Tight control

During the first trimester, tight control of blood glucose helps minimize risks of birth defects and miscarriage. In the second and third trimesters, tight control helps keep your baby from growing too large (macrosomia), a condition that affects about 43% of babies born to women with diabetes. Caused by fetal exposure to high maternal blood levels of glucose, macrosomia may result in delivery problems.

Be especially wary of hypoglycemia during pregnancy and revise target glucose ranges with your healthcare team as your pregnancy progresses.

As pregnancy progresses, hormonal changes increase insulin resistance. Women with type 2 diabetes or previous gestational diabetes who do not use insulin may need to inject the hormone during pregnancy. Those already using insulin may need to use more during pregnancy or adjust the type(s) they use and their injection schedules. In the last trimester, women may need to increase insulin by as much as two or three times. This is normal.

Oral diabetes medications can cause birth defects, so women using them should switch to insulin while pregnant.

Talk to your doctor or midwife

The information in this brochure is for educational purposes only. It is not intended to replace the advice from your healthcare professional.

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WeeCare

Contact Us

If you have questions for your WeeCare representative, call between 9 a.m. and 5 p.m. Monday through Friday.

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Keys to a Healthy Pregnancy

Tips for expectant moms with diabetes

An informational brochure provided by PEHP

Diet and exercise

Consult your dietitian before you get pregnant. Your dietitian can help tailor your caloric needs to your recommended weight gain. It's normal to gain 22 to 32 pounds during pregnancy but women who get pregnant while very thin may be advised to gain more, while those who are overweight may be advised to limit weight gain to 15 pounds. Continue taking folic acid, iron, calcium, and other vitamins.
Consider ketone testing every morning so you know if you're getting the right amounts of carbohydrate and insulin. More tips:

- To maintain tight control, it often helps to eat five or six small, snack-like meals a day instead of three major meals. Small meals can also help with the nausea of pregnancy. (It's often called "morning sickness" but it can strike at any time of day.)
- If you have nausea, keep starchy but low-fat snacks close at hand: crackers, pretzels, or rice or popcorn cakes.
- Eat if you begin to feel nauseated.
- To prevent early morning nausea, eat a mini-meal around bedtime: a sandwich, a bowl of soup, or a fruit salad.
- Keep exercising during your pregnancy. Take walks, swim, or do yoga, but nothing too strenuous or high-impact.

Self-testing

If you take insulin, your healthcare team may recommend monitoring before meals during the first trimester, then before and after meals during the second and third trimesters.

Women with type 2 diabetes who control it through meal planning and exercise should test more frequently than normal: before meals, an hour or two after meals, before bed, and around 2 a.m. Keep a log of your blood glucose test results so you can monitor them more easily.

Tight control can triple your episodes of hypoglycemia. And pregnancy can change your early warning symptoms of hypoglycemia, or make you less aware of incipient hypoglycemia. Be alert and test frequently to keep your glucose from falling too low.

In some pregnant women who have diabetes, hypoglycemia causes surprisingly rapid loss of consciousness. This can be life-threatening if you're driving or performing any other potentially dangerous activity. Experts recommend testing before and after exercise, and before you drive. Carry a glucagon kit with you and train several people you see every day how to use it. One encouraging note: If hypoglycemia does happen, there is no evidence that it will harm your baby.

Labor & Birth

Babies born to women with diabetes are often unusually large because they were exposed to high levels of blood glucose. To reduce the risk of problems during labor, women with diabetes often have labor induced a week or two before term.

Tight control of blood glucose helps prevent their babies from growing too much, but even with the best control, babies of mothers with diabetes tend to be oversized. When a baby is too large or a woman's pelvis too small, vaginal delivery can result in shoulder damage to the baby or respiratory distress. Babies at risk for these problems are usually delivered by a cesarean section (C-section).

High blood pressure also complicates labor

Compared with those without diabetes, pregnant women with diabetes are at increased risk for pre-eclampsia, a condition where a combination of high blood pressure and other problems may cause convulsions and coma. If you develop high blood pressure while pregnant, you may need to deliver your baby by C-section.

Women are usually not allowed to eat during labor; they are fed intravenously. In addition, pregnant women with diabetes must be monitored frequently to keep blood glucose levels close to normal. If you need insulin, it can be added to the IV line.

Babies born to mothers with diabetes are at risk for such perinatal complications as hypoglycemia and jaundice. They must be monitored closely for four to six hours after birth. Ask your doctor more about these possible conditions, and how your baby will be taken care of in the first hours of his or her life.