this & that

07

OBSTETRIC QUICK GUIDES · IF THIS, THEN THAT

NO.

Gestational Diabetes

& hyperglycaemia in pregnancy

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Diagnosis & management

Verified against ACOG · SMFM · RCOG · SOGC — October 2026

Gestational diabetes & hyperglycaemia in pregnancy

At a glance: the numbers to remember

24–28 wk
standard testing window for GDM

92 · 180 · 153
mg/dL, 75 g OGTT: any one value = GDM (IADPSG/WHO)

95 · 140 · 120
mg/dL targets: fasting · 1-h · 2-h (ACOG/ADA)

39^{+0}–39^{+6}
birth if well controlled on medication (ACOG)

4–12 wk
postpartum 75 g OGTT (ACOG/ADA)

Glucose values are venous plasma in mg/dL with mmol/L in brackets (divide mg/dL by 18). Where societies disagree, each position carries the society name; follow your local protocol. Doses are for singleton pregnancies unless stated.

01 Definitions

Term	Meaning	What follows
Gestational diabetes (GDM)	Hyperglycaemia first recognised in pregnancy that is below the diabetes range	This guide
A1GDM	GDM controlled with diet and activity alone	No routine fetal testing (ACOG); birth 39^{+0}–40^{+6}
A2GDM	GDM needing insulin or metformin	Fetal testing from 32 wk; birth 39^{+0}–39^{+6} if well controlled
Diabetes in pregnancy (overt diabetes)	Any one: HbA1c ≥6.5% (48 mmol/mol) · FPG ≥126 (7.0) · 2-h 75 g ≥200 (11.1) · random ≥200 (11.1) with confirmation (IADPSG, ADA, WHO)	Manage as pregestational diabetes; confirm after birth
Early hyperglycaemia	Glucose or HbA1c above normal before 20 wk but below the diabetes range	Societies disagree on whether this is GDM (Section 2)

Bedside rule

- Diabetes-range values at the **first visit** are not GDM: treat as pregestational diabetes (insulin, retinal and renal assessment, detailed fetal heart scan, earlier birth planning).
- Hyperglycaemia found before 20 wk is likely pre-existing (MFM EBG): counsel and manage as for pregestational diabetes.
- GDM itself carries little or no excess of major anomalies or stillbirth when treated (Williams); a high fasting glucose behaves more like overt diabetes.

02 Who to test, and when

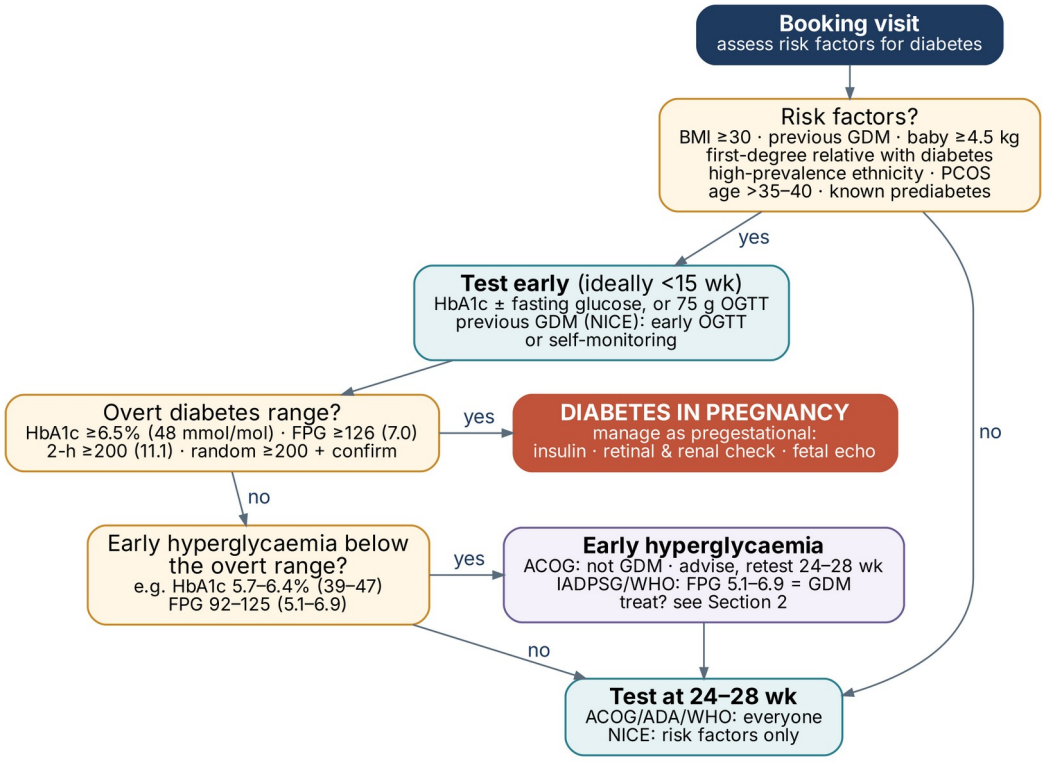


Figure 1. *First-visit risk assessment and early testing. Risk factors from NICE NG3, SIGN 171 and MFM EBG 4e; overt-diabetes thresholds from IADPSG and ADA.*

