We are IntechOpen, the world’s leading publisher of Open Access books
Built by scientists, for scientists

4,900
Open access books available

124,000
International authors and editors

140M
Downloads

154
Countries delivered to

TOP 1%
Our authors are among the most cited scientists

12.2%
Contributors from top 500 universities

WEB OF SCIENCE™
Selection of our books indexed in the Book Citation Index in Web of Science™ Core Collection (BKCI)

Interested in publishing with us?
Contact book.department@intechopen.com

Numbers displayed above are based on latest data collected.
For more information visit www.intechopen.com
Chapter 2

Multidisciplinary Care of Pregnant Women with Gestational Diabetes Mellitus: Non-Pharmacological Strategies to Improve Maternal and Perinatal Outcomes

Elaine Christine Dantas Moisés

Additional information is available at the end of the chapter

http://dx.doi.org/10.5772/55295

1. Introduction

Diabetes Mellitus (DM) is an endocrine disorder characterized by hyperglycemia due to insulin deficiency. This deficiency can be caused by reduced pancreatic production, inadequate release in response to increased carbohydrates or peripheral insulin resistance (ADA, 2009).

2. Classification

The first classification for Diabetes Mellitus has been published in 1949 by White Priscilla, categorizing this pathology in classes A, B, C, D, E, F, R, H and T, according to the severity of the disease, age of onset, duration, need for insulin use and the presence or absence of vascular disease arising from the Diabetes Mellitus. This classification is still widely used for predicting complications during pregnancy and is considered as an etiologic and prognostic system (Calderon et al., 2007).

The National Diabetes Data Group (1979) suggested a clinical classification based on the type of Diabetes Mellitus, considering three groups: insulin-dependent Diabetes Mellitus or Type I, Non-insulin-dependent Diabetes mellitus or Type II, and Gestational Diabetes Mellitus (GDM), which is diagnosed during pregnancy. This classification was recommended in 1980 by the World Health Organization Expert Committee on Diabetes Mellitus, being included in the same group of glucose intolerance. This classification was intended to establish a uniform structure for clinical and epidemiological research (Bennett, 1985).
The American Diabetes Association (ADA) restructured the classification and diagnostic
criteria for Diabetes mellitus in 1999, emphasizing its etiology. Subsequently, the ADA (2005) ratified this
classification recognized two intermediate stages of the disease, being called pre-diabetes, characterized by impaired glucose tolerance and fasting glucose intolerance (Table 1).

I. Diabetes mellitus type 1: beta-cell destruction, usually leading to absolute insulin deficiency

II. Type 2 diabetes mellitus: can vary from primarily due to insulin resistance with relative insulin deficiency to a predominantly secretory defect with insulin resistance

III. Other specific types
- Genetic defects of beta cell function
- Genetic defects in insulin action
- Diseases of the exocrine pancreas
- Endocrinopathies
- Drug or chemical induced
- Infection
- Unusual forms of Diabetes immunomediated
- Other genetic syndromes sometimes associated with diabetes

IV. Gestational diabetes mellitus

Table 1. Etiological classification of Diabetes mellitus (adapted from ADA, 2005; ADA, 2009).

3. Epidemiological data on pregnancy

The dysglycemia is the most common metabolic disorder in pregnancy, but its frequency varies
worldwide and among racial and ethnic groups. Broadly in general, the prevalence of
dysglycemia during pregnancy can be up to 13%, corresponding to 0.1% of type 1 diabetes
(T1DM), 2-3% of type 2 diabetes (T2DM) and 12 to 13% Gestational Diabetes Mellitus,
depending on the diagnostic criteria used and the population studied (Hod; Diamant, 1991).

GDM is defined as glucose intolerance of variable severity, which appears or is first diagnosed
during pregnancy (ADA, 2009), disappears after childbirth and that does not correspond to a
pre-gestational diabetes (ADA, 2011). There has been a significant increase in the number of
diagnoses of GDM over time, possibly related to an increase in average maternal weight and
age (Getahun et al, 2008). Prevalence also varies according to the method of testing and
diagnostic criteria.

