NATIONAL INSTITUTES OF HEALTH
CONSENSUS DEVELOPMENT CONFERENCE

DIAGNOSING GESTATIONAL DIABETES MELLITUS

OCTOBER 29–31, 2012
NATCHER CONFERENCE CENTER
NATIONAL INSTITUTES OF HEALTH
BETHESDA, MARYLAND

180  EQUALS  10 mmol/l
100gm GTT
95/180/155/140  CHECK Fasting
CARPENTER/COURTAN
92/180/153  2 HOUR
105/190/165/145

TO REGISTER
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U.S. Department of Health and Human Services | National Institutes of Health | Office of Disease Prevention
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Diagnosing Gestational Diabetes Mellitus

NIH CONSENSUS DEVELOPMENT CONFERENCE

Gestational diabetes mellitus (GDM) is a condition in which women without previously diagnosed diabetes exhibit high blood glucose levels during pregnancy (especially during the third trimester of pregnancy). It is defined as carbohydrate intolerance, which is the inability of the body to adequately process carbohydrates (sugars and starches) into energy for the body, that develops or is first recognized during pregnancy. GDM is estimated to occur in 1-14% of U.S. pregnancies, affecting more than 200,000 women annually. It is one of the most common disorders in pregnancy and is associated with an increased risk of complications for the mother and child. Potential complications during pregnancy and delivery include preeclampsia (high blood pressure and excess protein in the urine), cesarean delivery, macrosomia (large birth weight), shoulder dystocia (when a baby’s shoulders become lodged during delivery), and birth injuries. For the neonate, complications include difficulty breathing at birth, hypoglycemia (low blood sugar), and jaundice. Up to one-half of women who have GDM during pregnancy will develop type 2 diabetes later in life.

Although the U.S. Preventive Services Task Force found in 2008 that the evidence was insufficient to assess the balance between the benefits and harms of screening women for GDM, the American College of Obstetricians and Gynecologists recommends universal screening for gestational diabetes using patient history, risk factors, or laboratory testing, such as with a glucose challenge test (GCT). Different approaches are used internationally for screening and diagnosis of GDM. The standard method in the United States begins with a GCT, which involves drinking a sweetened liquid containing 50 grams of sugar (glucose). A blood sample is taken after 1 hour, which measures the glucose level. If high, a diagnostic test is administered using a larger dose of glucose, and several blood tests are performed over 3 hours. Depending on the test used, and the chosen blood glucose levels that are used to diagnose GDM, the number of women who will receive the diagnosis will vary. Debate continues regarding the choice of tests and the effectiveness of treatment, especially in women with mild to moderate glucose intolerance. Potential harms of screening for GDM include anxiety for patients and the potentially adverse effects of a “high-risk” label in pregnancy. In addition, women diagnosed with GDM face stressors including dietary constraints, a need to add or increase exercise, frequent self-monitoring of blood glucose levels, and for some, self-administration of insulin which will require adjustments of insulin doses.

To better understand the benefits and risks of various GDM screening and diagnostic approaches, the National Institutes of Health has engaged in a rigorous assessment of the available scientific evidence. This process is sponsored by the Eunice Kennedy Shriver National Institute of Child Health and Human Development and the Office of Disease Prevention. A multidisciplinary planning committee developed the following key questions:

1. What are the current screening and diagnostic approaches for gestational diabetes mellitus, what are the glycemic thresholds for each approach, and how were these thresholds chosen?

2. What are the effects of various gestational diabetes mellitus screening/diagnostic approaches for patients, providers, and U.S. healthcare systems?

3. In the absence of treatment, how do health outcomes of mothers who meet various criteria for gestational diabetes mellitus and their offspring compare with those who do not?

4. Does treatment modify the health outcomes of mothers who meet various criteria for gestational diabetes mellitus and their offspring?

5. What are the harms of treating gestational diabetes mellitus, and do they vary by diagnostic approach?

6. Given all of the above, what diagnostic approach(es) for gestational diabetes mellitus should be recommended, if any?

7. What are the key research gaps in the diagnostic approach of gestational diabetes mellitus?

An evidence report on GDM will be prepared through the Agency for Healthcare Research and Quality’s Evidence-based Practice Centers program, and a Consensus Development Conference will be held on October 29-31, 2012.

During the conference, invited experts, including the authors of the evidence report, will present scientific data. Attendees will have opportunities to ask questions and provide comments during open discussion periods. After weighing the evidence, an unbiased, independent panel will prepare and present a consensus statement addressing the key questions. The statement will be widely disseminated to practitioners, policymakers, patients, researchers, the general public, and the media.

The conference is free and open to the public and will be held at the National Institutes of Health, Natcher Conference Center, Building 45, 9000 Rockville Pike, Bethesda, Maryland.

TO REGISTER
ONLINE consensus.nih.gov  EMAIL consensus@mail.nih.gov  PHONE 888-644-2667

CAN’T ATTEND?
Webcast: consensus.nih.gov/gdmvideocast.htm

To ensure adequate capacity, register for the webcast. Please note that the archived webcast will be available approximately one week following the conference.

Speakers’ Abstracts: Once the conference opens, you will also be able to access abstracts of the speakers’ presentations at consensus.nih.gov.

Pre-order Conference Statement: consensus.nih.gov/gdmstmt.htm

For additional information about the conference agenda, speakers, logistics, and how to get involved, please visit consensus.nih.gov.

If you have any disabilities that may require specific aids or services during the conference, please call 888-644-2667 or e-mail consensus@mail.nih.gov.

Continuing education credit for this activity is pending. Please see final announcement for details.

ABOUT THE PROGRAM
The NIH Consensus Development Program was established in 1977 as a mechanism to judge controversial topics in medicine and public health in an unbiased, impartial manner. NIH has conducted more than 150 conferences addressing a wide range of issues. For more information about the program, past conferences and statements, or upcoming conferences, visit consensus.nih.gov.