IF	THEN
Every pregnancy (ACOG, ADA, USPSTF, WHO, FIGO; Saudi MOH)	Universal testing at 24–28 wk. USPSTF: grade B at ≥24 wk; insufficient evidence before 24 wk.
UK (NICE NG3)	• Test only women with a risk factor: BMI ≥30, previous GDM, previous baby ≥4.5 kg, first-degree relative with diabetes, high-prevalence ethnicity • Do not use fasting or random glucose, HbA1c, GCT or urine dipstick to assess risk
Risk factors at booking (ACOG, ADA)	• Test for **pregestational** diabetes early, preferably at the first visit: HbA1c or 75 g OGTT • ACOG 2024 update: **no routine early testing for GDM itself**
Previous GDM	• NICE: 75 g OGTT as soon as possible after booking (or early self-monitoring); repeat at 24–28 wk if normal • Recurrence about 48% (Williams)
Early HbA1c 5.7–6.4% (39–47 mmol/mol)	• ACOG: diet and activity advice; test at 24–28 wk • SIGN, ADIPS: 42–47 mmol/mol (6.0–6.4%) = high risk; ADIPS: OGTT before 20 wk • ADA: HbA1c 5.9–6.4% or FPG 110–125 (6.1–6.9) = early abnormal glucose metabolism

IF	THEN
Early 75 g OGTT meets WHO criteria before 20 wk	• IADPSG/WHO: GDM. ACOG: not GDM; retest at 24–28 wk • TOBOGM (NEJM 2023): immediate treatment cut the neonatal composite 30.5% (deferred) → 24.9% (immediate), risk difference −5.6 points; benefit concentrated in the higher band (FPG 95–109, 1-h ≥191, 2-h 162–199 mg/dL) and diagnosis <14 wk • ADIPS 2025 and SIGN 2024 use 5.3 · 10.6 · 9.0 mmol/L at any gestation
Early test negative	Repeat at 24–28 wk. If an early GCT is abnormal but the early OGTT is normal, offer the OGTT again at 24–28 wk (MFM EBG).
Symptoms, glycosuria 2+ once or 1+ twice, polyhydramnios or a large fetus later	Test at any gestation; NICE suggests testing for GDM with repeated glycosuria.

03 Diagnosis at 24–28 weeks

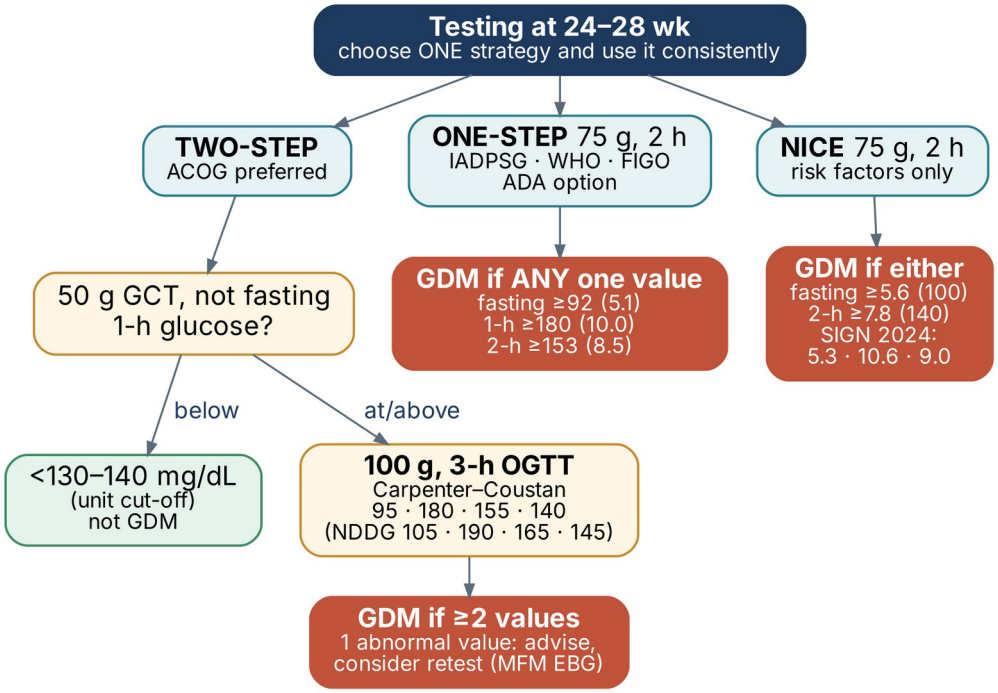


Figure 2. *Two-step, one-step and NICE approaches. Values in mg/dL unless marked mmol/L.*

