Changes in preconception treatment and glycemic control in women with type 1 diabetes mellitus: a 15-year single-center follow-up

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KEY WORDS
metabolic control, pregnancy, type 1 diabetes

ABSTRACT

INTRODUCTION Pregnancy in women with type 1 diabetes mellitus (T1DM) is associated with higher risk of complications. Strict glycemic control before conception reduces the risk of unfavorable outcomes.

OBJECTIVES The aim of the study was to assess changes in clinical characteristics, preconception treatment, and glycemic control of women with T1DM at the first antenatal visit.

PATIENTS AND METHODS We analyzed the records from the first antenatal visit of 524 women with T1DM in the years 1998–2012. The follow-up period was divided into 3 5-year periods.

RESULTS Differences in the age of patients between the 3 follow-up periods were observed (28.2 ±5.7 years for 1998–2002; 27.3 ±4.5 years for 2003–2007; and 29.4 ±4.8 years for 2008–2012; P < 0.0001). The number of women planning pregnancy did not change and reached 32.1% in the first, 44.4% in the second, and 40.4% in the third period (P = 0.2). The use of rapid-acting insulin analogues increased from 2.6% to 46.5% and then to 95.6% (P < 0.001). The rate of therapy with personal insulin pumps before pregnancy increased from 4.6% in the first, through 23.5% in the second, to 33.3% in the third period (P <0.001). Over the subsequent periods, we observed a decrease in hemoglobin A1c (HbA1c) levels at the first antenatal visit (from 7.4% ±1.6%, through 6.9% ±1.4%, to 7.0% ±1.4%; P = 0.06), as well as a decrease in HbA1c levels between the subgroups of women planning pregnancy (6.8% ±1.4%, 6.6% ±1.2%, and 6.1% ±0.8%, P = 0.015).

CONCLUSIONS In the years 1998–2012, an increase in the use of insulin analogues and personal insulin pumps by women with T1DM before conception was observed, and these changes were accompanied by a slight improvement in glycemic control, particularly among women planning pregnancy. The percentage of women planning pregnancy did not change during the follow-up.
showed that the probability of these events was 2 to 5 times higher in patients with T1DM as compared with nondiabetic women. One of the reasons may be the limited participation of these women in preconception care and counseling. Periconception glycemia is a critical modifiable risk factor for limiting adverse obstetric outcomes, but more than half of all pregnancies are unplanned, which contributes to suboptimal glycemic control at the beginning of pregnancy in the majority of women with T1DM. Several studies have shown that preconception counseling in women with T1DM was associated with better glycemic control during 3 months before conception and in the first pregnancy trimester, as well as with reduced risk of adverse pregnancy outcome. Thus, it is important to monitor shifts occurring in this aspect of diabetes care.

In this large observational study conducted at a single Polish university center, we assessed the changes that occurred over a period of 15 years in the clinical characteristics of women with T1DM during their first pregnancy visit, as well as in their preconception treatment and glycemic control.

**Patients and Methods** This study was performed at the Department of Metabolic Diseases, Kraków, Poland, a tertiary academic referral center for diabetes in South-Eastern Poland. All pregnant women with pre-existing T1DM were registered between the years 1998 and 2012, and their data were collected at the time of the first antenatal visit. All participants were Caucasians and residents of South-Eastern Poland. Data from medical records about the patients’ pregestational characteristics, mode of treatment, glycemic control, and presence of microvascular complications as well as other clinical data were collected during the first pregnancy visit, as described earlier.

All women with diabetes who entered the pregnancy planning program received intensive diabetes management in the clinic at our department. According to the recommendations of the Polish Diabetes Association that were in force when these data were collected, the therapeutic targets for women planning pregnancy were: 1) hemoglobin A1c (HbA1c) <6.1%, 2) fasting self-monitored blood glucose (SMBG) measured using a glucose meter within the range of 60 to 90 mg/dl, and 3) subsequent postprandial and 1-hour postprandial glucose self-measurements within the range of 60 to 120 mg/dl. The monitoring of SMBG was structured. Women who did not plan their pregnancies entered the intensive diabetes care program after conception, at the first antenatal visit clinic visit. Their clinical characteristics reflect the effects of routine diabetes management in nonpregnant patients. Two insulin regimens were used before pregnancy: multiple daily injections or continuous subcutaneous insulin infusion (CSII) with a personal insulin pump.

