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Gestational Diabetes Mellitus: Case Scenario

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1. Background

Gestational diabetes mellitus is defined as glucose intolerance that begins or is first detected during pregnancy. GDM affects ~ 7% of all pregnancies, resulting in > 200,000 cases per year. The importance of GDM is that two generations are at risk of developing diabetes in the future. GDM is a condition that occurs during pregnancy when the body cannot produce enough insulin to handle the effects of a growing baby and changing hormone levels. This paper presents an outline of clinical issues as well as GDM diagnosis and management.

2. Case Presentation

In 2013, a 36 year old woman was admitted in Apollo hospitals, Bangalore with the complaint of decreased urine output, burning micturation. Patient presented with increased swelling since two weeks over the hand bilateral. At the time of admission patient was diagnosed with nephritic syndrome with diabetic nephropathy, hypertension and hypothyroidism, type II diabetes mellitus associated with bilateral swelling over both limbs. Patient gives history of similar episodes since one month on and off, per orbital swelling more during morning. Patient had LSCS ten years ago. Patient is known case of diabetes mellitus since pregnancy managed on diet and started medications one year back. Gestational diabetes progressed to diabetes since one year. Diabetic nephropathy proves in May 2013, on OHA since one year. Diabetes nephropathy biopsy proved in may 2011. She was in volume overload with stable renal dysfunction proteinurea and hypoalbuminia.

3. Management

She was treated with diuretics and albumin following which she has improved symptomatically. The primary management method for women with GDM is nutritional therapy. Some women with GDM require diet therapy alone, while some women require both diet therapy and insulin therapy to control their diabetes. Currently, there is no universal management method for GDM because there are no universal diagnostic criteria and genomic backgrounds differ according to ethnicity. Diabetes in pregnancy must be treated with utmost seriousness both in terms of proper nutrition, dietary management as well as change in life style.

4. Medication Prescribed

Medicine	*Dose*	*Frequency*	*Purpose*
Tab Augmentin	625 mg	1-0-1	To treat bacterial infections
Inj. Lantus	16 units (at bed time)		To treat diabetic ketoacidosis
Tab Galvus	50 mg (with breakfast)	1-0-0	To lower blood sugar level
Tab Dytor	40 mg (8 am,4pm)	2-1-0	To treat high blood pressure
Tab Prazopress	5 mg	0-0-1	To treat high blood pressure
Tab Telma	40 mg	1-0-0	Anti – hypertensive
Tab Ecosprin	150 mg	0-1-0	Analgesic
Tab Rosuvas	10 mg	0-0-1	To lower cholesterol
Tab Thyronorm	50 mcg	1-0-0	To treat hypothyroidism
Tab Pregaster	75 mg	0-0-1	Anticonvulsant
Cap Becosule		1-0-0	B – complex
Tab Ultracet	SOS (for pain)		To treat severe pain

Medical Nutrition Therapy For Diabetes Management

- To prevent malnutrition
- To obtain adequate nutrition
- To improve nutritional status and maintain desirable body weight
- To maintain normal blood sugar level and avoid episodes of hypoglycemia
- To prevent delay or minimize the onset of chronic degenerative complications

5. Conclusion

Patient is 36 year old lady, with known case of diabetes, HTN and hypothyroidism with diabetic nephropathy presented with increasing pedal edema since two weeks. Clinically she was in volume overload with stable renal dysfunction, protein urea and hypoalbuminea. She was treated with diuretics and albumin following which she has improved symptomatically and blood sugar level controlled. Diet counseling was given for diabetic low salt diet as well as diet chart was given.