

Smirmakis KV, Chasan-Taber L, Wolf M, et al. Postpartum diabetes screening in women with a history of gestational diabetes. *Obstet Gynecol.* 2005;106:1297–1303.

Q Are we doing a good job of screening for postpartum type 2 diabetes?

A No, for the most part. Only slightly more than one third of eligible women undergo the postpartum screening tests recommended by the American Diabetes Association (ADA). In at least half of the women who ultimately have such screening, the delay is more than a year after delivery—the median is 428 days. In contrast, 94% of women have a postpartum Papanicolaou test after a median interval of only 49 days.

EXPERT COMMENTARY

Although the clinical impact of gestational diabetes on pregnancy outcomes is still under debate, we know the condition heightens risk of developing type 2 diabetes later in life. As many as one third of parous women with diabetes had gestational diabetes, and the incidence of both gestational diabetes and subsequent type 2 diabetes seems to be increasing.

While the ADA recommends that maternal glycemic status be reassessed at roughly 6 weeks postpartum in women with gestational diabetes, the American College of Obstetricians and Gynecologists (ACOG) makes no clear recommendation. The ACOG practice bulletin on gestational diabetes¹ acknowledges that such testing may be performed, but points out that no studies have confirmed its benefit.

Only 37% had the right kind of test

In the Smirmakis study, two thirds of the population of 197 women had some form of postpartum glucose measurement—but only 37% were tested according to ADA

recommendations, which call for measurement of fasting glucose levels or undergoing the oral glucose tolerance test. In many cases, postpartum assessment consisted of only random glucose testing, which can overlook serious carbohydrate intolerance.

The only factors that significantly increased the likelihood of postpartum screening were glucose values after the 1-hour glucose loading test (during pregnancy) at or above the geometric mean (≥ 171 mg/dL) and/or a fasting glucose level (from the pregnancy diagnostic test) at or above the geometric mean (≥ 98 mg/dL).

This study did not report whether the need for insulin or an oral agent (class A2) during pregnancy was independently associated with the frequency of postpartum testing for type 2 diabetes. Such an association seems likely, given the fasting cutoff of 98 mg/dL.

Why aren't we doing a better job?

Possible explanations of the low screening rates include a lack of direction from ACOG, confusion over provider responsibility (obstetrician versus primary care provider), lack of patient education, and the difficulty of mothers pursuing such testing while caring for a newborn.

Although it is unclear whether the 2-hour oral glucose tolerance test is clinically superior to a fasting glucose level for postpartum screening, it is generally accepted that some form of postpartum glucose assessment is needed in this high-risk group of women.

FAST TRACK

All women with gestational diabetes should have a postpartum glucose tolerance test

CONTINUED

Unfortunately, we lack studies of efficacy and timing of diabetes screening in women with gestational diabetes.

Gestational diabetes always calls for postpartum glucose tolerance testing

A formal recommendation from ACOG would be a good first step, until further data are available. Even without such a recommendation, however, the ADA and most of us agree that early diagnosis and treatment of diabetes can potentially decrease long-term complications. For this reason, obstetricians should conduct postpartum glucose assessment using the 2-hour oral glucose tolerance test or fasting glucose for all women with a history of gestational diabetes.

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REFERENCE

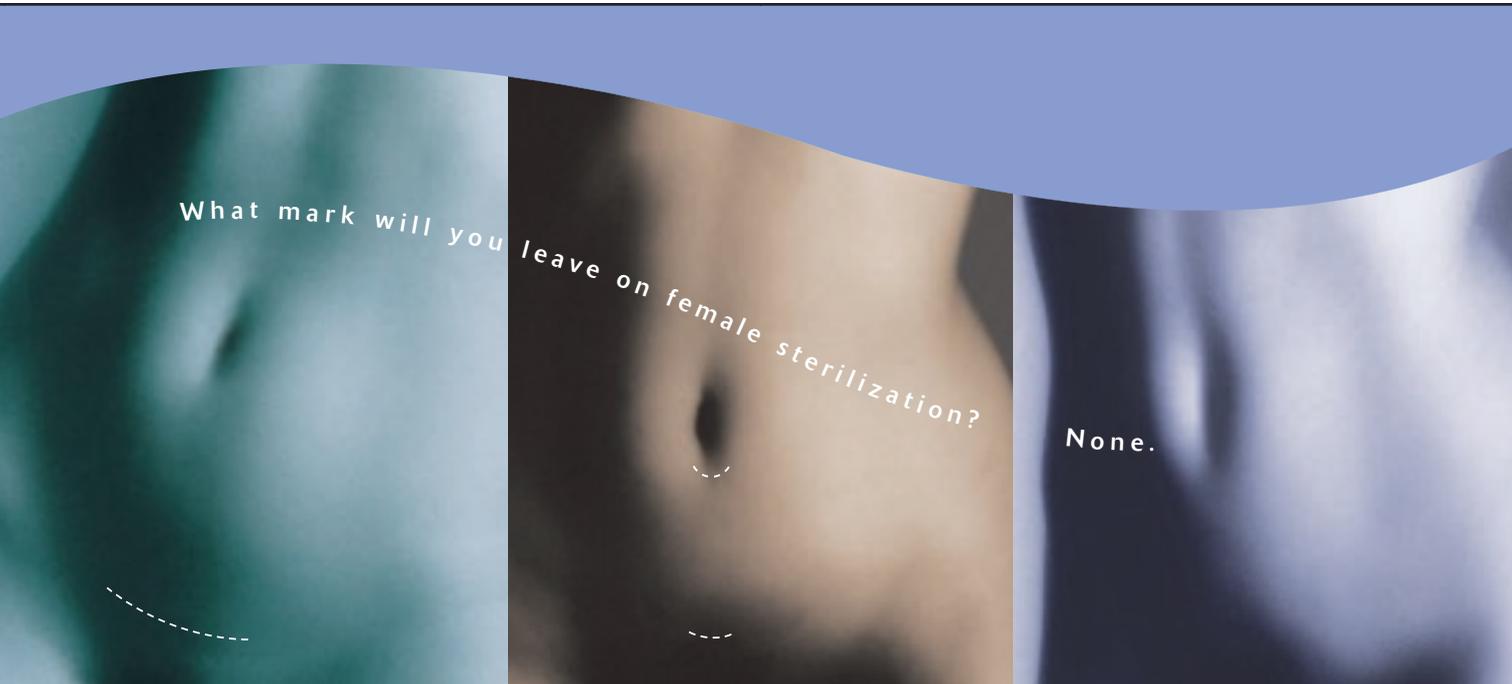
1. American College of Obstetricians and Gynecologists. Practice Bulletin #30: Gestational Diabetes. Washington, DC: ACOG; 2001.

The author reports no financial relationships relevant to this article.

Erratum

Irvin W, Hullfish K. Abdominal techniques for surgical management of vaginal vault prolapse. *OBG Management*. 2005;17(12):19–23.

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