The HbA1c level was measured during the first pregnancy visit with high-performance liquid chromatography on a Variant apparatus (Bio-Rad, Hercules, California, United States) and was DCCT-adjusted at the central laboratory. The inter- and intra-assay coefficient of variation was less than 2%. Retinopathy was diagnosed by ophthalmoscopy, while the diagnosis of nephropathy was based on the albumin-to-creatinine ratio, with values 30 mg/g or higher classified as albuminuria, and creatinine-derived estimated glomerular filtration rate, with values of less than 60 ml/min/1.73 m² defined as abnormal.

**Statistical analysis** A statistical analysis was performed to determine the difference between 2 groups (t test) and several groups (analysis of variance), where applicable. If necessary, non-parametric tests were used as equivalents (Wilcoxon test, Kruskal–Wallis test with post hoc tests). Normality was tested with the Shapiro–Wilk test. For categorical variables, we used the χ² test or the Fisher exact test, as appropriate. The analysis was performed with the R statistical software v. 3.2.4 (The R Foundation, Vienna, Austria). P values of less than 0.05 were considered significant.

This observational study was concordant with the Helsinki Declaration and was approved by the Jagiellonian University Bioethical Committee.

**Results** The patients’ characteristics for each study period are presented in Table 1. We observed differences between the 3 groups in terms of the women’s age at the initial pregnancy visit (P <0.0001). In the post hoc analysis, women signing up for the first antenatal appointment in the years 2008–2012 were older than those in the previous 2 time periods (29.4 ±4.8 years vs 28.2 ±5.7 years in 1998–2002 and vs 27.3 ±4.5 years in 2002–2008, P = 0.03 and P <0.0001, respectively). We did not observe differences in T1DM duration (mean, 11.7 ±7.5 years for the entire study period) and prepregnancy body mass index (mean, 23.9 ±4.4 kg/m²). We also found no differences in the week of pregnancy at the first visit in an outpatient clinic (8.7 ±4.4 weeks of pregnancy). The clinical characteristics of the study subgroups based on the pregnancy planning status are presented in Table 2.

Consistently with long T1DM duration, the mean prevalence of retinopathy in the whole group was high: 26.7% (n = 136). The 3 groups differed in terms of the prevalence of retinopathy (P = 0.003). The proportion of this complication changed from 35.8% in the first analyzed period, through 18.2% in the second period, to 27.6% in the third period; the prevalence of this complication was lower in the second period (2003–2007) than in the other periods (P <0.001 and P = 0.03, respectively). The proportion of diabetic nephropathy as defined in this analysis remained low and stable throughout the entire follow-up.

We observed substantial changes in the types of insulin and treatment models used. The use of rapid-acting analogues increased from 2.6% in the first period to 46.5% in the second period,
reach 95.6% in the third period (P < 0.0001 for all 3 groups and for each pairwise comparison). Long-acting analogues were not used over the entire study period by any patient. Additionally, there was a notable increase in the use of insulin pumps in the analyzed period. In the first period, personal pumps before pregnancy were used to treat only 4.6% of women with T1DM, and this rate increased to 23.5% and 33.3% in the periods 2003–2007 and 2008–2012, respectively (P < 0.0001 for a 3-group comparison, P < 0.0001 and P = 0.03 for period 1 vs 2 and period 2 vs period 3, respectively). Over the years, the number of T1DM women planning their pregnancies did not change (P = 0.2). Overall, the proportion of patients entering the intensive diabetes care program (pregnancy planning) during the entire follow-up (1998–2012) reached 39.0% (n = 210).

