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Proposal for the Reconsideration of the Definition of Gestational Diabetes

Response to Omori and Jovanovic

I read with interest the letter by Omori and Jovanovic (1) in the October 2005 issue of *Diabetes Care* and have the following comments.

In the Clinical Practice Recommendations from 2002 to 2005 (2–5), you will find the following statements.

“A fasting plasma glucose level >126 mg/dl (7.0 mmol/l) or a casual plasma glucose level >200 mg/dl (11.1 mmol/l) meets the threshold for the diagnosis of diabetes, if confirmed on a subsequent day, and precludes the need for any glucose challenge.”

Although these two patient populations (i.e., patients with gestational diabetes mellitus [GDM] and patients with diabetes diagnosed during pregnancy) were not formally separated in relation to patient outcome or risk of congenital malformations, we, in our institution, have adopted the policy of labeling these pregnant women, who have blood glucose levels in the diabetic range, as “diabetic patients first discovered during pregnancy.” This labeling would be even further substantiated if the index case was discovered during the first trimester.

The second point is the surprising finding in the Japanese study of having the highest frequency of both GDM and type 2 diabetes in the first trimester and the lowest in the third trimester, which is against the classical teaching and against the fact that insulin resistance, and consequently the frequency and incidence of

GDM, is highest in the third trimester. This reversed incidence of GDM in different trimesters of pregnancy needs to be further analyzed and explained.

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Proposal for the Reconsideration of the Definition of Gestational Diabetes

Response to Dawood

We thank Dawood for his comments (1) concerning our letter (2), in which we reported the results of our two populations (from Japan and California). Our results underscore the need for a unique diagnosis for those women with moderate to severe hyperglycemia and/or other evidence of long-standing diabetes complications, and thus the label of gestational diabetes mellitus (GDM) is not adequate to identify the urgent need for more intensive surveillance and treatment than would other-

wise be available for gestational diabetic women.

Dawood is correct; the American Diabetes Association (ADA) would not label our cohorts as having “type 2 diabetes” because their blood glucose concentrations did not reach the criteria of the ADA guidelines or position statements. The point is that regardless of whether these pregnant women are called type 2 diabetic women or, as Dawood suggests, “diabetic patients first discovered during pregnancy,” it is a matter of semantics. The bottom line is that these women would receive better care if they were not thought to have merely GDM. It is time to reconsider the definition of GDM.

Dawood’s second question was related to our lowest prevalence of GDM in the third trimester (first trimester: 33 of 250 [13.2%]; second trimester: 32 of 417 [7.7%]; and third trimester: 37 of 749 [4.9%]). In our Japanese cohort, our observation is based on the protocol that administers the oral glucose tolerance test in only those pregnant women with risk factors, not the population of pregnant women in general without risk factors for diabetes. The risk factors for diabetes have the highest likelihood of identifying those women who have diabetes already in the first trimester. The third-trimester increase in prevalence of GDM that Dawood questions only occurs in women without risk factors, when the pregnancy per se has the strongest impact on glucose intolerance, not age, obesity, history of glycosuria, glucose intolerance, hypertension, or delivery of a previous infant with macrosomia.

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