It is recommended the early screening of high-risk pregnant women in the first prenatal visit,
which allows identifying preexisting diabetes mellitus cases, which should not be erroneously
termed as gestational diabetes. Excluding preexisting diabetes mellitus, pregnancy calls for
the testing of employing glucose overload, from the second trimester of gestation for the diagnosis of GDM. Currently, the American Diabetes Association (ADA, 2011) and the International Association of Diabetes and Pregnancy Study Groups (IADPSG, 2010) recommend 75-g oral glucose tolerance test, with a duration of 2 hours, adopting as diagnostic criteria for GDM cutoff points suggested by the Hyperglycemia and Adverse Pregnancy Outcomes-HAPO study (2008), with plasma levels of fasting glucose greater than or equal to 92 mg/dl one hour post glucose load, greater than or equal to 180 mg/dl two hours post glucose load, greater than or equal to 153 mg/dl, requiring only a single point change for the diagnosis of GDM. Using the diagnostic criteria proposed by IADPSG, there is detection rate of diabetes during pregnancy in about 18% of pregnant women.

4. Glycemic control

The assessment of glycemic control, through laboratory evaluation of fasting and postprandial blood glucose, supplemented with daily home blood glucose self-monitoring, should be considered every one to two weeks by the treating physician or a member of the multidisciplinary team.

Glycemic control is considered appropriate if blood glucose levels remain within the reference values (fasting less than 95 mg/dl, before meals less than 100 mg/dl, one hour postprandial less than 140 mg/dl, two hours postprandial less than 120 mg/dl) and glycosylated hemoglobin test is less than or equal to 6%. The permanence of the blood glucose above the reference values indicates the need for adjustment or inclusion of pharmacological and non-pharmaceutical therapies (ADA, 2011).

The criterion of excessive fetal growth, through the measurement of fetal abdominal circumference greater than or equal to the 70th percentile on ultrasound between the 29th and 33rd week, can also be used to indicate drug therapy in GDM (Buchanan et al, 1994).

5. Multidisciplinary care for pregnant women with diabetes mellitus

During prenatal care, it is essential to focus on providing information to patients about the pathophysiology and prognosis of diabetes mellitus, either pre-existing or gestational. Therefore, consultation should include targeted guidelines for diabetes care, in addition to whole routine prenatal. Its periodicity depends directly on glycemic control, beyond existence and progression of maternal and fetal complications, detected by clinical examination and complementary propaedeutic, whose discussion is not the focus of this chapter.

Poorly controlled DM is often associated with increased risks of adverse maternal and perinatal outcomes. Education and care programs in diabetes, provided by multidisciplinary team in support of the medical staff, acting either alone or associated with pharmacological treatment, may determine changes in the natural history of the disease, improving maternal and perinatal outcomes.
6. Nutritionist: Adequacy of food habit to nutritional need

Initial treatment of GDM and important part of preexisting diabetes treatment consist of nutritional guidance to provide appropriate levels of caloric intake for adequate weight gain during pregnancy, normalization of glycemia, absence of ketones and promote fetal well-being.

Dietary recommendations follow similar patterns to those aimed at the general population. The nutritional prescription constitutes the calculation of caloric intake and mounting the daily menu, in addition to providing basic concepts about nutrition, healthy eating, the food pyramid and food fractionation to the patient in order to arouse attention to the importance of nutrition in pregnancy.

The ideal weight should preferably be achieved prior to pregnancy, since that is the determining factor of the optimum setting of the nutrition prescription throughout gestation cycle. The calculation of caloric value diet and adequate weight gain can be made according to the idealized tables for this purpose (table 2), based on the Body Mass Index prior to pregnancy, frequency and intensity of physical exercises and fetal growth pattern (Kaiser, Allen, 2008).

| Nutritional status       | BMI prior to pregnancy (Kg/m²) | Total weight gain in the first trimester (Kg) | Weekly weight gain in the second and third trimesters (Kg) | Total weight gain in the pregnancy (Kg) |
|--------------------------|--------------------------------|-----------------------------------------------|-------------------------------------------------------------|----------------------------------------|
| Underweight              | < 18.5                         | 2.3                                           | 0.5                                                         | 12.5 - 18                              |
| Normal Weight            | 18.5 – 24.9                    | 1.6                                           | 0.4                                                         | 11.5 - 16                              |
| Overweight               | 25.0 – 29.9                    | 0.9                                           | 0.3                                                         | 7 – 11.5                               |
| Obese                    | ≥ 30.0                         | -                                             | 0.3                                                         | 5 - 9                                  |

Kg: kilogram
Kg/m²: kilograms per square meter
BMI: Body Mass Index

Table 2. Recommendation for total gain weight during pregnancy according to the Body Mass Index (BMI) before pregnancy (adapted from Kuehn, 2009).