There was a borderline difference in glycemic control before pregnancy as assessed by the HbA\textsubscript{1c} level at the first antenatal visit (P = 0.06 for 3-group comparison). HbA\textsubscript{1c} levels tended to be higher in the first period as compared with the two other periods (P = 0.05 and P = 0.07, respectively).

Two additional analyses were performed based on pregnancy planning status. A lower HbA\textsubscript{1c} level was found at the first visit in patients who entered the pregnancy planning program (FIGURE 1). Specifically, in the first period, the HbA\textsubscript{1c} level in women who planned pregnancies reached 6.8% ±1.4% and was lower than that in women with unplanned pregnancies (7.7% ±1.6%) (P = 0.003). For the second and third periods, the following values were recorded: 6.6% ±1.2% vs 7.2% ±1.4% (P = 0.009) and 6.1% ±0.8% vs 7.5% ±1.5% (P = 0.0000). For the entire study group, the HbA\textsubscript{1c} level in women who planned their pregnancies was 6.4% ±1.1% as compared with 7.5% ±1.5% in the “non-planning” patients (P = 0.0000). Additionally, we searched for potential changes in HbA\textsubscript{1c} levels in the subsequent time periods for the planning and nonplanning groups. A decrease in HbA\textsubscript{1c} levels in the planning groups was observed, as they reached 6.8% ±1.4%, 6.6% ±1.2%, and 6.1% ±0.8% in the subsequent periods (P = 0.015). This improvement was not seen in the nonplanning group, in whom the values were as follows: 7.7% ±1.6%, 7.2% ±1.4%, and 7.5% ±1.5% (P = 0.21). Additionally, women who planned pregnancy were more often treated with CSII before conception in each analyzed period as compared with women who did not plan their pregnancies. For the years 1998–2002, we recorded 7% (n = 44) of patients on CSII in the planning group as compared with 0.9% (n = 1) in the nonplanning group (P = 0.006). For the second and third periods, the values were 16.1% (n = 30) vs 7.5% (n = 12), P = 0.001, and 22.5% (n = 50) vs 10.6% (n = 25), P < 0.001, respectively.

**DISCUSSION** In this observational study, we assessed the clinical characteristics, preconception care, and glycemic control in women with T1DM treated at the Department of Metabolic Diseases of the Jagiellonian University Hospital, Kraków, Poland, over the years 1998–2012. We observed some important changes in the analyzed features in this study, which was performed on one of the largest single-center databases of T1DM-complicated pregnancies in Europe.

Almost 30 years after the St Vincent Declaration, the risk of fetal and newborn death as well as other unfavorable outcomes in children and

### TABLE 1 Clinical characteristics of study groups

| Variable                        | 1998–2002 | 2003–2007 | 2008–2012 | P value |
|---------------------------------|-----------|-----------|-----------|---------|
| age, y                          | 28.2 ±5.7 | 27.3 ±4.5 | 29.4 ±4.8 | 0.001   |
| duration of diabetes, y         | 11.8 ±7.2 | 11.3 ±7.6 | 12.2 ±7.7 | 0.4     |
| BMI before pregnancy, kg/m²     | 24.3 ±3.3 | 23.8 ±3.4 | 24.1 ±4.0 | 0.3     |
| retinopathy (any form)          | 39 (35.8) | 34 (18.2) | 63 (27.6) | 0.003   |
| proliferative retinopathy       | 7 (17.9)  | 3 (8.8)   | 11 (11.7) | 0.09    |
| nephropathy                     | 3 (2.8)   | 2 (1.1)   | 9 (3.9)   | 0.2     |
| planned pregnancy               | 35 (32.1) | 83 (44.4) | 92 (40.4) | 0.2     |
| HbA\textsubscript{1c} at 1st pregnancy visit | 8.9 ±4.5 | 8.8 ±4.6 | 8.5 ±4.3 | 0.9     |
| CSII before pregnancy           | 5 (4.6)   | 44 (23.5) | 76 (33.3) | 0.001   |
| treatment with insulin analogues| 3 (2.7)   | 87 (46.5) | 218 (95.6)| 0.0001  |

Data are presented as mean ± SD or as number of cases (percentage).

