Original Research Article

Screening for GDM in first trimester of pregnancy and its outcome

Mamata Soren1, Sudhanshu Sekhar Nath1*, Debananda Tudu2, Polaki Srilekha1

1Department of Obstetrics and Gynaecology, 2Department of General Surgery, VIMSAR, Burla, Odisha, India

Received: 24 November 2017
Accepted: 21 December 2017

*Correspondence:
Dr. Sudhanshu Sekhar Nath,
E-mail: dr.sudhanshus84@gmail.com

ABSTRACT

Background: GDM is associated with increased risk of complications for both mother and fetus both during pregnancy as well as in the postpartum period. Screening for GDM is important to improve short and long term maternal and fetal outcomes. The main purpose of this review is to provide an update on screening for GDM. As per DIPSI criteria women can be diagnosed to have GDM in the first trimester, if the 2hour 75gms OGTTS IS 140-199 mg/dL. A prospective observational study with 300 cases was conducted for a period of 1year and 11months (December 2012-2014) in VIMSAR Burla, Sambalpur.

Methods: Universal screening was applied by means of DIPSI. Analysis was done by means of t-test, Odd’s ratio, chi square test. P<.05 was taken as significant.

Results: In the present study, 25 cases were diagnosed as GDM with an incidence of 8.33%. Hypertensive disorders of pregnancy (HDP) was found significantly associated with GDM cases (p value 0.02). The mean birth weight in women with GDM (3.05±0.47Kg) was higher than in women with non-GDM (2.65±0.43 Kg). Overall the macrosomia (≥4Kg) rate was 0.67% with 8% in case of GDM mothers. Not a single case of congenital fetal anomaly was detected in the GDM group under our study 20% of the GDM group had their babies admitted to NICU as compared to 17.65% of the non-GDM group (p value 0.76).

Conclusions: Women with GDM are at an increased risk for adverse obstetric and perinatal outcomes. Due to high prevalence of GDM in India early universal screening is essential. Screening for glucose intolerance during the early weeks of pregnancy is beneficial as this policy would help in identifying undiagnosed diabetes prior to conception and to render appropriate care. Screening and diagnosis of GDM with a single test procedure of 75g 2hr PGBS in a non-fasting woman i.e. following DIPSI guidelines is found to be effective, simple, economical and feasible.

Keywords: GDM, Maternal and Perinatal outcome, Screening

INTRODUCTION

Pregnancy is a diabetogenic condition as a result of progressive rise in the level of estrogen, progesterone, human placental lactogen, cortisol, prolactin, and are major contributors to the insulin-resistance and cause abnormal glucose tolerance in some women rendering them prone for gestational diabetes mellitus.1 O’Sullivan was the first person to use the term Gestational Diabetes Mellitus in 1961.2

Gestational diabetes mellitus (GDM) is defined as, “carbohydrate intolerance of variable severity with onset or first recognition during pregnancy”.3 Every 1 out of 200 pregnancies is complicated by diabetes mellitus and additionally 5 in every 200 pregnant women will develop gestational diabetes mellitus (GDM).4 GDM is diagnosed in approximately 3-7% of pregnancies.5 7 The incidence of GDM increases in older and more obese pregnant women. GDM increases the risk of certain pregnancy complications like pregnancy induced hypertension and
adverse perinatal outcome, it carries the risk of later development of type 2 diabetes mellitus (DM) in 75% of cases.\textsuperscript{2,3-5} The diabetes in pregnancy study group India (DIPSI) is reporting practice guidelines for GDM in the Indian environment. Due to high prevalence, screening is essential for all Indian pregnant women.

Women with GDM are at increased risk for the development of diabetes, usually type 2, after pregnancy. Obesity and other factors that promote insulin resistance appear to enhance the risk of type 2 diabetes after GDM. Offspring of women with GDM are at increased risk of obesity, glucose intolerance, and diabetes in late adolescence and young adulthood.\textsuperscript{10}

The incidence of GDM varies widely amongst populations, with significantly higher rates among South East Asian Region (SEAR), compared to whites.\textsuperscript{11,12} Women diagnosed with GDM are at increased risk for a variety of pregnancy complications including gestational hypertensive disorders, foetal macrosomia, shoulder dystocia, and caesarean delivery.\textsuperscript{13,14} Diagnosis of both GDM and milder abnormal glucose tolerance in pregnancy helps to identify women who are at high risk for type 2 diabetes.\textsuperscript{15-18} GDM confers a 7-fold risk for future type 2 diabetes and up to one-third of women with type 2 diabetes have been diagnosed with GDM.\textsuperscript{19,20}

