RESPONSE TO COMMENT ON McINTYRE

Diagnosing Gestational Diabetes Mellitus: Rationed or Rationally Related to Risk? Diabetes Care 2013;36:2879–2880

Diabetes Care 2014;37:e82 | DOI: 10.2337/dc13-2889

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Dr. Ryan (1) questions the arguments advanced in favor of the American Diabetes Association (ADA)/ International Association of the Diabetes and Pregnancy Study Groups (IADPSG) diagnostic process and criteria for gestational diabetes mellitus (GDM) (2) and vigorously supports a "minimal change" approach to GDM diagnosis. Several of his points deserve comment.

With respect to "two-step" testing, O'Sullivan's (3) initial cohort of 752 women did undergo a nonfasting, 1-h 50-g glucose "challenge" test (GCT) prior to their 100-g oral glucose tolerance test (OGTT). However, the OGTT was performed on all women (752 /986) who *attended for testing*, irrespective of prior GCT results and is therefore equivalent to a "one-step" process. The suggested use of GCT thresholds to determine the "need" for an OGTT was a much later development.

Ryan has correctly calculated the relative time burdens of GCT + OGTT versus universal OGTT. However, this view of the issue is incomplete. In addition to the time spent undergoing the test, the inevitable delay in initiation of treatment, the impact of missing 25% of GDM cases, and the true cost of the additional pregnancy complications seen in these cases must be considered. Further, as noted previously, it appears that even the Canadian system is susceptible to process errors (2), with only 64% of women reportedly proceeding to the recommended diagnostic test after a positive GCT.

Ryan reiterates his previously published arguments (4) in favor of two glucose abnormalities being required to diagnose GDM. However, his suggestion of a GCT-based "postload" screen ignores the importance of fasting glucose elevations, which have been clearly demonstrated to carry at least as strong an association with adverse pregnancy outcomes as postload values (5).

In the end, given the continuous relationship between all glycemic measures and adverse pregnancy outcomes, this comes down to a value judgment: at what level of glycemia is it preferable to "label" a woman as GDM and provide lifestyle modification advice, glucose monitoring, potential pharmacotherapy, and later follow-up rather than to consider her as "normal"—avoiding the "GDM label" but also the potential health benefits of treatment?

There are reasonable, but no absolutely "right" answers to this question. After careful consideration of the available evidence, the IADPSG panel, the ADA, and more recently the World Health Organization (6) have all concluded in favor of very similar GDM diagnostic processes and identical thresholds. Dr. Ryan (1) and the National Institutes of Health consensus panel disagree. They are certainly entitled to their opinions, but would be well served by arguments more cogent than the maintenance of the status quo.

Duality of Interest. H.D.M. is currently chair of the IADPSG and was a principal investigator on the Hyperglycemia and Adverse Pregnancy Outcome Study. No other potential conflicts of interest relevant to this article were reported.

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