

# Gestational Diabetes: Medication Management

(Poorly controlled despite nutritional & exercise therapy)

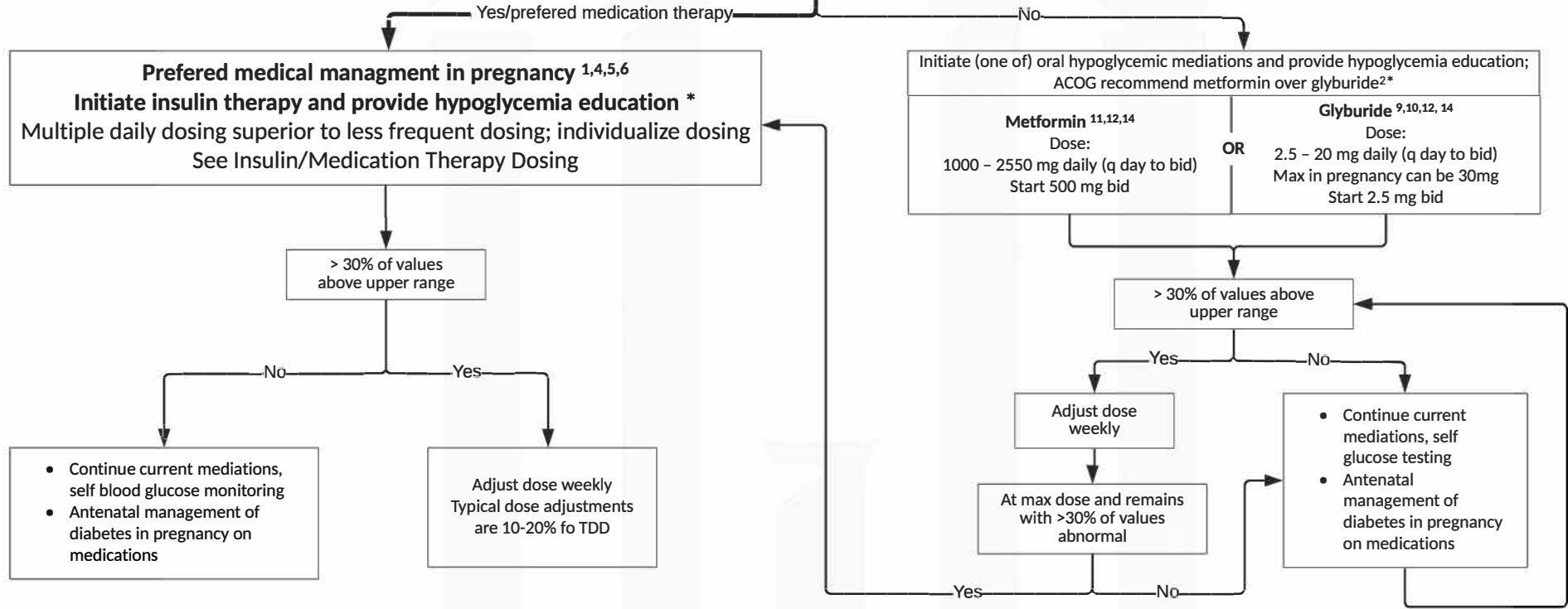
Target glycemic range  
 Fasting : 60-90 (<95)  
 Premeal: 60-105  
 1 hour post prandial < 140  
 2 hour post prandial < 120  
 2am-6am > 60  
 Ref: 1-4

Reinforce diet, exercise (30 minutes per day physical activity)(16); continue glucose monitoring (FBS and 1 hour PP)

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

At high risk of poor control on oral agents

- Current BMI > 35
- Prior pregnancy with GDM; FHx diabetes
- More than 50% of abnormal FBS > 110
- Able/willing to utilize sc insulin



**Preferred medical management in pregnancy 1,4,5,6**  
**Initiate insulin therapy and provide hypoglycemia education \***  
 Multiple daily dosing superior to less frequent dosing; individualize dosing  
 See Insulin/Medication Therapy Dosing

Initiate (one of) oral hypoglycemic medications and provide hypoglycemia education; ACOG recommend metformin over glyburide2\*

<p><b>Metformin 11,12,14</b>                  Dose:                  1000 - 2550 mg daily (q day to bid)                  Start 500 mg bid</p>	OR	<p><b>Glyburide 9,10,12, 14</b>                  Dose:                  2.5 - 20 mg daily (q day to bid)                  Max in pregnancy can be 30mg                  Start 2.5 mg bid</p>
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• Continue current medications, self blood glucose monitoring  
 • Antenatal management of diabetes in pregnancy on medications

Adjust dose weekly  
 Typical dose adjustments are 10-20% fo TDD

**Metformin (9,11,14)**  
 54% success in achieving euglycemia  
 Not direct cause of maternal hypoglycemia  
 Associated with less maternal weight gain than insulin; lower neonatal weight than glyburide  
 Placenta transfer; no known congenital anomalies

**Glyburide (9,10, 12, 14)**  
 79-96% success in achieving glycemic control  
 Can cause maternal hypoglycemia  
 Risk of neonatal hypoglycemia  
 Placenta transfer; no known congenital anomalies

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***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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