.1) TIR $> 70\%$, TBR $< 4\%$, TAR $< 25\%$ BP $< 130/80$ FBS and Preprandial BG: < 5.3 mmol/L 1 hr postprandial BG: < 7.8 mmol/L 2 hr postprandial BG: < 6.7 mmol/L (Be prepared to raise these targets if needed because of the increased risk of severe hypoglycemia) Manage gestational weight gain as per IOM guidelines	A1C $\leq 6.1\%$ (increased risk of stillbirth if A1c > 6.1) BP $< 130/80$ FBS and Preprandial BG: < 5.3 mmol/L 1 hr postprandial BG: < 7.8 mmol/L 2 hr postprandial BG: < 6.7 mmol/L Manage gestational weight gain as per IOM guidelines	BP $< 130/80$ FBS and Preprandial BG: < 5.3 mmol/L 1 hr postprandial BG: < 7.8 mmol/L 2 hr postprandial BG: < 6.7 mmol/L Manage gestational weight gain as per IOM guidelines	BP $< 130/80$ FBS and Preprandial BG: < 5.3 mmol/L 1 hr postprandial BG: < 7.8 mmol/L 2 hr postprandial BG: < 6.7 mmol/L Manage gestational weight gain as per IOM guidelines
	Treatment	Prenatal Vitamins with 0.4 to 1.0 mg Folic Acid, & 400-4000 IU VD Basal Bolus Insulin or Insulin Pump Ongoing insulin adjustments Aspirin 81 mg Consider induction @ 38-39 weeks with uncomplicated diabetes If fetal macrosomia, consider early induction at 37-38 weeks	Prenatal Vitamins with 0.4 to 1.0 mg Folic Acid & 400-4000 IU VD Basal Bolus Insulin or Insulin Pump Ongoing insulin adjustments Aspirin 81 mg Consider induction @ 38-39 weeks with uncomplicated diabetes If fetal macrosomia, consider early induction at 37-38 weeks	Prenatal Vitamins with 0.4 mg Folic Acid & 400-4000 IU VD Initiate Insulin therapy if: <ul style="list-style-type: none"> Fasting Blood glucose above target Initiate 4-5 units basal insulin at bedtime (NPH, Detemir, Glargine) Postprandial blood glucose above target Initiate 2-4 units rapid (Lispro, Aspart, glulisine) before the meal If insulin therapy refused, consider 2 nd line- Metformin, 3 rd Line- Glyburide Consider elective delivery @ 38-40 weeks If fetal macrosomia, consider early induction at 37-38 weeks If diet controlled, no special intervention unless other obstetrical concerns	Prenatal Vitamins with 0.4 mg Folic Acid & 400-4000 IU VD Initiate Insulin therapy if: <ul style="list-style-type: none"> Fasting Blood glucose above target Initiate 4-5 units basal insulin at bedtime (NPH, Detemir, Glargine) Postprandial blood glucose above target Initiate 2-4 units rapid (Lispro, Aspart, glulisine) before the meal If insulin therapy refused, consider 2 nd line- Metformin, 3 rd Line- Glyburide Consider elective delivery @ 38-40 weeks If fetal macrosomia, consider early induction @ 37-38 weeks If diet controlled, no special intervention unless other obstetrical concerns

