General Practitioner Symposium

— WEST MORETON — 2025 —

9:40am – 10:20am

Medical Obstetric Update and
Infections in Pregnancy Update

Dr Vishwas Raghunath and Dr Jill Parkes Smith

Symposium organisers

Australian Government

phn DARLING DOWNS AND WEST MORETON
An Australian Government Initiative

West Moreton Health

Queensland Government

Got a question?
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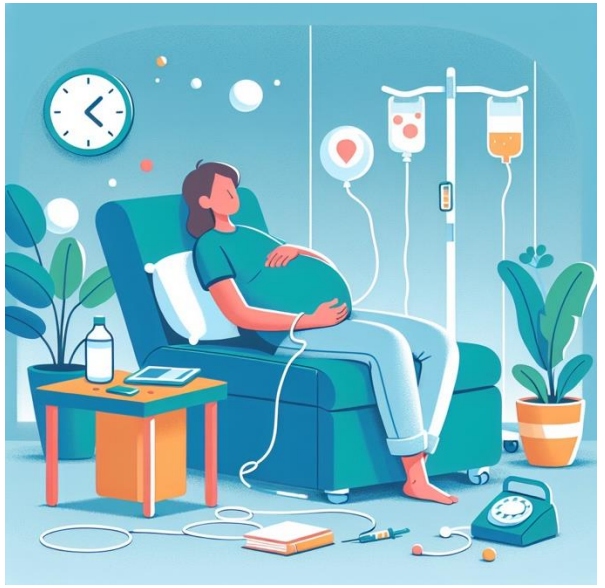
General Practitioner Symposium
WEST MORETON – 2025

West Moreton Maternity Symposium

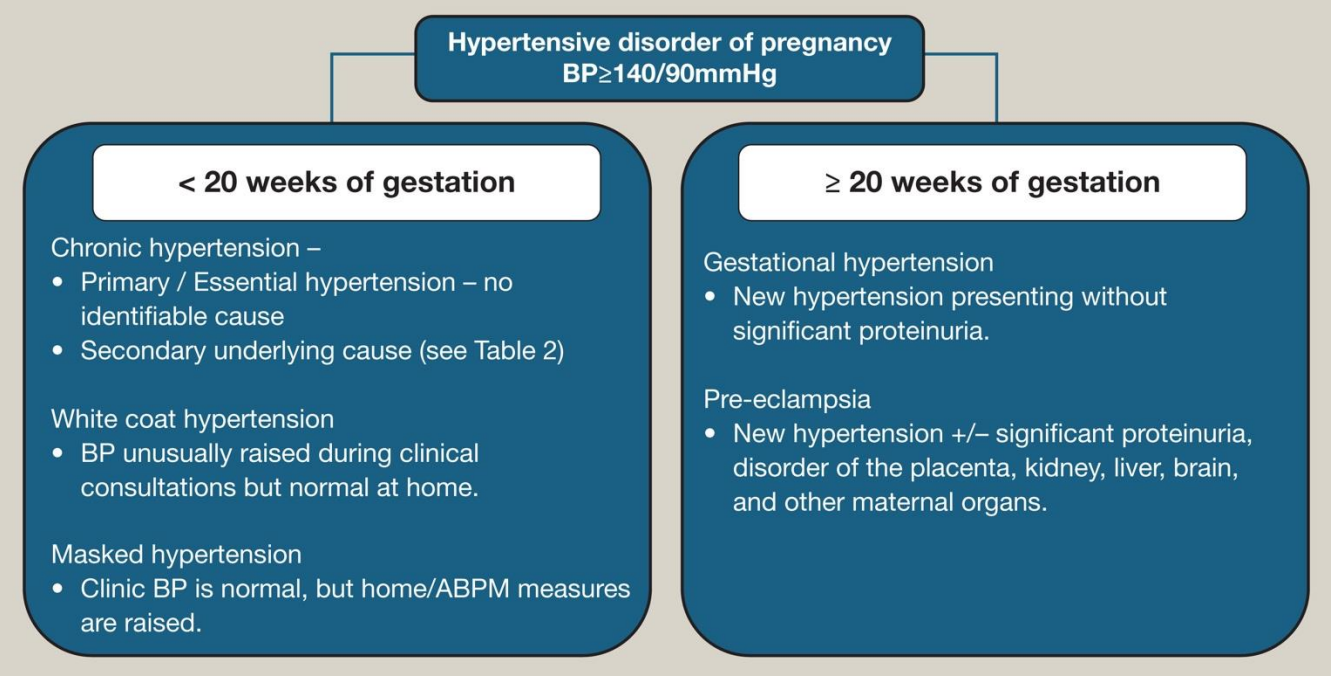
High Risk Pregnancy



2nd August 2025

Dr Vishwas Raghunath
Nephrologist & Obstetric Physician
West Moreton HHS and Mater Mother's Hospital

Preeclampsia



Preeclampsia is a multi-system disorder - **new onset** of hypertension (SBP≥140 mmHg **and/or** DBP≥90 mmHg) **after 20 weeks'** gestation accompanied by one or more signs of **new onset organ involvement**.