Criteria	Load	Fasting	1 h	2 h	3 h	Positive if
IADPSG / WHO 2013 / ADA one-step / FIGO	75 g	92 (5.1)	180 (10.0)	153 (8.5)	—	Any one
Carpenter–Coustan (ACOG two-step)	100 g	95 (5.3)	180 (10.0)	155 (8.6)	140 (7.8)	Two or more
NDDG (ACOG two-step alternative)	100 g	105 (5.8)	190 (10.6)	165 (9.2)	145 (8.0)	Two or more
NICE NG3	75 g	100 (5.6)	—	140 (7.8)	—	Either
SIGN 171 (2024) · ADIPS (2025)	75 g	95 (5.3)	191 (10.6)	162 (9.0)	—	Any one
Diabetes Canada / SOGC 393 (preferred)	50 g GCT → 75 g	95 (5.3)	191 (10.6)	162 (9.0)	—	Any one

50 g GCT (not fasting): ACOG allows 130, 135 or 140 mg/dL (7.2, 7.5, 7.8) as the cut-off; choose one and keep it. Diabetes Canada: 7.8–11.0 mmol/L → OGTT; ≥11.1 mmol/L = GDM.

IF	THEN
Preparing for an OGTT	Overnight fast of 8–14 h, unrestricted diet in the days before, seated and not smoking during the test (MFM EBG). Venous plasma, not a meter.
GCT ≥200 mg/dL (11.1)	Over 80% fail the OGTT; many units treat as GDM without the OGTT (MFM EBG). Check a fasting glucose first to exclude overt diabetes.
One abnormal value on the 100 g OGTT	Not diagnostic of GDM. Counsel on diet; consider fasting and post-meal checks or a repeat OGTT in 3–4 wk (MFM EBG).
On metformin for PCOS	Metformin may mask GDM; consider stopping it 2 days before testing (MFM EBG; half-life ~6 h).
Ramadan	Do not schedule the OGTT during fasting days: more women test positive (BMC Med 2026). Women with GDM who wish to fast need individual specialist review.

If an OGTT is not possible or not safe

IF	THEN
Vomits during the OGTT	• The test is invalid: do not interpret the values • Repeat on another day if she is willing; glucose-polymer drinks are better tolerated than plain glucose (MFM EBG) • Otherwise use a capillary glucose profile (below)
Cannot or will not take the glucose drink (nausea, hyperemesis, previous intolerance)	• Fasting plasma glucose and HbA1c to exclude overt diabetes (FPG ≥126 [7.0] or HbA1c ≥6.5% = diabetes) • Then 1 week of capillary glucose monitoring at 24–28 wk • Jelly beans or candy loads are not validated substitutes (MFM EBG)
Sleeve gastrectomy or gastric bypass	• **Do not give a GCT or OGTT.** Rapid gastric emptying causes early dumping (flushing, palpitations, faintness within 60 min) and late hypoglycaemia at 1–3 h, so the test is unsafe and inaccurate (2019 international consensus; ACOG: consider home glucose monitoring instead) • Booking: fasting glucose or HbA1c to exclude pre-existing diabetes • 24–28 wk: 7-point capillary profile (fasting, before and after each meal, bedtime) or CGM for 1 week • Some UK units also do a week of capillary testing before 16 wk
Adjustable gastric band	A standard OGTT can be used at 24–28 wk (2019 consensus).
Type 2 diabetes in remission after surgery	Fasting glucose or HbA1c at booking and again in the second trimester; test again in T3 if growth accelerates (2019 consensus).
Reading the capillary profile	• No validated diagnostic cut-offs exist after bariatric surgery • Most units apply the treatment targets: fasting ≥5.3 mmol/L (95), 1-h ≥7.8 (140) or 2-h ≥6.4–6.7 (115–120) on repeated readings → manage as GDM; agree the rule locally • Low readings 1–3 h after meals suggest late dumping, not good control
Post-meal hypoglycaemia after bariatric surgery	Six small meals, low-glycaemic carbohydrate with protein, no drinks for 30 min around meals; avoid rapidly absorbed sugars; refer to endocrinology if symptomatic lows persist.
GDM diagnosed after bariatric surgery	Treat as usual, but avoid strict carbohydrate restriction (protein ≥60 g/day). SGA risk is higher after bypass: monthly growth scans from viability (2019 consensus).

