Australasian Diabetes in Pregnancy Society

ADIPS 2025 Consensus Recommendations for the Screening, Diagnosis and Classification of Gestational Diabetes (GDM)

Frequently asked questions: For health professionals

Healthcare professionals wishing to understand what has changed and the rationale for the current recommendations are encouraged to read the full Consensus Recommendations published in the MJA on 23rd June 2025. ADIPS notes that the new recommendations are being implemented in Australia. Separate national GDM guidelines are used in Aotearoa New Zealand.

1. What are the key changes?

The 2025 ADIPS Consensus Recommendations raise the glucose thresholds for diagnosing GDM during the OGTT. The changes are intended to improve clinical specificity without compromising safety.

GDM is now diagnosed if any one of the following criteria is met:

- Fasting plasma glucose (FPG): 5.3–6.9 mmol/L
- 1-hour plasma glucose (1hPG): ≥10.6 mmol/L
- 2-hour plasma glucose (2hPG): 9.0–11.0 mmol/L

The 2025 ADIPS recommendations also clarify the suggested approach to early pregnancy screening. Women with risk factors for hyperglycaemia in pregnancy are recommended to have haemoglobin A1c (HbA1c) tested in first trimester along with other initial antenatal bloods. This is to screen for undiagnosed pre-existing diabetes.

Type 2 diabetes can't be diagnosed during pregnancy and requires confirmation post-partum. Instead the term "overt diabetes in pregnancy" (overt DIP) is used. The criteria for overt DIP are:

- HbA1c ≥ 6.5%,
- FPG ≥ 7.0 mmol/L, OR
- 2hPG ≥ 11.1 mmol/L

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Early pregnancy OGTT is now only routinely recommended for women with a history of prior GDM or if the HbA1c is intermediately elevated (6.0-6.4%). The ADIPS recommendations outline a standard screening program relevant nationally. Early pregnancy OGTT could be considered if you are worried about a woman with multiple risk factors for hyperglycaemia or if local guidelines indicate early GDM screening.

2. What is the recommended plan for pregnant women who have a GDM diagnosis under the previous guideline and would now fall outside the diagnostic range under the new guideline?

Management decisions should be individualised, involving women in the decision-making. ADIPS suggests continuing care based on the original diagnosis rather than reclassifying based on updated thresholds alone. Self-monitored blood glucose levels (BGLs), prior pregnancy outcomes, and clinical context should all be considered. Decisions to reduce the frequency of blood glucose monitoring or to change treatment, follow-up or model of care, should be based on current BGLs and the whole clinical context, rather than the initial diagnostic OGTT results.

3. Can GDM be diagnosed using fasting glucose alone?

A fasting plasma glucose (FPG) of ≥5.3 mmol/L is diagnostic of GDM. However, a full OGTT remains the recommended screening test unless it is not tolerated. All three cut-off values are equally predictive of adverse obstetric outcomes. In early pregnancy, isolated FPG results should be interpreted with caution.

4. When will laboratory reporting ranges for the pregnancy oral glucose tolerance test change?

The Royal College of Pathologists of Australasia (RCPA) and Australasian Association for Clinical Biochemistry and Laboratory Medicine (AACB) have endorsed the new Consensus Recommendations and prepared communication to their members throughout Australia. Laboratories have been informed that reporting of the new criteria can commence from 1st July 2025. Decisions to change reporting criteria are determined by the supervising chemical pathologist in consultation with their local referrers.

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5. Are there any Medicare Benefits Scheme (MBS) considerations with the early pregnancy screening recommendations regarding haemoglobin A1c (HbA1c)?

The recommendation for HbA1c measurement for a woman with risk factors for hyperglycaemia in pregnancy is intended to detect overt diabetes in pregnancy, which likely represents pre-existing type 2 diabetes. It is not a screening test for GDM. The Consensus Recommendations suggest this should only be performed if HbA1c screening for type 2 diabetes has not already been undertaken in the last 12 months. The MBS supports annual screening for type 2 diabetes in people at high risk.

6. Have BGL treatment targets changed for people with GDM?

The 2025 ADIPS recommendations focus on screening approaches and diagnostic criteria, not GDM management. Treatment targets were not within scope of these consensus recommendations. The need for clear guidance regarding treatment targets is recognised as an important priority. ADIPS has begun a process to develop updated consensus recommendations for the management of GDM. Clinicians are advised to follow the local clinical guidance relevant to their jurisdiction or health service.

ADIPS is aware that some health services and jurisdictional guidelines are now recommending a fasting BGL target of ≤5.2 mmol/L and post-meal targets of ≤7.4 mmol/L at one hour and ≤6.7 mmol/L at two hours. This is a reasonable approach while updated consensus recommendations are being developed.

7. Do these new recommendations impact the follow-up of people who had GDM diagnosed in a previous pregnancy?

The new recommendations emphasise the importance of early pregnancy screening with an OGTT for women with a prior history of GDM. Outside of pregnancy, women with a history of GDM diagnosed by the previous ADIPS criteria, should still be offered screening for type 2 diabetes and advice regarding prevention of type 2 diabetes. Evidence from observational studies shows that women meeting the previous ADIPS GDM criteria are at increased risk of type 2 diabetes later in life.