

Gestational Diabetes

GP Update, 2025

Frequently Asked Questions, with Dr Simone Gonzo

Q: Can managing overweight before pregnancy help reduce the risk of gestational diabetes (GDM)?

A: Yes, definitely. While it's not specifically covered in the guidelines, pre-pregnancy planning is an ideal time to discuss gestational diabetes, its risks, and long-term complications. Achieving a healthy BMI before pregnancy can significantly reduce risk. Even modest weight loss, whether through lifestyle changes, medications like semaglutide or tirzepatide, or bariatric surgery, lowers the risk of GDM and diabetes. Pre-pregnancy is also the best time to stop smoking and avoid alcohol, both of which improve outcomes.

Q: Should we monitor women in the first year after delivery?

A: Yes, monitoring is important even though it's not strongly emphasised in the guideline. Queensland Health provides comprehensive postpartum recommendations. For women diagnosed with GDM, an oral glucose tolerance test (OGTT) at around six weeks postpartum is recommended, though this can be difficult for new mothers. If an OGTT isn't feasible, HbA1c or fasting glucose testing is acceptable. Ongoing monitoring should continue annually for at least five years postpartum.

Q: Are new CGM monitors (like Dexcom One Plus for type 2 diabetes) useful in diagnosing or managing GDM?

A: Not for diagnosis. Guidelines don't recommend CGM for GDM, but some health services provide it for management under diabetes educators. CGMs are expensive, though costs may be falling. If a woman is already using CGM before pregnancy, she'll likely be considered high-risk and managed accordingly. However, diagnosis of GDM should still rely on OGTT, fasting glucose, or HbA1c for accuracy.

Q: In Cameroon, we only have access to glycaemic index and glycated haemoglobin. How can GDM be managed during pregnancy in this setting?

A: Glycated haemoglobin corresponds to HbA1c. If an OGTT isn't available, HbA1c can be used to guide diagnosis and management. Depending on results, management may include lifestyle modification (diet, exercise, self-monitoring with a glucometer) or pharmacological treatment (metformin, insulin). HbA1c and glucometer readings can provide adequate control and safe decision-making.

Q: Does changing the thyroxine dose help prevent the development of GDM?

A: No, there's no evidence of any correlation between thyroxine dose adjustment and GDM prevention.

Q: What about Medicare restrictions on HbA1c testing for GDM and the postpartum period?

A: It's important to provide clear clinical notes justifying HbA1c requests, such as early pregnancy risk factors or postpartum monitoring. This increases the likelihood of Medicare covering the test. If past HbA1c results aren't available, repeating the test may be necessary, and it's very unlikely that patients would be billed when adequate documentation is provided.

Q: Why is GDM so common?

A: Several factors contribute: rising BMI, increasing maternal age, and demographic changes (higher prevalence among South Sea Islander and Southeast Asian populations). In Australia, lowering the diagnostic threshold in 2014 led to more diagnoses, including in women with minimal risk. This sometimes caused unnecessary stress and healthcare strain. The updated guidelines aim to identify women truly at risk while avoiding overdiagnosis, allowing better-targeted care without compromising safety or outcomes.

Where to next

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