04 Glucose targets & monitoring

Society	Fasting	1 h after meal	2 h after meal	Notes
ACOG · ADA	<95 (5.3)	<140 (7.8)	<120 (6.7)	Either 1-h or 2-h checks; neither is superior
NICE NG3	<5.3 (95)	<7.8 (140)	<6.4 (115)	Keep above 4.0 (72) if on insulin
SIGN 171	<5.5 (99)	<8.0 (144)	<7.0 (126)	No HbA1c target in GDM
Diabetes Canada	<5.3 (95)	<7.8 (140)	<6.7 (120)	Ranges from summaries (see Sources)

IF	THEN
Monitoring schedule	Capillary glucose 4 times daily: fasting plus 1 h or 2 h after each main meal. Post-meal monitoring beats pre-meal (less macrosomia and caesarean).
All values at target for weeks on diet alone	Checking every other day is acceptable (non-inferior in an RCT, MFM EBG).
Targets not met consistently after 1–2 wk of diet and activity	Start medication (Section 5). Do not wait for growth scans.
CGM in GDM	Not routine (NICE, SIGN, ADA 2026). Consider only for problematic hypoglycaemia or unstable glucose on insulin.
HbA1c to monitor GDM	Not useful in pregnancy; use meter readings.

05 Treatment

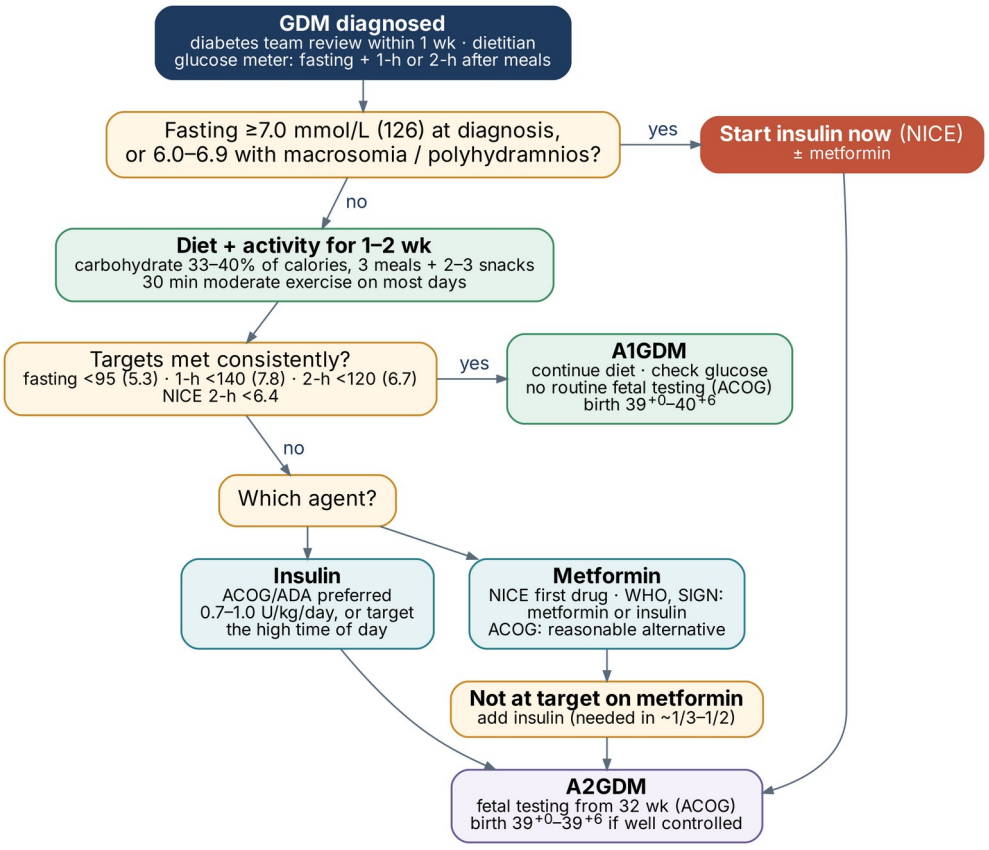


Figure 3. *Treatment escalation. Targets ACOG/ADA (NICE 2-h <6.4 mmol/L); immediate-insulin rule from NICE NG3.*