The usual recommendation is to perform screening between 24-28 weeks of gestation though 40% of women with GDM could be detected in the early weeks of pregnancy. Screening for glucose intolerance during the early weeks of pregnancy is beneficial as this policy would help in identifying undiagnosed diabetes prior to conception and to render appropriate care. It is also prudent to advise a pregnant woman to undergo rescreening in the later weeks of pregnancy if she had normal glucose tolerance (NGT) in the first visit that is likely to predict the possibility of pregnant women developing gestational diabetes in the later weeks of pregnancy to keep them under surveillance. Hence this study was undertaken.

The most recent research relating to GDM, endeavours to address aspects of the debate by determining the association of maternal hyperglycaemia with an increased risk of adverse pregnancy outcome (Hyperglycaemia and Adverse Pregnancy Outcome (HAPO) study cooperative group, 2008) and ascertaining whether treatment of the condition can decrease perinatal morbidity.\textsuperscript{21,22} The different screening tests used are

- Random blood sugar estimation
- Fasting blood sugar estimation
- 50g fast tolerance test (GCT)
- 75g oral glucose tolerance test (OGTT)
- Serum fructosamine estimation
- Glycosylated haemoglobin (HbA1c) estimation
- Urine test- Glycosuria.

| 2hr Plasma glucose | In pregnancy | Outside pregnancy |
|--------------------|--------------|-------------------|
| ≥ 200 mg/dl        | Diabetes     | Diabetes          |
| 140 - 199 mg/dl    | GDM          | IGT               |
| 120 - 139 mg/dl    | GGI          | Normal            |
| < 120 mg/dl        | Normal       |                   |

**Table 1: With 75gm OGTT (WHO criteria).**

**Gestational weeks at which screening is recommended**

Insulin is detectable in the fetal pancreas as early as 9 weeks after conception. An increase in pancreatic beta cell mass and insulin secretion in the foetus occurs by the 16th week of gestation, in response to maternal hyperglycemia.\textsuperscript{23,24} The priming of the fetal beta cells may account for the persistence of fetal hyperinsulinemia throughout pregnancy and the risk of accelerated fetal growth, even when the mother enjoys good metabolic control in later pregnancy.\textsuperscript{25,26} This necessitates performing the test procedures to diagnose GDM in the first trimester itself. Further, early detection and care results in a better fetal outcome.\textsuperscript{27} The aims and objectives of the present study were to screen all pregnant women in the 1st trimester of pregnancy as per DIPSI guidelines and to know the prevalence of GDM in our community. Also, to determine the risk factors of GDM and to determine the maternal and foetal outcome of GDM.

**METHODS**

**Study place**

The present study entitled “Screening for GDM in first trimester of pregnancy and its outcome” was conducted in the department of obstetrics and gynaecology, V.S.S. Medical College and Hospital, Burla, Sambalpur, Odisha.

**Study period**

December 2012 to October 2014.

**Study type**

Prospective Observational study

**Inclusion criteria**

Pregnant women attending antenatal clinic of Obstetrics and Gynaecology department of VSS MCH, Burla who were in first trimester of pregnancy were taken as cases.

**Exclusion criteria**

- Patients with known type 1 or type 2 Diabetes mellitus,
- Chronic diseases / cardiac / hepatic / respiratory diseases,
• Taking drugs that alter glucose metabolism.

**RESULTS**

Out of 300 subjects evaluated, 25 (8.33%) were diagnosed as GDM. The remaining formed the non GDM group. The overall mean age is 24.77±3.67 years.

The mean age of GDM group is 32.08±3.29 years and the mean age of non-GDM is 24.11±2.91 years. Most (80%) of GDM women were in the age group of >30 years which is significantly associated (p value <0.001 whereas most (61.82%) of the non-GDM women were in the age group of 21-25 yrs.

