# Gestational Diabetes Mellitus

## Who to test. How to test.

The articles by Moses and his colleagues in this issue of *Diabetes Care* (1,2) address two important issues that have plagued the obstetrician for decades—what women need to be tested for gestational diabetes mellitus (GDM)? and how should they be tested? In the late 1970s, after years of nonstandardized testing for diabetes, the world finally adopted a standard glucose load and testing procedure to be used under most circumstances (3,4). During pregnancy, however, several different testing regimens are still used. The World Health Organization recommends that pregnant women be tested for diabetes during pregnancy with the same 75-g oral glucose load used in nonpregnant adults (5). In the U.S., the American Diabetes Association (ADA) and the American College of Obstetricians and Gynecologists endorse a two-step procedure using a screening test and a diagnostic test (6,7). The screening test, using a glucose load at 24–28 weeks of gestation, was implemented so that every woman would have at least one challenge with a glucose load during pregnancy that would identify unsuspected cases of GDM. It was not intended to be a substitute for diagnostic testing earlier in pregnancy when indicated. Unfortunately, it has been generally interpreted as the only test needed, and this has resulted in a delay in the diagnosis of GDM even in women recognized to be at very high risk. Widespread dissatisfaction with these criteria has led obstetricians to try a number of modifications, including lowering cut points for diagnosis, diagnosing on the basis of a single elevated value, and diagnosing on the basis of an abnormal screen alone. The result has been the identification and treatment of more subtle abnormalities of glucose tolerance with the realization that most adverse outcomes associated with GDM are correlated not with a threshold concentration, but with the glucose concentration over a continuum.

Now the ADA has reversed itself and recommended that a group of women at low risk of developing GDM need not even be screened (6). Moses et al. (1) evaluated the impact of following this new recommendation in a population that was universally tested with a standard 75-g oral glucose load and found that outcomes in low-risk women were similar to those in high-risk women. Furthermore, 10% of all cases of GDM would have been missed if the new recommendations had been followed. These data clearly suggest that the new ADA recommendation should be reconsidered. Before physicians can be justified in not screening pregnant women with an oral glucose load, they need to replicate the type of study presented here by Moses et al. (1). Until more data are available to support the new ADA recommendations, the health of children will best be served by making every effort to determine the presence and degree of glucose intolerance in every pregnancy. A single diagnostic test, as proposed here by Moses et al. (2) and as already used in much of the world, rather than the two-step test used in most of the U.S., will greatly simplify the procedure. In their companion article, these authors also provide excellent data to support the World Health Organization's recommendation that with a single 75-g load, gestational impaired glucose tolerance (2-h postload glucose concentration ≥140 mg/dl or 7.8 mmol/l) constitutes a diagnosis of GDM and warrants treatment.

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