IF	THEN
Diet	• Dietitian review; about 30–35 kcal/kg/day, spread over 3 meals and 2–3 snacks • Carbohydrate 33–40% of calories, protein 20%, fat 40% (ACOG); favour low-glycaemic, high-fibre carbohydrate • Avoid ketosis: do not advise skipping meals
Activity	30 min of moderate aerobic exercise 5 days a week (MFM EBG).
Weight gain	IOM 2009 ranges by pre-pregnancy BMI: <18.5: 12.5–18 kg · 18.5–24.9: 11.5–16 · 25–29.9: 7–11.5 · ≥30: 5–9 kg.
Fasting values high, post-meal values fine	Targeted basal insulin at bedtime (NPH or long-acting analogue), titrated to the fasting target.
High values through the day	• Total daily insulin 0.7–1.0 U/kg (actual weight) to start; needs rise with gestation (about 0.7–0.8 U/kg in T1, 0.8–1.0 in T2, 0.9–1.2 in T3, MFM EBG) • Basal–bolus: half as long-acting at bedtime, half as rapid-acting split across 3 meals • Or NPH + regular: two-thirds in the morning (2/3 NPH, 1/3 regular), one-third in the evening (1/2 NPH, 1/2 regular) (Williams)
Woman declines insulin, or NICE pathway	Metformin. About a third to a half will still need insulin added; more likely with obesity, high fasting values or need for treatment before 24 wk.
Insulin ≥1.12 U/kg/day and still above target	Adding metformin improves control and reduces maternal and neonatal hypoglycaemia (MFM EBG).
Fasting ≥7.0 mmol/L (126) at diagnosis, or 6.0–6.9 with macrosomia or polyhydramnios	Start insulin at once ± metformin (NICE).

Drugs

Agent	Regimen	Avoid / caution	Know this
Insulin **ACOG/ADA preferred**	Rapid-acting (lispro, aspart) with meals; NPH or long-acting analogue (glargine, detemir) for basal. Start 0.7–1.0 U/kg/day or target the high time of day	Hypoglycaemia: teach treatment; keep glucose >4.0 mmol/L (72) on insulin (NICE)	Does not cross the placenta. UK: insulin detemir (Levemir) supply ends Dec 2026
Metformin **NICE first drug; ACOG reasonable alternative**	500 mg once or twice daily with food, increase weekly to target; usual maximum 2000–2500 mg/day (check your formulary)	eGFR <30, hepatic failure, acidosis, dehydration; stop if acutely unwell	Crosses the placenta. vs insulin: less weight gain and neonatal hypoglycaemia, more preterm birth; MiTy (type 2 diabetes): more SGA babies; offspring adiposity data reassuring so far
Glyburide (glibenclamide) **not first line**	2.5 mg in the morning; maximum 20 mg/day (MFM EBG)	Not recommended first line (ACOG); removed from NICE in 2020 (discontinued in the UK)	More macrosomia and neonatal hypoglycaemia than insulin; fetal levels reach two-thirds of maternal

06 Special situations

IF	THEN
Antenatal corticosteroids needed	• GDM is not a reason to withhold steroids, including late-preterm courses (SMFM #58 excludes pregestational diabetes only) • Expect hyperglycaemia for several days: increase glucose checks • On insulin, SOGC 393: increase the night dose by 25% on day 1 and all doses by 40% on days 2–3, then taper; or use a variable-rate insulin infusion by protocol
Diet-controlled GDM given steroids	Monitor glucose closely for the next few days; temporary insulin if above target.
Twins	Insulin needs are higher; same targets and timing principles.
Hypertension or pre-eclampsia	Common association. GDM alone is **not** an indication for aspirin (USPSTF lists pregestational diabetes only); give aspirin for other risk factors.
Woman wishes to fast in Ramadan	Individual specialist assessment before Ramadan; if she fasts, adjust doses and increase glucose monitoring.
Diabetes-range values or ketones	Check for DKA (it occurs at lower glucose in pregnancy): blood ketones, gas, electrolytes; escalate.

07 Fetal surveillance & growth

IF	THEN
A1GDM, well controlled	No routine antenatal testing (ACOG CO 828 has no row for it). Fetal movement awareness.
A2GDM, controlled on medication, no other problems	NST or BPP from 32^{+0} wk, once or twice weekly (ACOG CO 828).
Poorly controlled GDM	Testing from 32^{+0} wk, twice weekly (ACOG CO 828); add growth and liquor scans; consider earlier birth.
Growth scans	• SOGC 393: every 3–4 wk from 28 wk; weekly fetal well-being from 36 wk • Dewhurst: growth and liquor every 4 wk from 28 to 36 wk in all women with diabetes • EFW is imprecise near term: only about a fifth of fetuses called LGA are LGA at birth (Williams)
Polyhydramnios or EFW >90th centile	Review glucose control and adherence; consider adding or increasing medication (NICE immediate-insulin rule if FPG 6.0–6.9).