Majority of the patients with GDM were second gravida and above (19/25, 76%) whereas majority in the non GDM group were primigravida (168/275, 61.1%). So, GDM is more common in multigravida which is statistically highly significant (p value <0.001).

| Table 2: Distribution of GDM and Non-GDM cases according to past history of GDM and family history of DM. |
|---------------------------------------------------------------|
| **GDM** | **NON-GDM** | **Total** | **P value** |
| Past history of GDM | Number (25) | % | Number (275) | % | Number (300) | % |  |
| 3 | 12 | 0 | 0 | 3 | 1 | <0.0001 |
| Family history of DM | 19 | 76 | 97 | 35.27 | 116 | 38.67 | <0.0001 |

12% of women with GDM had past history of GDM and 76% of GDM women had family history of DM whereas none of the women of non-GDM had past history and 35.27% of non-GDM group had family history of DM. Both, past history of GDM and family history of DM are significantly associated with GDM (p value <0.001).

| Table 3: Distribution of GDM and Non-GDM cases according to past history of foetal loss. |
|---------------------------------------------------------------|
| **Past history of foetal loss** | **GDM** | **Non-GDM** | **Total** |
| | Number (25) | % | Number (275) | % | Number (300) | % |
| Present | 16 | 64 | 46 | 16.73 | 62 | 20.67 |
| P value | < 0.0001 |

| Table 4: Distribution of BMI in GDM group and non-GDM group. |
|---------------------------------------------------------------|
| **BMI (kg/m²)** | **GDM** | **Non-GDM** | **Total** |
| Number (25) | Number (275) | % | Number (275) | % | Number (300) | % |  |
| < 25 | 4 | 16 | 160 | 58.18 | 164 | 54.66 |
| 25-29 | 5 | 20 | 67 | 24.36 | 72 | 24 |
| ≥ 30 | 16 | 64 | 48 | 17.46 | 64 | 21.34 |
| Mean | 30.57 | 24.87 | 25.34 |
| SD | 4.09 | 3.41 | 3.8 |

GDM is significantly associated with past history of foetal loss (p value < 0.0001).

64% women of GDM group had BMI ≥30Kg/m² showing a highly significant association (p value <0.001) between obesity (BMI ≥30 Kg/m²) and GDM.

Mean BMI was higher in women with GDM (30.57±4.09Kg/m²) than non-GDM (24.87±3.41Kg/m²).

HDP is seen in 5 out of 25 (20%) of GDM cases whereas it is seen in 19 out of 275 (6.91%) of non-GDM cases. HDP is found to be significantly associated with GDM (p value 0.02) as shown in Table 5.
Table 5: Presence of Hypertensive disorders of pregnancy (HDP) in GDM group and non-GDM group.

| HDP          | GDM (Number (25)) | Non-GDM (Number (275)) | Total (Number (300)) |
|--------------|-------------------|------------------------|---------------------|
| Present      | 5 (20%)           | 19 (6.91%)             | 22 (7.33%)          |
| Absent       | 20 (80%)          | 256 (93.09%)           | 278 (92.67%)        |
| P value      | 0.02              |                        |                     |

Table 6: Distribution of GDM and Non-GDM cases according to mode of delivery.

| Mode of delivery | GDM (Number (25)) | Non-GDM (Number (275)) | Total (Number (300)) |
|------------------|-------------------|------------------------|---------------------|
| Normal vaginal   | 14 (56%)          | 170 (61.82%)           | 179 (59.67%)        |
| Instrumental     | 3 (12%)           | 22 (8%)                | 25 (8.33%)          |
| LSCS             | 8 (32%)           | 83 (30.18%)            | 96 (32%)            |

Incidence of operative delivery is more in GDM cases, i.e. 12% had instrumental delivery and 32% had LSCS whereas in non-GDM cases 8% had instrumental delivery and 30.18% had LSCS which is not statistically significant (p value 0.56) as shown in Table 6.

Table 7: Distribution of GDM and Non-GDM group according to maternal morbidity during puerperium.

| Puerperal complications | GDM (Number (25)) | Non-GDM (Number (275)) | Total (Number (300)) | P value |
|-------------------------|-------------------|------------------------|---------------------|---------|
| Normal puerperium       | 21 (84%)          | 248 (90.18%)           | 269 (89.67%)        | 0.33    |
| Puerperal pyrexia       | 1 (4%)            | 8 (2.91%)              | 9 (3.06%)           | 0.76    |
| Perineal wound infection| 1 (4%)            | 19 (6.91%)             | 20 (6.67%)          | 0.57    |
| Sub-involutio of uterus | 2 (8%)            | 0 (0%)                 | 2 (0.66%)           | < 0.001 |

The mean birth weight in women with GDM (3.05±0.47 Kg) was higher than in women with non-GDM (2.65±0.43Kg). Majority (52%) of GDM cases had birth weight of 3-3.9Kg whereas majority (76.73%) of non-GDM cases had birth weight of 2-2.9Kg. GDM is significantly associated with birth weight of ≥3Kg (p value < 0.0001).