P values were derived from one-way analysis of variance; otherwise, the Wilcoxon test or the Kruskal–Wallis test was used to detect a significant difference between the study groups. P values of less than 0.05 were considered significant.

Abbreviations: BMI, body mass index; CSII, continuous subcutaneous insulin infusion; HbA\textsubscript{1c}, hemoglobin A\textsubscript{1c}; Hbd, week of gestation.
women in pregnancy complicated by T1DM remains increased as compared to the healthy population. One of the reasons seems to be related to suboptimal glycemic control before conception and in early pregnancy. Several studies described a continuous association between first-trimester HbA1c levels and the risk of fetal complications. \(^7\)\(^-\)\(^9\) Moreover, poor glycemic control in early pregnancy usually continues in the subsequent trimesters; therefore, high HbA1c values in early pregnancy are significant predictors of adverse perinatal outcomes. \(^17\)\(^-\)\(^20\) Thus, reaching optimal glycemic control in early pregnancy should be one of the major targets in women with T1DM.

The importance of pregnancy planning and periconception care in women with pregestational diabetes was shown in several populations. \(^17\)\(^-\)\(^20\) \(^24\)\(^-\)\(^27\) A meta-analysis of 12 studies revealed that women who were under periconception care showed HbA1c levels lower by almost 2% in the first trimester of pregnancy in comparison with those who were not. \(^13\) Another meta-analysis of studies proved that preconception care for women with pregestational T1DM or type 2 diabetes mellitus is effective in reducing maternal HbA1c levels in the first trimester of pregnancy and, even more importantly, in improving the rates of outcomes. \(^24\)\(^-\)\(^26\) In this study, a slight increase over the years in the number of women with T1DM who planned their pregnancy did not reach significant value. On average, less than 40% of the women recorded at our center planned their pregnancy. These data may not be representative for the entire country, as the current cohort included mostly women from a large city (Kraków), many of whom were under our care long before pregnancy. Observations made in several other populations revealed a trend of an increasing number of women planning pregnancy and receiving preconception counseling. For example, during the ATLANTIC DIP program, the pregnancy planning rate increased almost twice from 28% to 52%, which resulted in an improvement of outcomes for women with pregestational diabetes. \(^30\)

The proportion of planning women reached almost 50% in northern England and was as high as 84% in the Netherlands. \(^24\)\(^-\)\(^26\) The lack of a significant rise in pregnancy planning rate shows a necessity for further educational efforts in this and other Polish centers providing diabetes care.

Our data showed a slight improvement of glycemic control in the early pregnancy of our patients with T1DM. Interestingly, a larger and significant decline in HbA1c levels was seen in patients who planned pregnancy, which further underlines the importance of pregnancy planning. This progress was accompanied by an increased use of new technologies and therapeutic tools, such as insulin analogues and personal insulin pumps; although, this clinical study cannot prove a causal relationship. We observed a steady rise in the number of women treated with short-acting insulin analogues; in the last analyzed period, most patients used analogues of human insulin. The same trend has been recently described in other populations. It also concerned personal pumps, which were shown to be effective and safe in achieving normoglycemia in all patients.
Prepregnancy glycemic control in T1DM

lies beyond the scope of the current research as does a search for associations between diabetic complications and clinical and biochemical characteristics. Some of these data were reported earlier.\textsuperscript{14,15,37} Additionally, plural comparisons were made in the current report, and it is possible that some of them, particularly those that produced borderline significance, could have produced significant results simply by chance. The lowest prevalence of diabetic retinopathy in the middle time period is probably a random result.

In conclusion, we observed a rise in the use of insulin analogues and personal pumps before conception but not in pregnancy planning in women with T1DM. This was accompanied by a slight improvement in glycemic control.