In clinical practice, for women with BMI below 18.5 kg/m², the prescription of caloric intake can be up to 40 kcal / kg / day; for women with BMI between 18.5 and 24.9 kg / m², energy
intake should be 30 kcal / kg / day; for women who are overweight, the caloric supply is 22 to 25 kcal / kg / day; for the morbid obese women the caloric prescription must be from 12 to 14 kcal / kg / day.

The diet should be planned throughout the day, being split into three large meals and three snacks (ADA, 2004), being the carbohydrate intake distributed between them, aiming to prevent postprandial hyperglycemia. The nutritional requirement of carbohydrates should be restricted to less than 40% of total daily calories, with the remainder distributed among proteins (15% to 20% of total calories per day, at least 1.1 g / kg / day) and fats (30% to 40% of total calories per day). The adjustment of the postprandial insulin dose can be done by calculating the carbohydrate content of each meal.

Non-nutritive artificial sweeteners such as aspartame, saccharin, acesulfame-K and sucralose can be used sparingly, aiding the adaptation of taste to food (ADA, 2004).

7. Physical educator and therapist: Physical activity as a strategy for prevention and adjuvant treatment

Physical activity reduces insulin resistance, facilitating peripheral glucose utilization with consequent improvement of glycemic control while also helping to control weight gain during pregnancy (Reader, 2007).

The recommended exercise prescription is low-impact physical activity, ideally being practiced daily for at least 30 minutes, which can be divided into three sessions of ten minutes each, keeping levels not exceeding 50% of the aerobic capacity of the patient (table 3).

| Parameter     | Programa                                      |
|---------------|-----------------------------------------------|
| Frequency     | 3 to 4 days / week                            |
| Intensity     | Variable (according to the previous fitness)  |
| Duration      | Initially 15 minutes with gradual increase up to a maximum of 30 minutes / session |
| Modality      | Low impact aerobic                            |
|               | Strength training and endurance               |

Table 3. Prescription of exercise during pregnancy (adapted from Davies et al, 2003).
It constitutes safe method to be used during pregnancy (Szymanski, Satin, 2012). Some precautions should be observed in handling (Ferraro, Gaudet, Adamo, 2012), such as starting the physical activity sessions preferably after meals, avoiding beginning if the blood glucose is below 60 mg/dL or above 250 mg/dL (Artal, 2003). The practice of physical exercises during pregnancy is also contraindicated in cases of obstetric complications and / or concomitant medical complications, as reported in Table 4.

| Obstetric contraindications                      | Clinical contraindications                |
|-------------------------------------------------|------------------------------------------|
| Previous Miscarriage or preterm childbirth       | Cardiovascular disease                   |
| Cervical incompetence                           | Hypertensive disease                     |
| Premature rupture of membranes                   | Respiratory disease                      |
| Preterm labor                                    | Anemia (Hb <10 g/dl)                     |
| Intrauterine growth restriction                  | Malnutrition or eating disorder          |
| Multiple pregnancy: (two fetuses after 28th week or three or more fetuses at any gestational age) | Uncontrolled Diabetes Mellitus Type 1 |
| Placenta previa after 28th week                  | Decompensated thyroid disease            |
| Persistent bleeding in the second and / or third trimesters |                                |

Hb: hemoglobin  
g/dl: grams per deciliter

Table 4. Contraindications to physical exercise during pregnancy (adapted from Davies et al, 2003).

8. Psychologist: Emotional support as a strategy for treatment adherence

Pregnancy, by itself, constitutes a period marked by several changes in women’s lives, involving social, biological, marital and psychological changes, which are aggravated because of the occurrence of clinical and / or obstetric conditions that may potentially alter the maternal and / or fetal outcomes. These changes may act as stressors and may interfere in a positively or negatively way in adherence to the proposed treatment.

Psychological care has an evaluative component and, on the other hand, it also has an instructional feature that serves as a basis for reflection and construction of behavior in the situation experienced.

The initial characterization of the social, emotional and psychological aspects involving a pregnant woman can be accomplished through evaluation instruments (Cohen, Kamarck, Meremelstein, 1983; Zigmond, Snaith, 1983; Sherbourne, Stewart, 1991; Herrmann, 1997).

Regarding psychological intervention approach should initially focus on the demands related to pregnancy and Diabetes Mellitus brought by the patient herself and, subsequently, expand the focus to the instructional aspect, based on the information acquired. The understanding of the whole process of health care and the benefits of the proposed interventions are the basis
for building the strategy of treatment adherence, particularly with regard to diet (Gardner et al, 2012).