Apgar score of 1-3, 4-6 and 7-10 is seen in 0.73%, 4.03% and 95.24% of babies of non-GDM whereas in GDM it is 0%, 8% and 92% respectively which is not statistically significant (p value > 0.05). Neonatal complications like IUGR, macrosomia, meconium stained liquor (MSL) and hypoglycemia are proportionately more in GDM group than in non-GDM group. Only macrosomia and hypoglycemia are found to be significantly associated with GDM (p value < 0.05). Amongst 300 women, 53 women had their babies with some or the other complication leading to NICU (Neonatal Intensive Care Unit) admission. 20% women belonging to GDM group had their babies admitted to NICU as compared to 17.65% women of the non-GDM group with babies requiring NICU admission which is not statistically significant (p value 0.76) as shown in Table 7.

3 out of 25 GDM cases were lost to follow-up. The above table reveals that 22.73% of GDM cases had Impaired fasting glucose (IFG) and 27.27% of GDM cases had Impaired glucose tolerance (IGT) during follow-up at 6-12 weeks post-partum and 77.27% of GDM cases had normal FBS and 72.73% of GDM cases had reverted to normal 2hr PGBS level.

DISCUSSION

The prevalence of GDM is reported to vary widely from 3.8 to 21% in different parts of India depending on the geographical location and on the diagnostic criteria used.28 GDM has been associated with neonatal morbidity and mortality, including macrosomia, shoulder dystocia, other birth injuries, and neonatal hypoglycemia, in addition to congenital anomalies and still births.29 Further, the offsprings are potentially at a higher risk of developing childhood obesity later in life.30 Women with GDM have higher rates of cesarean deliveries and pregnancy-induced hypertension.31 and are at increased risk of future diabetes predominantly type 2 DM as are their children.32 Compared to selective screening, universal screening for GDM detects more cases and
improves maternal and neonatal prognosis. Diagnosis of GDM should be done as early as possible so that effective treatment can be initiated early.

Out of 300 subjects in our study, 25 were diagnosed as GDM with an incidence of 8.33%. Latest Indian study conducted by Rajput R et al reported an incidence of 7.1% respectively. Seshiah V et al have found an incidence of 14.6% by IADPSG criteria and 13.4% by DIPSI criteria. The above variations may be due to geographical, ethnicity and racial variation.

**Maternal outcome**

In the present study HDP was to be significantly associated with GDM cases (p value 0.02). Pikee Saxena et al observed that the incidence of PIH is more in GDM group (40%) than non-GDM group (10%) which is quite more than the present study. Abdulbari Bener et al also found that women with GDM were more likely to develop pregnancy induced hypertension (26.4%) in comparison to 14.1% of non-GDM women (P <0.001) which is slightly more than the present study. There was a slight increase in incidence of caesarean section. According to a recent study in 2007, the rate of CS and induction of labour were increased in GDM mother.

**Neonatal outcome**

Mean birth weight obtained in present study in cases of GDM (3.05±0.47Kg) was higher than in women with non-GDM (2.65±0.43Kg). Incidence of macrosomia (≥ 4Kg) was 8% in GDM mothers. GDM was significantly associated with birth weight of ≥3Kg (p value <0.001). Other neonatal complications like IUGR, meconium stained liquor and hypoglycemia were also proportionately more in GDM group than in non-GDM group.

In the present study apgar score of 1-3, 4-6 and 7-10 was seen in 0.73%, 4.03% and 95.24% of babies of non-GDM whereas in GDM it is 0%, 8% and 92% respectively which is not significantly associated (p value >0.05). Amongst 300 women, 53 women had their babies with some or the other complication leading to NICU admission. 20% women belonging to GDM group had their babies admitted to NICU as compared to 17.65% women of the non-GDM group with babies requiring NICU admission which is not significantly associated (p value 0.76).

**CONCLUSION**

Women with GDM are at an increased risk for adverse obstetrics and perinatal outcomes. Due to high prevalence of GDM in India early universal screening is essential. Screening for glucose intolerance during the early weeks of pregnancy is beneficial as this policy would help in identifying undiagnosed diabetes prior to conception and to render appropriate care. Screening and diagnosis of GDM with a single test procedure of 75g 2hr PGBS in a non-fasting woman i.e. following DIPSI guidelines is found to be effective, simple, economical and feasible.

