COMMENTS AND RESPONSES

Response to Comment on: American Diabetes Association. Standards of Medical Care in Diabetes—2011. Diabetes Care 2011;34(Suppl. 1): S11–S61

We appreciate the opportunity to respond to the letter of Basevi et al. (1). The new recommendations by the American Diabetes Association (ADA) for gestational diabetes mellitus (GDM) screening and diagnosis are level B recommendations ("supportive evidence from well-conducted cohort studies"). As described in our Standards of Medical Care (2), the ADA adopted the consensus recommendations of an international group convened by the International Association of Diabetes and Pregnancy Study Groups (IADPSG), on the basis of the group's extensive review of published and unpublished data from the multinational Hyperglycemia and Adverse Pregnancy Outcome (HAPO) study. The cut points chosen represent those that confer an odds ratio of 1.75, compared with the mean values, for a number of prespecified adverse pregnancy outcomes (3).

The recommendation for universal GDM screening is not a major change. Prior ADA recommendations were to screen all but very low-risk women (in the U.S., a very small minority of pregnant women), either with a one- or two-step protocol. The fasting plasma glucose (FPG) cut point is only slightly lower than the prior recommendation (95 mg/dL [5.3 mmol/L]). Using an FPG cut point of 126 mg/dL (7 mmol/L) to diagnose GDM is not the standard of care in most systems. In fact, in the HAPO study, women with FPG >105 mg/dL (5.8 mmol/L) were unblinded and not included in the untreated observational cohort for ethical reasons.

The main critique of the recommendations is that more women will be diagnosed with GDM because only one abnormal oral glucose tolerance test value is required. The IADPSG group's analyses showed that values at any of the three oral glucose tolerance time points were informative of risk. By definition, women identified with the new criteria who would not have been identified by prior ADA criteria will have milder GDM. We disagree that treatment of GDM has limited benefit beyond reduction in shoulder dystocia. The U.S. study (with diagnostic criteria similar to the IADPSG criteria) showed significant reductions in rates of primary cesarean section and in preeclampsia and gestational hypertension with identification and treatment of mild GDM (4). Both the U.S. and Australian studies showed significant reductions in macrosomia (a known risk factor for future obesity and diabetes) (4,5). The latter study showed improved postpartum measures of maternal quality of life and lower rates of depression (5). In the U.S. study, 93% of treated women were managed with lifestyle therapy alone. It is likely that the more hyperglycemic women requiring insulin treatment would have been diagnosed by prior criteria.

For years GDM has been defined differently throughout the world—a patchwork that stymies epidemiological analyses and harmonization of clinical research and care. Prior diagnostic criteria were not based on evidence for pregnancy-related outcomes. The IADPSG recommendations are a highly rational way to identify women at higher risk of adverse pregnancy outcomes—outcomes that can be reduced primarily with lifestyle interventions. The ADA therefore joined numerous diabetes and obstetrical organizations worldwide in adopting these recommendations.

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