08 Timing & mode of birth

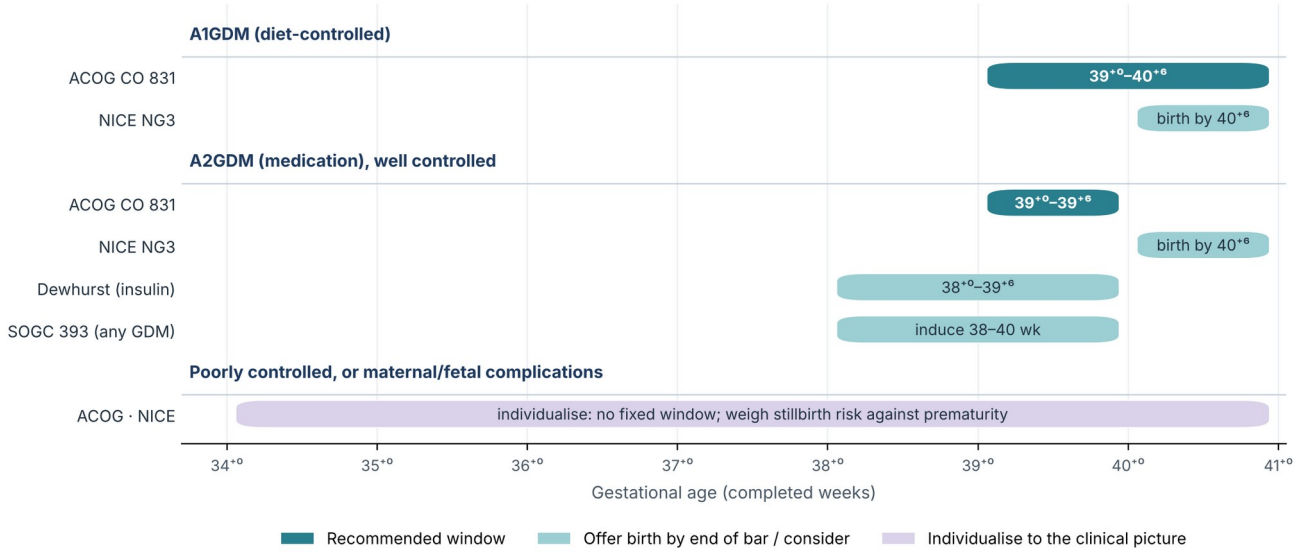


Figure 4. *Timing of birth by control and society: ACOG CO 831 (2021), NICE NG3, SOGC 393, Dewhurst 9e.*

IF	THEN
A1GDM, well controlled	ACOG: 39⁺⁰–40⁺⁶ wk; no routine induction before 39 wk. NICE: offer birth by 40⁺⁶.
A2GDM, well controlled	ACOG: 39⁺⁰–39⁺⁶ wk. NICE: by 40⁺⁶. Dewhurst (insulin): 38⁺⁰–39⁺⁶. SOGC: induce at 38–40 wk depending on control.
Poorly controlled, or maternal or fetal complications	Individualise (ACOG, NICE); weigh stillbirth risk against late-preterm morbidity. Give steroids if <34 wk, or late-preterm steroids as indicated.
EFW ≥4500 g	Discuss planned caesarean (ACOG PB 216: may be beneficial with diabetes; ≥5000 g without diabetes). Suspected macrosomia alone is not an indication for induction before 39⁺⁰ wk.
EFW >4000 g with a prolonged second stage	Avoid operative vaginal birth (MFM EBG); prepare for shoulder dystocia.
Otherwise	Aim for vaginal birth; GDM alone is not an indication for caesarean.

09 Labour & caesarean

IF	THEN
A1GDM in labour	Glucose on admission, then about every 4 h. Hourly checks do not improve neonatal glucose (Hamel RCT).
A2GDM in labour or induction	• Give the usual evening (basal) insulin the night before; **withhold the morning dose** on the day of induction or caesarean • Hourly capillary glucose in active labour • Target 70–110 mg/dL (3.9–6.1; MFM EBG) · NICE: 4–7 mmol/L (72–126)
Above target in labour	Variable-rate IV insulin with dextrose by protocol (see table). Women with GDM on <1.0 U/kg/day insulin rarely need it (Dewhurst).
Glucose <70 mg/dL (3.9)	Dextrose 5% at 100–150 mL/h, no insulin; recheck in 1 h.

IF	THEN
Planned caesarean	First on the morning list. Usual meal insulin with the evening meal; two-thirds of the usual basal dose the night before (Dewhurst); hourly glucose; IV insulin and dextrose only if above target.

Capillary glucose	Fluids	IV insulin (regular, 10 U in 1000 mL D5NS = 1 U/100 mL)
<70 mg/dL (<3.9)	D5NS 100–150 mL/h	None; recheck in 1 h
70–99 (3.9–5.5)	D5NS 100–150 mL/h	None (or 0.5 U/h by local protocol)
100–140 (5.6–7.8)	D5NS	Start 1.0 U/h
141–180 (7.8–10.0)	D5NS	Start 1.5 U/h
>180 (>10.0)	Consider normal saline instead of dextrose	Start 2.0 U/h; check ketones and gas for DKA

Adapted from MFM EBG 4e Figure 4.1 (A2GDM and pregestational diabetes): check hourly; adjust by 0.5–1 U/h. Use your unit's protocol where one exists.