9. Nurse: Combination of communication strategies and training techniques

Nursing staff has fundamental integrator role in the care program for pregnant women with diabetes mellitus. It features functions such as consolidation of primary communication channel created by other professionals, technical training of specialized care and monitoring of metabolic control of patient.

Different communication strategies can be adopted in order to achieve success in providing guidance and establishing appropriate relationship with patients, that allow effective training techniques of glycemic control monitoring. The establishment of this open channel of communication between the patient and nursing staff provides another opportunity to solidify concepts, in addition to allowing the sharing of anxieties and doubts, minimized by this team of professionals, collaborating to treatment adherence (Furskog et al, 2012; Mendelson et al, 2008; Persson et al, 2011).

Active and constant participation of nursing staff in the monitoring of glycemic control can determine the establishment of the patient’s attention to self-care and, consequently, the drop in rates of adverse events, improving maternal-fetal prognosis (Ferrara et al, 2012)

10. Social worker: Creation of favorable environmental conditions for the treatment

The Social Services is responsible for providing guidance on social rights and social security, as well as duties related to treatment. Actions related to insertion of pregnant women in social support networks can facilitate access to certain resources, which allows better adherence to treatment and success of such proposals.

The social worker must also foster opportunities for discussion in order to create conditions for pregnant women develop their critical capacity as subjects of rights.

Reviews regarding the effectiveness of interventions offered to women during pregnancy who have been identified with social risk factors in relation to the development of depression and adherence to clinical follow-up are under development in literature (Kenyon et al, 2012).

11. Multidisciplinary group: Strategy of sharing experiences

Considering that the behavior of a pregnant woman can act as a multiplier of information and influence the conduct of another patient, it is possible to use pregnant women with adequate
adhesion to treatment as a reference to be followed. In this context, multidisciplinary care with groups of diabetic pregnant women can be an effective complementary strategy to individual assistance.

Acknowledgements

To the multidisciplinary team of Clinical Hospital of Faculty of Medicine of Ribeirão Preto, University of São Paulo:
Psychologist: Juliana Caseiro
Social Worker: Renata Cecílio
Nutritionist: Daniella Cristina Fernandes da Silva
Head nurse: Ana Lúcia Moreira Fernandes

Author details

Elaine Christine Dantas Moisés
Department of Gynecology and Obstetrics, Faculty of Medicine of Ribeirão Preto, University of São Paulo, Brazil

References

[1] American Diabetes Association (2005). Diagnosis and Classification of Diabetes Mellitus. Diabetes Care 28 (Suppl 1): SS42., 37.
[2] American Diabetes Association (2009). Diagnosis and Classification of Diabetes Mellitus. Diabetes Care 32 (Suppl 1): SS67., 62.
[3] American Diabetes Association- ReportsPosition of the American Dietetic Association: use of nutritive and nonnutritive sweeteners (2004). J Am Diet Assoc., 255-275.
[4] American Diabetes Association (2011). Standards of medical care in diabetes-2011. Diabetes Care 34 (Suppl 1): SS61., 11.
[5] Artal, R. (2003). Exercise: the alternative therapeutic intervention for gestational diabetes. Clin Obstet Gynecol, 46(2), 479-487.
[6] Bennett, P. H. (1985). Basis of the present classification of Diabetes. Adv Exp Med Biol., 189, 17-29.
[7] Buchanan, T, Kjos, S. L, & Montoro, M. N. Wu PYK, Madrilejo NG, Gonzales M (1994). Use of fetal ultrasound to select metabolic therapy for pregnancies complicated by mild diabetes. Diabetes Care, 17, 275-283.

[8] Calderon IMPKerche LTRL, Damasceno DC, Rudge MVC (2007). Diabetes and Pregnancy: an Update of the Problem. ARBS Annu Rev Biomed Sci, 9, 1-11.

[9] Cohen, S, Kamarck, T, & Mermelstein, R. (1983). A global measure of perceived stress. J Health Soc Behav, 24(4), 385-396.

[10] Davies, G. A, Wolfe, L. A, & Mottola, M. F. MacKinnon C; Society of Obstetricians and gynecologists of Canada, SOGC Clinical Practice Obstetrics Committee (2003). Joint SOGC/CSEP clinical practice guideline: exercise in pregnancy and the postpartum period. Can J Appl Physiol, 28(3), 330-341.