The present study illustrates that the incidence of gestational diabetes in our community is 8.33%. Age >30 years, up, past history of GDM and family history of DM, multigravida, past history of foetal loss and obesity are significant risk factors in GDM population. Compared to non-diabetics, gestational diabetics have higher maternal and neonatal complications. With the availability of early antenatal diagnosis of GDM and good antenatal and intranatal care maternal and perinatal outcome can be improved.

**Funding:** No funding sources  
**Conflict of interest:** None declared  
**Ethical approval:** The study was approved by the Institutional Ethics Committee

**REFERENCES**

1. Diana R Danilenko-Dixon, Van Winter, Roger L Nelson, Paul L Ogurn. Universal Versus Selective gestational diabetes survey: Application Recommendation. AM J Obslet Gynecol. 1999;181:789-802.
2. O’Sullivan JB. Gestational diabetes, unsuspected, asymptomatic diabetes in pregnancy. N Eng J Med. 1961;264:1082-85.
3. Metzger BE, Coustan DR. Summary and recommendations of the Fourth International Workshop-conference on Gestational Diabetes Mellitus. The Organizing Committee. Diabetes Care. 1998;21 Suppl 2:B161-B167.
4. Albert RE. Diabetes in pregnancy obstetrics and gynecology. Clinics of North America. WB Saunders Company. 1996;23(1):10.
5. Kjos S, Buchanan T. Gestational diabetes mellitus. N Eng J Med. 1999;341(23):1749-54.
6. Jovanovic L, Pettit D. Gestational Diabetes Mellitus. JAMA. 2001;286:2516-8.
7. Ben Haroush A, Yogev Y, Hod M. Epidemiology of gestational diabetes mellitus and its association with Type 2 diabetes. Diabet Med. 2004;21(2):103-13.
8. Glueck C, Goldenberg N, Streicher P, Wang P. Metformin and gestational diabetes mellitus. Curr Diabet Rep. 2003;3:303-12.
9. Kim C, Newton K, Knopp R. Gestational diabetes and the incidence of type 2 diabetes. Diabetes Care. 2002;25:1862-8.
10. American Diabetes Association. Gestational diabetes mellitus. Diabetes care. 2004;27(suppl 1):S88-90.
11. Lawrence JM, Contreras R, Chen W, Sacks DA. Trends in the prevalence of pre-existing diabetes gestational diabetes mellitus among a racially/ethnically diverse population of pregnant women, 1999-2005. Diabetes Care. 2008;31:899-904.
12. Caughey AB, Cheng YW, Stotland NE, Washington AE, Escobar GJ. Maternal and paternal race/ethnicity are both associated with gestational diabetes. Am J Obstetrics Gynecol. 2010;202(6):616-e1.
13. American Diabetes Association. Gestational Diabetes Mellitus. Diabetes Care. 2004;27:S88-90.
14. Nesbitt TS, Gilbert WM, Herrchen B. Shoulder dystocia and associated risk factors with macrosomic infants born in California. Ame J Obstetrics Gynecol. 1998;179(2):476-80.
15. Retnakaran R, Qi Y, Connelly PW, Sermer M, Hanley AJ, Zinman B. Risk of early progression to pre-diabetes or diabetes in women with recent gestational dysglycemia but normal glucose tolerance at 3-month postpartum. Clin Endocrinol. 2010;73(4):476-83.
16. Buchanan TA, Xiang AH. Gestational diabetes mellitus. J Clin Invest. 2005;115(3):485-91.
17. Feige DS, Zinman B, Wang X, Hux JE. Risk of development of diabetes mellitus after diagnosis of gestational diabetes. CMAJ. 2008;179(3):229-34.
18. Retnakaran R, Qi Y, Connelly PW, Sermer M, Hanley AJ, Zinman B. An abnormal screening glucose challenge test in pregnancy predicts postpartum metabolic dysfunction, even when the antepartum oral glucose tolerance test is normal. Clin Endocrinol. 2009;71(2):208-14.
19. Bellamy L, Casas JP, Hingorani AD, Williams D. Type 2 diabetes mellitus after gestational diabetes: a systematic review and meta-analysis. Lancet. 2009;373(9677):1773-9.
20. Cheung NW, Byth K. Population health significance of gestational diabetes. Diabetes Care. 2003;26(7):2005-9.