10 The baby

IF	THEN
At birth	Skin-to-skin; first feed within 30–60 min (NICE: 30 min; BAPM: 60 min), then every 2–3 h. Inform the neonatal team if on medication.
First glucose check	Before the second feed, at 2–4 h of age (NICE, BAPM). Do not check in the first 1–2 h unless the baby has signs.
Low values (BAPM 2024)	• Any value <1.0 mmol/L, or <2.5 with abnormal signs → urgent neonatal review • 1.0–1.9 without signs → buccal 40% dextrose gel 200 mg/kg and feed • NICE: act if <2.0 mmol/L on 2 consecutive readings despite feeding
Two consecutive pre-feed values ≥2.0 mmol/L	Stop routine monitoring (BAPM).
Other neonatal problems	Jaundice, polycythaemia, hypocalcaemia, respiratory distress, and birth trauma with macrosomia.

11 After birth & long term

IF	THEN
Immediately after birth	Stop insulin and metformin. Check glucose before discharge (NICE); persistent hyperglycaemia suggests pre-existing diabetes.
Formal test: US (ACOG, ADA)	• 75 g 2-h OGTT at 4–12 wk • An inpatient OGTT before discharge is a reasonable alternative (ACOG 2024): completion 92% vs 27% in the DIP RCT
Formal test: UK (NICE)	• Fasting glucose at 6–13 wk; after 13 wk fasting glucose or HbA1c; no routine OGTT • FPG <6.0 or HbA1c <39: low risk → annual HbA1c • FPG 6.0–6.9 or HbA1c 39–47: high risk → prevention programme • FPG ≥7.0 or HbA1c ≥48: likely type 2 diabetes → confirm and refer

IF	THEN
Formal test: Canada (SOGC, Diabetes Canada)	75 g OGTT between 6 wk and 6 months postpartum.
Normal postpartum result	Retest every 1–3 years (ACOG); at least every 3 years (ADA); every year (NICE). Test before any future pregnancy.
Impaired fasting glucose or impaired glucose tolerance	Intensive lifestyle programme and weight loss; consider metformin, especially with both IFG and IGT (MFM EBG).
Diabetes range	Refer to diabetes care; preconception counselling and HbA1c optimisation before the next pregnancy.
Breastfeeding	Encourage: longer breastfeeding lowers progression to type 2 diabetes. Metformin and insulin are compatible with breastfeeding.
Contraception	All methods are suitable unless hypertension or vascular disease is present.
Long-term risk	About half develop type 2 diabetes within 15–25 years (Williams; ~10-fold lifetime risk); cardiovascular risk about doubled; GDM recurs in about half of later pregnancies. Lifelong screening and risk-factor care.

12 Do not

- Label diabetes-range values at the first visit as GDM: manage as pregestational diabetes.
- Use HbA1c, fasting glucose or a urine dipstick to rule out GDM at 24–28 wk, or HbA1c to monitor it.
- Mix criteria: one abnormal value diagnoses GDM only on the 75 g one-step test, not on the 100 g test.
- Do an OGTT during Ramadan fasting, or give a GCT or OGTT after sleeve gastrectomy or gastric bypass.
- Interpret an OGTT when the woman vomited during the test.
- Wait more than 1–2 wk on diet if targets are not being met, or wait for a growth scan before starting medication.
- Use glyburide (glibenclamide) as first-line treatment.
- Withhold indicated corticosteroids because of GDM; plan glucose monitoring and insulin adjustment instead.
- Induce before 39^{+0} wk for well-controlled GDM or for suspected macrosomia alone.
- Continue GDM medication after birth, or discharge without a plan for postpartum glucose testing.
- Give aspirin for GDM alone.

13 Where the guidelines differ

Topic	ACOG / ADA (USA)	NICE / SIGN (UK)	Others
Who is tested at 24–28 wk	Everyone	NICE: risk factors only · SIGN: risk factors	WHO, FIGO, Saudi MOH: everyone · Canada: everyone
Test	ACOG: two-step (50 g → 100 g) · ADA: one-step or two-step	75 g OGTT	WHO/FIGO: 75 g one-step · Canada: 50 g → 75 g preferred
Thresholds (mg/dL)	CC 95/180/155/140 (≥2) or IADPSG 92/180/153 (≥1)	NICE 100/–/140 · SIGN 95/191/162	WHO 92/180/153 · ADIPS, Canada 95/191/162
Early testing	Screen for pregestational diabetes if at risk; no routine early GDM testing (ACOG 2024)	NICE: early OGTT if previous GDM · SIGN: first-trimester HbA1c	IADPSG/WHO: early FPG 92–125 = GDM · ADIPS: early OGTT if risk
Targets (fasting / 1 h / 2 h)	<95 / <140 / <120 mg/dL	NICE 5.3 / 7.8 / 6.4 · SIGN 5.5 / 8.0 / 7.0 mmol/L	Canada 5.3 / 7.8 / 6.7 mmol/L · WHO 2025: individualise