[11] Ferrara, A, Hedderson, M. M, Ching, J, Kim, C, Peng, T, & Crites, Y. M. (2012). Referral to telephonic nurse management improves outcomes in women with gestational diabetes. Am J Obstet Gynecol206(6):491.e, 1-5.

[12] Ferraro, Z. M, Gaudet, L, & Adamo, K. B. (2012). The potential impact of physical activity during pregnancy on maternal and neonatal outcomes. Obstet Gynecol Surv, 67(2), 99-110.

[13] Furskog Risa C, Friberg F, Lidén E (2012). Experts’ encounters in antenatal diabetes care: a descriptive study of verbal communication in midwife-led consultations. Nurs Res Pract2012:121360

[14] Gardner, B, Croker, H, Barr, S, Briley, A, Poston, L, & Wardle, J. UPBEAT Trial (2012). Psychological predictors of dietary intentions in pregnancy. J Hum Nutr Diet, 25(4), 345-353.

[15] Getahun, D, Nath, C, Ananth, C. V, Chavez, M. R, & Smulian, J. C. (2008). Gestational diabetes in the United States: temporal trends 1989 through 2004. Am J Obstet Gynecol 198(5):525.e, 1-5.

[16] HAPO Study Cooperative Research GroupMetzger BE, Lowe LP, Dyer AR, Trimble ER, Chevarinadr U, Coustan DR, Hadden DR, McCance DR, Hod M, McIntyre HD, Oats JJ, Persson B, Rogers MS, Sacks DA ((2008). Hyperglycemia and adverse pregnancy outcomes. N Engl J Med, 358(19), 1991-2002.

[17] Herrmann, C. (1997). International experiences with the Hospital Anxiety and Depression Scale--a review of validation data and clinical results. J Psychosom Res, 42(1), 17-41.

[18] Hod, M, & Diamant, Y. Z. (1991). Diabetes in pregnancy. Norbert Freinkel Memorial Issue. Isr J Med Sci, 27, 421-532.

[19] International Association of Diabetes and Pregnancy Study Groups Consensus PanelMetzger BE, Gabbe SG, Persson B, Buchanan TA, Catalano PA, Damm P, Dyer AR, Leiva A, Hod M, Kitzmiler JL, Lowe LP, McIntyre HD, Oats JJ, Omori Y, Schmidt MI
(2010). International association of diabetes and pregnancy study groups recommendations on the diagnosis and classification of hyperglycemia in pregnancy. Diabetes Care, 33(3), 676-682.

[20] Kaiser, L, & Allen, L. H. (2008). Position of the American Dietetic Association: nutrition and lifestyle for a healthy pregnancy outcome. J Am Diet Assoc, 108(3), 553-561.

[21] Kenyon, S, Jolly, K, Hemming, K, Ingram, L, Gale, N, Dann, S. A, & Chambers, J. MacArthur C (2012). Evaluation of Lay Support in Pregnant women with Social risk (ELSIPS): a randomised controlled trial. BMC Pregnancy Childbirth12:11.

[22] Kuehn, B. M. (2009). Guideline for pregnancy weight gain offers targets for obese women. JAMA, 302(3), 241-242.

[23] Mendelson, S. G, Mcneese-smith, D, Koniak-griffin, D, Nyamathi, A, & Lu, M. C. parish nurse intervention program for Mexican American women with gestational diabetes. J Obstet Gynecol Neonatal Nurs, 37(4), 415-425.

[24] National Academy of Sciences Institute of Medicine, Food and Nutrition Board, Committee on Nutritional Status During Pregnancy and Lactation, Subcommittee for a Clinical Application Guide: Nutrition During Pregnancy and Lactation: An Implementation Guide. Washington, D.C., National Academies Press (1992).

[25] Persson, M, Hörnsten, A, Winkvist, A, & Mogren, I. (2011). Mission impossible”? Midwives’ experiences counseling pregnant women with gestational diabetes mellitus. Patient Educ Couns, 84(1), 78-83.

[26] Sherbourne, C. D, & Stewart, A. L. (1991). The MOS social support survey. Soc Sci Med, 32(6), 705-14.

[27] Szymanski, L. M, & Satin, A. J. (2012). Exercise during pregnancy: fetal responses to current public health guidelines. Obstet Gynecol, 119(3), 603-10.

[28] Zigmond, A. S, & Snaith, R. P. (1983). The hospital anxiety and depression scale. Acta Psychiatr Scand, 67(6), 361-70.