21. Crowther CA, Hiller JE, Moss JR, McPhee AJ, Jeffries WS, Robinson JS. Effect of treatment of gestational diabetes mellitus on pregnancy outcomes. N Engl J Med. 2005;352(24):2477-86.
22. HAPO Study Cooperative Research Group. Hyperglycemia and adverse pregnancy outcomes. N Engl J Med. 2008(358):1991-2002.
23. Reiber H, Fuhrmann K, Noack S, Woltanski KP, Jutzi E, Hahn von Dorsche H, et al. Age-dependent insulin secretion of the endocrine pancreas in vitro from fetuses of diabetic and non-diabetic patients. Diabetes Care. 1983;6(5):446-51.
24. Nahum GG, Wilson SB, Stanislaw H. Early-pregnancy glucose screening for gestational diabetes mellitus. J Reprod Med. 2002;47(8):656-62.
25. Carpenter MW, Canick JA, Hogan JW, Shellen C, Somers M, Star JA. Amniotic fluid insulin at 14-20 weeks’ gestation: association with later maternal glucose intolerance and birth macrosomia. Diabetes Care. 2001;24(7):1259-63.
26. Schwartz R, Gruppuso PA, Petzold K, Brambilla D, Hillesmaa V, Teramo KA. Hyperinsulinemia and macrosomia in the fetus of the diabetic mother. Diabetes Care. 1994;17(7):640-8.
27. Seshiah V, Cynthia A, Balaji V, Balaji MS, Ashalata S, Sheela R, et al. Detection and Care of women with gestational diabetes mellitus from early weeks of pregnancy results in birth weight of newborn babies appropriate for gestational age. Diab Res Clin Pract. 2008;80(2):199-202.
28. Zargar AH, Sheikh MI, Bashir MI, Masoodi SR, Laway BA, Wani Al, et al. Prevalence of gestational diabetes mellitus in Kashmiri women form the Indian subcontinent. Diabetes Res Clin Pract. 2004;66:139-45.
29. Casey BM, Lucas MJ, McIntire DD, Leveno KJ. Pregnancy outcomes in women with gestational diabetes compared with the general obstetric population. Obstet Gynecol.1997;90:869-73.
30. Metzger BE, Lowe LP, Dyer AR, Trimble ER, Chaoavarindr U, Coustan DR, et al. HAPO Study Cooperative Research Group. Hyperglycemia and adverse pregnancy outcomes. N Engl J Med. 2008;358:1991-2002.
31. Naylor CD, Sermer M, Chen E, Sykora K. Cesarean delivery in relation to birth weight and gestational glucose tolerance: Pathophysiology or practice style. Toronto Trihospital Gestational Diabetes Investigators? JAMA, 1996;275:1165-70.
32. Dornhorst A, Rossi M. Risk and Prevention of Type 2 Diabetes in women with Gestational Diabetes. Diabetes Care. 1998;21(suppl 2):B43-9.
33. Cosson E. Screening and insulin sensitivity in gestational diabetes. Abstract volume of the 40th Annual Meeting of the EASD, 2004:A350.
34. Griffin ME, Coffey M, Johnson H, Scanlon P, Foley M, Stronge J, et al. Universal vs risk factor-based screening for gestational diabetes mellitus: detection rates, gestation at diagnosis and outcome. Diabet Med. 2000;17(1):26-32.
35. Rajput R, Yadav Y, Nanada S, Rajput M. Prevalence of gestational diabetes mellitus and associated risk factors at a tertiary care hospital in Haryana. Indian J Med Res. 2013;137:728-33.
36. Seshiah V, Balaji V, Shah SN, Joshi S, Das AK, Sahay BK, et al. Diagnosis of gestational diabetes mellitus in the community. J Assoc Physicians India. 2012;60:15-7.

37. Saxena P, Tyagi S, Prakash A, Nigam A, Trivedi SS. Pregnancy outcome of women with gestational diabetes in a tertiary level hospital of north India. Ind J com medicine: official publication of Ind Association Preventive So Med. 2011;36(2):120.

38. Bener A, Saleh NM, Al-Hamaq A. Prevalence of gestational diabetes and associated maternal and neonatal complications in a fast-developing community: global comparisons. Inter J Women's Health. 2011;3:367.

Cite this article as: Soren M, Nath SS, Tudu D, Srilekha P. Screening for GDM in first trimester of pregnancy and its outcome. Int J Res Med Sci 2018;6:603-9.