Type 1 Diabetes & Type 2 Diabetes

PRECONCEPTION CHECKLIST

Australasian Diabetes in Pregnancy Society

☐ **Provide advice and education:**

- healthy eating / glycaemic index / carbohydrate content (refer: APD)
- individualised weight management recommendation and healthy pre-pregnancy weight
- folic acid 2.5–5 mg daily in total, taking multivitamin supplementation into account, commenced ideally 3 months prior to conception and continued until 12 weeks gestation
- physical activity
- self-monitoring of blood glucose (SMBG) frequency and targets (refer: CDE)
- HbA1c target ≤6.5% (48 mmol/mol) without causing hypoglycaemia
- continuous glucose monitoring (CGM) use and targets:
  - range: 3.5–7.8 mmol/L
  - time in range: >70% (ie >16.8 h/day)
  - time below range: <4% (1 h/day) at <3.5 mmol/L and <1% (15 min/day) at <3.0 mmol/L
  - glycaemic variability (%CV): aim ≤36%
- sick day management / ketone testing
- hypoglycaemia management
- driving advice
- contraception until glycaemia optimised
- advise improved maternal and neonatal outcomes with optimal glycaemia
- routine preconception care, as applies to all women planning a pregnancy
- routine vaccination advice

☐ **Review medications:**

- review insulin doses and use of non-insulin glucose-lowering agents
- record preconception insulin requirements
- review and cease or replace medications not advised during pregnancy

☐ **Screen for comorbidities and complications and manage / refer as appropriate:**

- blood pressure (BP)
- coronary artery disease (CAD)
- retinal disease
- kidney disease
- autonomic neuropathy
- diabetic foot disease
- thyroid disease
- coeliac disease
- mental health
- dental health

☐ **Arrange baseline investigations:**

- HbA1c (repeat every 2–3 months)
- lipids
- thyroid-stimulating hormone (TSH) and thyroid peroxidase (TPO) autoantibodies (for type 1 diabetes)
- coeliac autoantibodies (for type 1 diabetes)
- B12 (for type 1 diabetes, metformin use, vegetarian or vegan diet, bowel disorders, bariatric surgery, megaloblastic anaemia) and red blood cell folate
- serum creatinine and estimated glomerular filtration rate (eGFR)
- spot urine albumin : creatinine ratio (ACR)
- routine pre-pregnancy investigations, as for all women planning a pregnancy

☐ **Refer to appropriate specialist(s) / centre**

Reprinted (adapted) from Rudland VL, Price SAL, Hughes R *et al.* ADIPS 2020 guideline for pre-existing diabetes and pregnancy. *Aust N Z J Obstet Gynaecol* 2020; 60: E18-E52, with permission from Wiley.

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CHECKLIST DURING PREGNANCY

Australasian Diabetes in Pregnancy Society

☐ **Complete preconception checklist if not yet performed**

☐ **Provide all usual antenatal care, as for all pregnant women**

☐ **Provide advice and education:**

- healthy eating in pregnancy (refer: APD)
- physical activity and reduction in sedentary time in pregnancy
- individualised weight gain recommendation
- advise improved maternal and neonatal outcomes with optimal glycaemia
- SMBG frequency and targets (refer: CDE)
- CGM use and targets
- HbA1c target
- sick day management / ketone testing
- hypoglycaemia management
- driving
- breastfeeding / consider referral to lactation consultant from 32 weeks gestation
- neonatal considerations

☐ **Assessment:**

- glycaemic monitoring:
  - review SMBG and/or CGM at each visit (every 1–2 weeks if on insulin)
  - HbA1c at least once each trimester
- obstetric monitoring:
  - monitoring of maternal weight gain
  - regular assessment for fetal growth and well-being
  - serial fetal growth scans every 2–4 weeks from 28 weeks gestation
  - weekly cardiotocography (CTG) from 34 weeks gestation
- medications:
  - if not done preconception, review medications not suitable for pregnancy
  - reassess insulin doses every 1–2 weeks or as required to achieve optimal glycaemia
- pre-eclampsia prevention:
  - commence aspirin 100–150 mg daily with evening meal (unless contraindicated) from 12 weeks gestation and cease at 36 weeks gestation
  - commence calcium supplementation (total 1.5 g daily including dietary calcium) from 12 weeks gestation
  - check BP and urinalysis at each visit
- screen for complications and manage / refer as appropriate:
  - retinal screening: first trimester (unless performed within 3 months prior to conception) and consider repeating in third trimester if no evidence of diabetic retinopathy on initial screen, or earlier if baseline retinopathy is detected as directed by ophthalmologist. Diabetic retinopathy requires specialist care.
  - renal screening: serum creatinine, and spot urine ACR or protein : creatinine ratio (PCR) each trimester. Increase to monthly monitoring if elevated creatinine or macroalbuminuria and arrange specialist review.

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POSTPARTUM CHECKLIST

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☐ **Birth plan:**
- multidisciplinary planning should occur regarding timing and mode of birth
- provide diabetes management plan for birth
- arrange neonatal assessment and management
- discuss effect of breastfeeding on blood glucose levels / insulin doses
- discuss postpartum contraception plan

☐ **Encourage breastfeeding for maternal and infant benefits**

☐ **Review diabetes management (insulin / non-insulin glucose lowering agents / healthy eating) in view of mode of infant feeding**

☐ **Provide advice and education:**
- advise SMBG frequency and targets or CGM targets (breastfeeding effect)
- promote a healthy lifestyle
- provide individualised weight target recommendation

☐ **Discuss contraception plan / pregnancy planning prior to discharge from hospital**

☐ **Arrange regular contact with usual diabetes care providers**

☐ **Arrange diabetes follow-up (glycaemia, BP, lipids) at least biannually**