Contribution statement KC and MTM contributed to study design and protocol development. KC, BK, AHS, IJ, ITM, PW, EK, and JH were responsible for searching medical databases. KC, JS, and BM contributed to data analysis. KC, JS, and MTM contributed to data research and interpretation. KC, JS, and MTM wrote the manuscript. BK, AHS, IJ, ITM, PW, EK, and BM contributed to critical review of the manuscript. MTM coordinated the project and approved the final version of the manuscript. MTM is the guarantor of the data and, as such, has full access to all data in the study and takes responsibility for the integrity of the data and the accuracy of data analysis.

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FIGURE 1  
Hemoglobin A\textsubscript{1c} level in the three study periods stratified by the pregnancy planning status

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure1}
\caption{Hemoglobin A\textsubscript{1c} level in the three study periods stratified by the pregnancy planning status.}
\end{figure}
REFERENCES

1. Guariguata L, Linnenkamp U, Beagley J, et al. Global estimates of the prevalence of hyperglycemia in pregnancy. Diabetes Res Clin Pract. 2014; 103: 176-185.

2. Patterson CC, Gyrös E, Rosenbauer J, et al. Trends in childhood type 1 diabetes incidence in Europe during 1989-2008: evidence of non-uniformity over time in rates of increase. Diabetologia. 2012; 55: 2143-2147.

3. Patterson CC, Dahlquist GG, Gyrös E, et al. Incidence trends for childhood type 1 diabetes in Europe during 1989-2003 and predicted new cases 2005-2020: a multicentre prospective registration study. Lancet. 2009; 373: 2037-2043.

4. Bell R, Bailey K, Cresswell T, et al. Trends in prevalence and outcomes of pregnancy in women with pre-existing type 1 and type 2 diabetes. BJOG. 2008; 115: 445-452.

5. Feig DS, Razzag A, Sykora K, et al. Trends in deliveries, prenatal care, and obstetrical complications in women with pregestational diabetes. A population-based study in Ontario, Canada, 1996-2001. Diabetes Care. 2006; 29: 232-235.

6. Balsevs M, Garcia-Patterson A, Gich J, Corcory R. Maternal and fetal outcome in women with type 2 versus type 1 diabetes mellitus: a systematic review and meta-analysis. J Clin Endocrinol Metab. 2009; 94: 4284-4291.

7. Garne E, Loane M, Dolk H, et al. Spectrum of congenital anomalies in pregnancies with pregestational diabetes. Birth Defects Res A Clin Mol Teratol. 2012; 94: 134-140.

8. Klemetti M, Naulla M, Tikkanen M, et al. Trends in maternal BMI, glycaemic control and perinatal outcome among type 1 diabetic pregnant women in 1989-2008. Diabetologia. 2012; 55: 2237-2334.

9. Colstrop M, Mathiesen ER, Damm P, et al. Pregnancy in women with type 1 diabetes: how have the goals of St. Vincent declaration been met concerning foetal and neonatal complications? J Matern Fetal Neonatal Med. 2013; 26: 1682-1686.

10. Murphy H, Roland J, Skinner TC, et al. Effectiveness of a regional pre-pregnancy care program in women with type 1 and type 2 diabetes. Benefits beyond glycaemic control. Diabetes Care. 2010; 33: 2514-2520.

11. Kolmiller JL, Buchanan TA, Kjes S, et al. Pre-conception care of diabetes, congenital malformations and spontaneous abortions. Diabetes Care. 1996; 19: 514-541.

12. Temple RC, Aldridge V, Murphy HR, et al. preconception care and pregnancy outcomes in women with type 1 diabetes. Diabetes Care. 2006; 29: 1744-1749.

13. Wahabi HA, Alzaidan RA, Bawazer GA, et al. Preconception care for diabetic women for improving maternal and fetal outcomes: a systematic review and meta-analysis. BMC Pregnancy Childbirth. 2010; 10: 63-77.

14. Cyganek K, Hebda-Szyllo A, Katra B, et al. Glycemic control and selected pregnancy outcomes in type 1 diabetes women on continuous subcutaneous insulin infusion and multiple daily injections: the significance of pregnancy planning. Diabetes Technol Ther. 2010; 12: 41-47.