Topic	ACOG / ADA (USA)	NICE / SIGN (UK)	Others
First drug	Insulin preferred; metformin reasonable alternative	NICE: metformin, then insulin · SIGN: metformin or insulin	WHO 2025: metformin or insulin
Glyburide	Not first line	Removed from NICE (2020)	FIGO 2015: acceptable
Timing of birth	A1 39^{+0}–40^{+6}; A2 39^{+0}–39^{+6}	By 40^{+6}; earlier if complications	SOGC: 38–40 wk
Postpartum test	75 g OGTT 4–12 wk (or before discharge)	FPG 6–13 wk, or HbA1c after 13 wk	Canada: 75 g OGTT 6 wk–6 mo
Long-term testing	Every 1–3 yr (ACOG); ≥ every 3 yr (ADA)	Annual HbA1c	Saudi MOH: every 3 yr

14 Abbreviations

Abbreviation	Meaning	Abbreviation	Meaning
Organisations and documents			
ACOG	American College of Obstetricians and Gynecologists	**ADA**	American Diabetes Association
ADIPS	Australasian Diabetes in Pregnancy Society	**BAPM**	British Association of Perinatal Medicine
CO	Committee Opinion (ACOG)	**EBG**	Evidence Based Guidelines (Berghella)
FIGO	International Federation of Gynecology and Obstetrics	**IADPSG**	International Association of Diabetes and Pregnancy Study Groups
IOM	Institute of Medicine (US)	**MFM**	Maternal-Fetal Medicine
MOH	Ministry of Health	**NDDG**	National Diabetes Data Group
NG	NICE guideline	**NICE**	National Institute for Health and Care Excellence
PB	Practice Bulletin (ACOG)	**RCT**	Randomised controlled trial
SIGN	Scottish Intercollegiate Guidelines Network	**SMFM**	Society for Maternal-Fetal Medicine
SOGC	Society of Obstetricians and Gynaecologists of Canada	**USPSTF**	US Preventive Services Task Force
WHO	World Health Organization	**CC**	Carpenter–Coustan criteria
Trials			
DIP	Postpartum diabetes testing RCT (inpatient vs outpatient OGTT)	**MiTy**	Metformin in women with Type 2 diabetes in pregnancy trial
TOBOGM	Treatment Of Booking Gestational diabetes Mellitus trial		
Clinical			
A1GDM / A2GDM	GDM on diet alone / on medication	**BMI**	Body mass index
BPP	Biophysical profile	**CGM**	Continuous glucose monitoring
D5NS	5% dextrose in normal saline	**DKA**	Diabetic ketoacidosis
EFW	Estimated fetal weight	**eGFR**	Estimated glomerular filtration rate
FPG	Fasting plasma glucose	**GCT**	Glucose challenge test (50 g)
GDM	Gestational diabetes mellitus	**HbA1c**	Glycated haemoglobin

Abbreviation	Meaning	Abbreviation	Meaning
IFG / IGT	Impaired fasting glucose / impaired glucose tolerance	**IV**	Intravenous
LGA / SGA	Large / small for gestational age	**NPH**	Neutral protamine Hagedorn (intermediate-acting) insulin
NST	Non-stress test	**OGTT**	Oral glucose tolerance test
PCOS	Polycystic ovary syndrome	**T1, T2, T3**	First, second, third trimester
U	Units of insulin	**wk**	Weeks of gestation

15 Sources

Textbooks

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- Berghella V (ed). Maternal-Fetal Evidence Based Guidelines, 4th ed. Ch. 5 Gestational Diabetes; Ch. 4 Pregestational Diabetes (Figure 4.1, intrapartum management).
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Guidelines checked (October 2026)

- ACOG Practice Bulletin 190, Gestational Diabetes Mellitus (2018), current; ACOG Clinical Practice Update, Screening for Gestational and Pregestational Diabetes in Pregnancy and Postpartum (2024), updates PB 190 and PB 201 on screening.
- ACOG Committee Opinion 831, Medically Indicated Late-Preterm and Early-Term Deliveries (2021); CO 828, Indications for Outpatient Antenatal Fetal Surveillance (2021); PB 216, Macrosomia (2020, reaffirmed 2023); PB 201, Pregestational Diabetes (2018).
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Decision aid only: it does not replace clinical judgement or local protocols. Verify drug doses against your formulary.