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3 rd Trimester	Teach	<p>Monitor fetal movement Unexplained hypoglycemia due to maturing placenta, may alert possible need for an early delivery or increased fetal monitoring Offer information and advice about:</p> <ul style="list-style-type: none"> • When to go to hospital • What diabetes supplies to take to hospital • What to do with insulin <p>Changes to insulin therapy during and after birth Importance of breastfeeding Continue maternal vitamins if breastfeeding</p>	<p>Monitor fetal movement Unexplained hypoglycemia due to maturing placenta, may alert possible need for an early delivery or increased fetal monitoring Offer information and advice about:</p> <ul style="list-style-type: none"> • When to go to hospital • What diabetes supplies to take to hospital • What to do with insulin <p>Changes to insulin therapy during and after birth Importance of breastfeeding Continue maternal vitamins if breastfeeding</p>	<p>Monitor fetal movement Unexplained hypoglycemia due to maturing placenta, may alert possible need for an early delivery or increased fetal monitoring Offer information and advice about:</p> <ul style="list-style-type: none"> • When to go to hospital • What diabetes supplies to take to hospital • What to do with insulin <p>Changes to insulin therapy during and after birth Importance of returning to pre-pregnancy weight to reduce risk of Type 2 diabetes Importance of post-partum OGTT Importance of breastfeeding Continue maternal vitamins if breastfeeding</p>	<p>Monitor fetal movement Unexplained hypoglycemia due to maturing placenta, may alert possible need for an early delivery or increased fetal monitoring Offer information and advice about:</p> <ul style="list-style-type: none"> • When to go to hospital • What diabetes supplies to take to hospital • What to do with insulin <p>Changes to insulin therapy during and after birth Importance of returning to pre-pregnancy weight to reduce risk of Type 2 diabetes Importance of post-partum OGTT Importance of breastfeeding Continue maternal vitamins if breastfeeding</p>	
	Frequency of Visits	Weekly after 36 weeks Book postpartum follow-up for diabetes education and diabetes specialist	Weekly after 36 weeks Book postpartum follow-up for diabetes education and diabetes specialist	Weekly after 36 weeks Book postpartum follow-up for diabetes education and diabetes specialist	Weekly after 36 weeks Book postpartum follow-up for diabetes education and diabetes specialist	
	Supporting Documents	At 34 weeks, give insulin orders for delivery Nutrition and breastfeeding guidelines	At 34 weeks, give insulin orders for delivery Nutrition and breastfeeding guidelines	At 34 weeks, give insulin orders for delivery Nutrition and breastfeeding guidelines	At 34 weeks, give insulin orders for delivery Nutrition and breastfeeding guidelines	
Stage: Labour and Delivery						
Labour and Delivery	Activities: Referrals	Consider elective delivery @ 38-39 weeks. If fetal macrosomia, consider early induction at 37-38 weeks	Consider elective delivery @ 38-39 weeks. If fetal macrosomia, consider early induction at 37-38 weeks If diet controlled, no special intervention unless other obstetrical concerns	Consider elective delivery at 38-40 weeks If fetal macrosomia, consider early induction at 37-38 weeks If diet controlled, no special intervention unless other obstetrical concerns	Consider elective delivery at 38-40 weeks If fetal macrosomia, consider early induction at 37-38 weeks If diet controlled, no special intervention unless other obstetrical concerns	
	Tests	Monitor blood glucose every 2 hours during early labour and every 1 hour during active labour Biophysical monitoring of baby	Monitor blood glucose every 2 hours during early labour and every 1 hour during active labour Biophysical monitoring of baby	Monitor blood glucose every 2 hours during early labour and every 1 hour during active labour Biophysical monitoring of baby	Monitor blood glucose every 2 hours during early labour and every 1 hour during active labour Biophysical monitoring of baby	
	Targets	BG 4-7mmol/L, BP <130/80	BG 4-7mmol/L BP <130/80	BG 4-7mmol/L BP <130/80	BG 4-7mmol/L BP <130/80	
	Treatment	Mainline: D5W @ 75mL/hr Piggy-back: Insulin infusion 50u/500 mL D5W—see patient care orders Insulin Pumps may be continued if patient or partner can safely manage	Mainline: D5W @ 75mL/hr Piggy-back: Insulin infusion 50u/500 mL D5W—see patient care orders Insulin Pumps may be continued if patient or partner can safely manage	Mainline: D5W @ 75mL/hr—see patient care orders For insulin infusion requirements—see patient care orders	Mainline: D5W @ 75mL/hr—see patient care orders For insulin infusion requirements—see patient care orders	
	Supporting Documents	Patient Care Orders—Intrapartum Management of Diabetes and Pregnancy Patient Care Orders—Post-partum Management of Diabetes and Pregnancy	Patient Care Orders—Intrapartum Management of Diabetes and Pregnancy Patient Care Orders—Post-partum Management of Diabetes and Pregnancy	Patient Care Orders—Intrapartum Management of Diabetes and Pregnancy Patient Care Orders—Post-partum Management of Diabetes and Pregnancy	Patient Care Orders—Intrapartum Management of Diabetes and Pregnancy Patient Care Orders—Post-partum Management of Diabetes and Pregnancy	
Post-Partum	Stage: Post-Partum (0 to 6 months)					
	Activities: Referrals	Reminder for diabetes education and diabetes specialist appointment	Reminder for diabetes education and diabetes specialist appointment	Reminder for diabetes education and diabetes specialist appointment	Reminder for diabetes education and diabetes specialist appointment	

Waterloo-Wellington Diabetes and Pregnancy Clinical Pathway



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***Referral to Diabetes Central Intake automatically generates a referral to a diabetes specialist. Physicians' billing number needs to be included on the referral.**

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