15. Cyganek K, Hebda-Szyllo A, Skupien J, et al. Glycemic control and pregnancy outcomes in women with type 2 diabetes from Poland. The impact of pregnancy planning and a comparison with type 1 diabetes subjects. Endocrine. 2011; 40: 243-249.

16. Polish Diabetes Association. [The clinical guidelines in patients with diabetes 2005]. Diabetologia Praktyczna. 2004; 5: D30-D34. Polish.

17. Jovanovic-Peterson L, Peterson CM, Reed GF, et al. Maternal postprandial glucose levels and infant birth weight: the diabetes in early pregnancy study. Am J Obstet Gynecol. 1991; 164: 103-111.

18. Subonen L, Hillesmaa V, Terano K. Glycemic control during early pregnancy and fetal malformations in women with type 1 diabetes mellitus. Diabetologia. 2000; 43: 79-84.

19. Tettens P, Glinianaia SV, Bilous RW, et al. Pre-existing diabetes, maternal glycated haemoglobin, and the risks of fetal and infant death: a population-based study. Diabetologia. 2014; 57: 285-294.

20. Temple R, Aldridge V, Greenwood R, et al. Association between outcome of pregnancy and glycemic control in early pregnancy in type 1 diabetes: population based study. BMJ. 2002; 325: 1275-1276.

21. Glinianaia SV, Tettens PW, Bilous RW, et al. HbA1c and birthweight in women with pre-conception type 1 and type 2 diabetes: a population-based cohort study. Diabetologia. 2012; 55: 3193-3203.

22. Ricklin-Mashiah S, Younges G, Damiri A, Auslander R. First-trimester fasting hyperglycemia and adverse pregnancy outcomes. Diabetes Care. 2009; 32: 1639-1643.

23. Nielsen GL, Moller M, Sorensen HT. HbA1c in early diabetic pregnancy and pregnancy outcomes: Danish population-based cohort study in 573 pregnancies in women with type 1 diabetes. Diabetes Care. 2006; 29: 2612-2616.

24. Tripathi A, Rankin J, Aarvold J, et al. Preconception counseling in women with diabetes: a population-based study in the north of England. Diabetes Care. 2010; 33: 598-608.

25. Gunton JE, Morris J, Broyie S, et al. Outcome of pregnancy complicated by pregestational diabetes – improvements in outcomes. Aust N Z J Obstet Gynaecol. 2002; 42: 478-481.

26. Evers I, de Valk H, Mol B, et al. Macrosomia despite good glycaemic control in type I diabetic pregnancy: results of a nationwide study in The Netherlands. Diabetologia. 2002; 45: 1484-1489.

27. Lapolla A, Dafra MG, Di Ciani G, et al. A multicenter Italian study on pregnancy outcome in women with diabetes. Nutr Metab Cardiovasc Dis. 2008; 18: 291-297.

28. Ray JG, O’Brien TE, Chan WS. Preconception care and the risk of congenital anomalies in the offspring of women with diabetes mellitus: a meta-analysis. BJM. 2001; 94: 435-444.

29. Simeone RM, Devine OJ, Marcinkewage JA, et al. Diabetes and congenital heart defects: a systematic review, meta-analysis, and modeling project. Am J Prev Med. 2015; 48: 195-204.

30. Owens IA, Avalos G, Kirwan B, et al. ATLANTIC DIP: Closing the Loop. A change in clinical practice can improve outcomes for women with pregestational diabetes. Diabetes Care. 2012; 35: 1669-1671.

31. Mukhopadhyay A, Farrell T, Fraser RB. Continuous subcutaneous insulin infusion vs intensive conventional insulin therapy in pregnant diabetic women: a systematic review and metaanalysis of randomized, controlled trials. Am J Obstet Gynecol. 2007; 197: 447-456.

