

# [Worldwide, tri annually thereafter with annual fbg in](https://assignbuster.com/worldwide-tri-annually-thereafter-with-annual-fbg-in/)

Worldwide, diabetes mellitus (DM) is currently the fastest growing non-communica­bledisease and has gained epidemic levelsi. Gestationaldiabetes mellitus (GDM) is a significant risk factor for the development oftype 2 diabetes (T2DM). It is defined as “ Any degree of glucose intolerance with onset orfirst recognition during pregnancy” ii. GDM poses increased risk of adverse pregnancy outcomes includingmaternal and perinatal mortality, obstructed labor, infections, spontaneousabortion, congenital abnormalities and macrosomiaiii. Laterin life, women with GDM are not only at increasedrisk for developing type 2 diabetes, but there is also increased risk ofcardiovascular disease iv’v. Inaddition, children of women with GDM are at increased risk of obesity, glucoseintolerance, and overt diabetes mellitus in adult life vi.

The Fifth InternationalWorkshop-Conference on GDM recommends intensive postpartum monitoring: Random/fasting blood glucose (FBG) 1 to 3 days postpartum; OGTT 6 to 12 weekslater, to be repeated 1 year postpartum and tri annually thereafter with annualFBG in between vii. Despite thesestrategies, it has been noted that postpartum screening rates are low amonghigh risk mothers and range from 23 to 58% viii’ix. Oneof the reasons for low screening rates is failure on the part of obstetrician toprovide appropriate test, along with patient non-compliance. The objective ofthis study is therefore toassess the adherence of obstetricians to therecommended guidelines for postpartum screening of GDM affected women. Indeveloping countries like Pakistan where appropriate obstetrical care islacking on a large scale, GDM may have particularly severe consequences for thehealth and wellbeing of mother and child. Studies have shown that postpartumdiabetes screening has the potential for future prevention of Type 2 Diabetesin the mother and offspring thus cost saving and reducing the burden ofdisease. Rationale: Women withGDM affected pregnancy have a 20% chance ofdeveloping type 2 diabetes in thefirst decade following pregnancy though the risk can be as high as 70% inhigherrisk populations. x’xiThe identification of pre-diabetes is important because up to70% of affected individuals may eventually develop type 2 diabetes.

Thus, thehigh rates of pre-diabetes in the category of abnormal antepartum glucosehomeostasis suggest that the young women in these groups have an increased riskof future type 2 diabetes. This risk is well established in women with GDM as compared towomen with normal OGTTs i. In ourstudy we found that during the pre-intervention period 27. 6% of women with GDM receiveda documented order for postpartum glucose screening; this increased to 50.

9%after the intervention. Although the obstetrician compliance to postpartum DMscreening guidelines increased after intervention but the rate of screening isstill low. Severalfactors have been noted in our study that influenced postpartum glucosetolerance testing. Women withGDM who had Cesarean section were four times more likely to get advice for OGTTtesting compared to women who delivered vaginally as almost all these women had1st postoperative visit for removal of stitches. In ourstudy it is evident that GDM women who were treated with metformin alone, metformin and insulin or insulin alone were given requisition for postpartumOGTT testing. Several studies have shown similar effect ii, others have shown opposite effect iii.

One of thereasons that patients did not get requisition seems that patients did notreturn for their follow-up visit. This is in keeping with other studies ivthat have noted that attendance at the postpartum visit is a major factor inglucose testing. This calls for looking into the factors leading tononcompliance on the part of the patients as well. Interestinglyit was found that full time faculty is more compliant towards DM screeningguidelines as compared to visiting obstetricians and the rate of advisingglucose tolerance testing has increased tremendously after intervention. Another factor is that though obstetricianprovided the requisition for OGTT but the patient had it performed at anotherlaboratory outside our hospital whose results may or may not be available.

Strengths: Our studydiffers from similar reports examining GDM postpartum care in the aspect of ourfocus on actual obstetric practice since our hospital is basically a maternityunit and we examined the postpartum paper work in medical records. Interventionin this study helped in refreshing the knowledge and improving the complianceof obstetriciansLimitations: This studywas limited to medical chart review for the documentation of OGTT testing byobstetrician only, therefore itcould not determine whether defects in testingwere attributable to patient, or health care system barriers, or toall threecombined. Another limitation is that compliance of obstetricians was seen atone secondary unit only, in view of global epidemic of DM it should be studiedin other centers also, including tertiary ones. Conclusion: Resultsfrom our study combined withglobal recent reports of low rates of postpartum DMscreeningstrongly suggest that it is time for more strategic planning and notonly monitoring of obstetrician adherence but also in particular patienteducation regarding consequences of DM and benefits of  detection of abnormal glucose tolerance inearly postpartum period. iCarr DB, Newton KM, UtzschneiderKM, Tong J, Gerchman F, Kahn SE, et al. Modestly elevated glucose levels duringpregnancy are associated with a higher risk of future diabetes among womenwithout gestational diabetes mellitus. Diabetes Care. 2008; 31(5): 1037-9.

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