

A Rare Case of Gestational Diabetes Mellitus Who Delivered 6 Kg Baby.

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I. Introduction

Gestational Diabetes Mellitus (GDM) is an important public health problem given its high prevalence and its association with adverse maternal and fetal outcomes. Recent evidence has confirmed that the risk of adverse outcomes is a continuum, increasing as maternal blood glucose levels rise [1] furthermore, women with prior GDM are a high-risk group for the future development of diabetes, metabolic syndrome and cardiovascular disease[2] GDM has adverse outcomes of pregnancy including preeclampsia, caesarean section rates(which varies from 30-40%)perinatal mortality(2-fold increased),birth defects, metabolic complications in Neonates and morbidity associated with subsequent childhood obesity. Furthermore, the recurrence risk with future pregnancies has been reported as high as 68% [3] and 26%[4] risk of developing type two diabetes at 15 years of follow up.

II. Case study

A 29-year-old G4P2L2 Ab1 has antenatal checkups from 5th months (20 weeks)of pregnancy in Niloufer Hospital for women and children (Hyderabad, Telangana). According to her, her LMP is on 19/12/2015. She had menstrual cycles of 5 days in 30-45days, irregular, moderate flow. Antenatal ultrasound at 9 weeks was done and according to it, Expected Date of Delivery (EDD) is on 19/9/2016.her mother is diabetic and hypertensive.

III. Obstetric History

1ST PREGNANCY:- she had a GDM ,she was on Insulin in 2nd and 3rd trimester. She also gave history of increased blood pressure. She had full term LSCS. Indication being CPD (cephalo pelvic disproportion).Female baby birth weight -3kg without any complications. She was told to have normal blood glucose level after delivery

2nd pregnancy:-had GDM in second trimester. She was on insulin in 2nd and 3rd trimester.

At term, she underwent elective LSCS indication CPD. She had a male baby of 3.5 kg without any anomalies. Her blood glucose level was normal.

3rd pregnancy:-she had spontaneous abortion at 2 months of gestation.

4th pregnancy:- the women had antenatal checkups in our hospital from 20 weeks onwards. Her body weight was 75kg, height 5feet 4inches. Her LMP is not reliable, hence EDD was calculated from 9 weeks' ultrasound scan and was on 19/9/16.At 20 weeks, her OGTT-201 mg/dl and other routine investigations were within normal range. Blood group O Positive. As her OGTT was high (upper limit is140mg /dl)she was advertised FBS,PLBS and endocrinologist opinion. She was started on (12Uto6U)R-insulin up to 28 weeks. Her blood glucose levels were in normal range. She was advised antenatal checkups once in every 15days.For some personal reasons, the women did not attend our hospital from 28 weeks to 36 weeks of gestation. At 36weeks, her FBS-163 mg/dl, PLBs 215mg/dl, HbA_{1c}-15.7%.Her body weight was 90kg.She was admission for control of blood sugars, but the women refused to get admitted. She again came to us at 38 weeks. Her blood pressure was 130/90, Fasting Blood sugar was 106 mg/dl. Antenatal ultrasound shows single live fetus, cephalic presentation placenta posterior upper segment. AFI-32.7cm with gestational age of 40weeks 2 days, estimated birth weight-5282 gm. We have decided for elective LSCS, indication being 2 previous LSCS and big baby (macrosomia) we have taken all measures to prevent postpartum hemorrhage. A male baby was born with an APGAR of 9 and10 at 1/5 minutes, an umbilical artery PH 7.32 and birth weight of 6000 gm (6Kg).weight of placenta was 11/2kg.There were no intraoperative and post-partum complications. Thorough workup was done to rule out anomalies in the baby and the woman was discharged on 7th postoperative day.



a birthweight of 6 Kg (13.2277 pound)



weight of placenta was 1 1/2kg(3.306pound)



Compared with another baby of weight 2.7kg(6.062pound)

IV. Conclusion

The detection of GDM can also have important consequences following pregnancy. Women with a prior diagnosis of GDM are at an increased risk for the future development of diabetes, metabolic syndrome and cardiovascular disease. Identification of the seat-risk women permits the implementation of lifestyle modifications and a targeted follow-up that would not be applied when GDM goes undetected. The timely action taken in screening all pregnant women for glucose intolerance, achieving euglycemia and ensuring adequate nutrition may prevent all probabilities, the vicious cycle of transmitting glucose intolerance from one generation to another.

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