



Editor Note on Gestational Diabetes Mellitus

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Description

It is a type of diabetes which occurs in women during pregnancy (usually in the middle of pregnancy i.e.; 24 and 28 weeks) when the blood glucose levels increases. It causes due to hormonal changes and the way body converts food for energy you take during pregnancy and other factors like heart disease, inactivity, obesity and PCOD. During pregnancy, hormones can interfere with the insulin work. It may not regulate your sugar levels like it is supposed to, which can cause gestational diabetes. There are no symptoms for gestational diabetes but some women experience Frequent urination, nausea, thirst, tiredness. It is important to treat gestational diabetes or it may cause risk to both mother and the child. Screening and diagnosis: GDM screening and diagnostic testing, on the other hand, are crucial in recognizing women who are at risk of contracting the disease and, as a result, reducing or avoiding the risk of adverse outcomes for both mother and child associated with GDM. Previous GDM, previous big for gestational age infants, diabetes (of any kind) in first degree relatives, pre-pregnancy adipositas, belonging to a specific ethnic group correlated with a high prevalence of GDM, glucosuria, and high maternal age are all criteria used in most countries. There is a possibility of missing GDM cases when selective scanning is used. Selective screening, on the other hand, may help focus medical attention on patients who are most at risk of complications. GDM can be found in both obese and lean women. The pathophysiology of the disease, however, is thought to vary between these types. In obese

women, the pathophysiology is mainly defined by pregnancy-induced insulin resistance being exacerbated by pre-pregnancy insulin resistance that was already high. The metabolic syndrome is believed to be associated with increased insulin resistance. The same factors appear to be at play in lean women, but a deficiency in the first-phase insulin response appears to play a larger role. Diabetes mellitus during pregnancy and birth, as well as later in life, is linked to an increased risk for the mother and foetus. Pre-eclampsia and caesarean delivery is two maternal complications. Shoulder dystocia, birth trauma, neonatal hyperbilirubinemia, hypoglycemia, and respiratory distress syndrome are all foetal complications. There is mounting evidence that gestational diabetes raises the likelihood of a variety of short- and long-term negative effects for the foetus and mother, the most serious of which is a predisposition to metabolic syndrome and Type 2 diabetes. Follow-up is needed for pregnant diabetic women. At 6–8 weeks postpartum, an OGTT with 75 g oral glucose should be performed using WHO criteria for the non-pregnant population. If standard, the glucose tolerance test is repeated after 6 months and once a year to see if the glucose tolerance has improved or deteriorated. Glucose intolerance can persist in a significant number of pregnant diabetic women. The WHO Classification of Blood Sugar Levels was used to diagnose Type II Diabetes in postpartum women, with >200 mg/dl after a 75 gm. Glucose 2 hour load being used as the criterion for diagnosis.

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