32. Murphy H, Rayman G, Lewis K, et al. Effectiveness of continuous glucose monitoring in pregnant women with diabetes: randomised clinical trial. BMJ. 2008; 337: 1680-1688.

33. Murphy HR, Kumaraswaran K, Elleri D, et al. Safety and efficacy of 24-h closed-loop insulin delivery in well-controlled pregnant women with type 1 diabetes: a randomized crossover case series. Diabetes Care. 2011; 34: 2527-2529.

34. Gutz P, Zawieja A, Brapart J, Wender-Dzegoskova E. Association between preconceptional treatment with insulin pumps and improved metabolic status in early pregnancy in women with type 1 diabetes. Pol Arch Med Wewn. 2015; 125: 325-336.

35. American Diabetes Association. Diagnosis and classification of diabetes mellitus. Diabetes Care. 2011; 5: S62-S69.

36. Polish Diabetes Association. [The clinical guidelines in patients with diabetes 2016]. Clinical Diabetology. 2016; 5: A49-A51. Polish.

37. Cyganek K, Hebda-Szyllo A, Skupien J, et al. Postpregnancy glycemic control and weight changes in type 1 diabetic women. Diabetes Care. 2012; 35: 1083-1087.
Zmiany w przedkoncepcyjnej terapii i wyrównaniu metabolicznym u pacjentek z cukrzycą typu 1 – 15-letnia jednoosśrodkowa obserwacja

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SŁOWA KLUCZOWE
ciąg, cukrzyca typu 1, wyrównanie metaboliczne

STRESZCZENIE

WProwadzenie U kobiet z cukrzycą typu 1 (type 1 diabetes mellitus – T1DM) ciąży wiąże się ze zwiększoną ryzykiem powikłań. Prawidłowa kontrola glikemii w okresie przedkoncepcyjnym zmniejsza ryzyko występowania zdarzeń niekorzystnych.

CELE Celem badania była ocena zmian w charakterystyce klinicznej, terapii przed ciążą oraz kontroli glikemii u pacjentek z T1DM zgłaszających się na pierwszą wizytę w ciąży.

PACJENCI I METODY Przeanalizowano dane z pierwszej wizyty w trakcie ciąży 524 kobiet z T1DM w latach 1998–2012. Czas obserwacji podzielono na 3 pięcioletnie okresy.

WYNIKI Zaobserwowano różnicę w wieku pacjentek między 3 okresami obserwacji (28,2 ±5,7 roku w latach 1998–2002 vs 27,3 ±4,5 roku w latach 2003–2007 vs 29,4 ±4,8 roku w latach 2008–2012; p <0,0001). Odsetek kobiet planujących ciążę nie zmienił się i wyniósł 32,1% w pierwszym okresie, 44,4% w drugim oraz 40,4% w trzecim (p = 0,2). Stosowanie szybko działających analogów insuliny wzrosło z 2,6% do 46,5% i ostatecznie do 95,6% (p <0,001). Częstość terapii z wykorzystaniem osobistych pomp insulinowych przed ciążą wzrosła z 4,6% do 23,5%, by w trzecim okresie osiągnąć 33,3% (p <0,001). W kolejnych okresach obserwowano niewielki spadek poziomu hemoglobiny A₁c (HbA₁c) na pierwszej wizycie ciąży (odpowiednio z 7,4 ±1,6% do 6,9 ±1,4% i 7,0 ±1,4%; p <0,06) oraz zmniejszenie poziomu HbA₁c między podgrupami pacjentek planujących ciążę (6,8 ±1,4%, 6,6 ±1,2% i 6,1 ±0,8%; p = 0,015).

WNIOSKI W latach 1998–2012 zwiększyło się stosowanie szybko działających analogów insuliny oraz osobistych pomp insulinowych przez pacjentki z T1DM w okresie przedkoncepcyjnym, czemu towarzyszyła niewielka poprawa wyrównania metabolicznego, szczególnie w podgrupach planujących ciąży. W analizowanym okresie nie zmienił się odsetek pacjentek z T1DM planujących ciążę.