- Renal – proteinuria (uPCR>30mg/mmol) or serum creatinine > 90 umol/l.
- Liver – raised serum transaminases
- Hematological – thrombocytopenia, hemolysis or DIC.
- Neurological – seizures, cerebral irritability (hyperreflexia/clonus, PRES or persistent visual changes) or cerebrovascular accident.
- Pulmonary oedema
- Placental dysfunction – fetal growth restriction with abnormal umbilical artery dopplers or oligohydramnios.
- Biomarkers - sFLT1:PlGF ratio as a ‘rule out’ test.

Risk stratification in preeclampsia

SOMANZ
SOCIETY OF OBSTETRIC MEDICINE OF AUSTRALIA AND NEW ZEALAND

SOMANZ
Hypertension in Pregnancy Guideline
2023

A summary of the 2023 Society of Obstetric Medicine of Australia and New Zealand (SOMANZ) hypertension in pregnancy guideline

Renuka Shanmugalingam[1,2], Helen L Barrett[3,4], Amanda Beech[3,4], Lucy Bowyer[3], Tim Crozier[5,6], Amanda Davidson[7], Marloes Dekker Nitert[8], Kerrie Doyle[2], Luke Grzeskowiak[9], Nicole Hall[1], Hicham Ibrahim Cheikh Hassan[10,11], Annemarie Hennessy[2,12], Amanda Henry[4,13], David Langsford[14,15], Vincent WS Lee[16,17], Zachary Munn[18], Michael J Peek[19,20], Joanne M Said[15,21], Helen Tanner[22], Rachel Taylor[23], Meredith Ward[3], Jason Waugh[24], Linda LY Yen[25], Ellie Medcalf[16], Katy JL Bell[16], Deonna Ackermann[16], Robin Turner[26], Angela Makris[1,2]

SOMANZ_Hypertension_in_Pregnancy_Guideline_2023.pdf

Contents lists available at ScienceDirect

Pregnancy Hypertension: An International Journal of Women's Cardiovascular Health

journal homepage: www.elsevier.com/locate/preghy

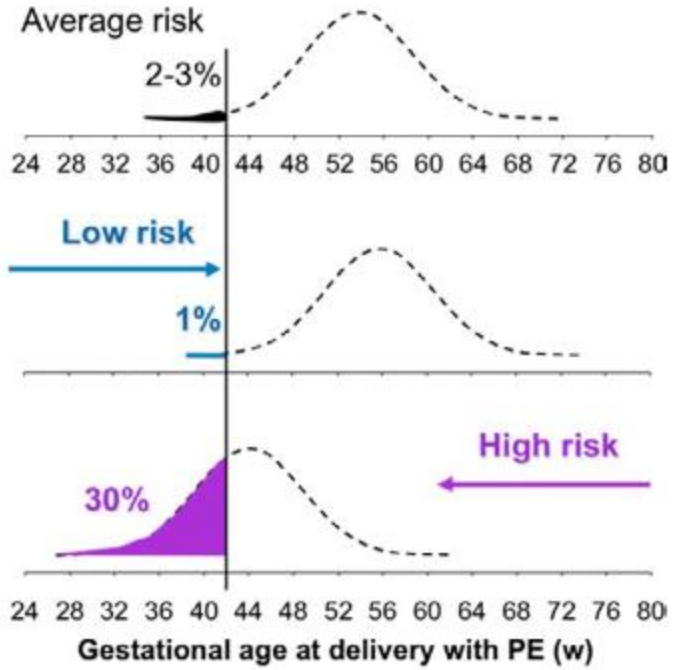
The 2021 International Society for the Study of Hypertension in Pregnancy classification, diagnosis & management recommendations for international practice☆

Laura A Magee[a,*], Mark A. Brown[b], David R. Hall[c], Sanjay Gupte[d], Annemarie Hennessy[e], S. Ananth Karumanchi[f], Louise C. Kenny[g], Fergus McCarthy[h], Jenny Myers[i], Liona C. Poon[j], Sarosh Rana[k], Shigeru Saito[l], Anne Cathrine Staff[m,n], Eleni Tsigas[o], Peter von Dadelszen[a]

The 2021 International Society for the Study of Hypertension in Pregnancy classification, diagnosis & management recommendations for international practice

Screening for women at risk of preeclampsia

- Women should be **screened** for their risk of preeclampsia **early** in the pregnancy. (1B)
- At a minimum, risk stratification should be done based on **maternal risk factors** (maternal characteristics, medical and obstetric history).
- Use of a **combined first trimester screen** (combined maternal features, biomarkers and sonography) to identify women at risk of developing preeclampsia is conditionally recommended (2B) based on local availability and access to the required resources.
  - Combined screening for preeclampsia and aneuploidy at K12-K14 during nuchal translucency appointment.



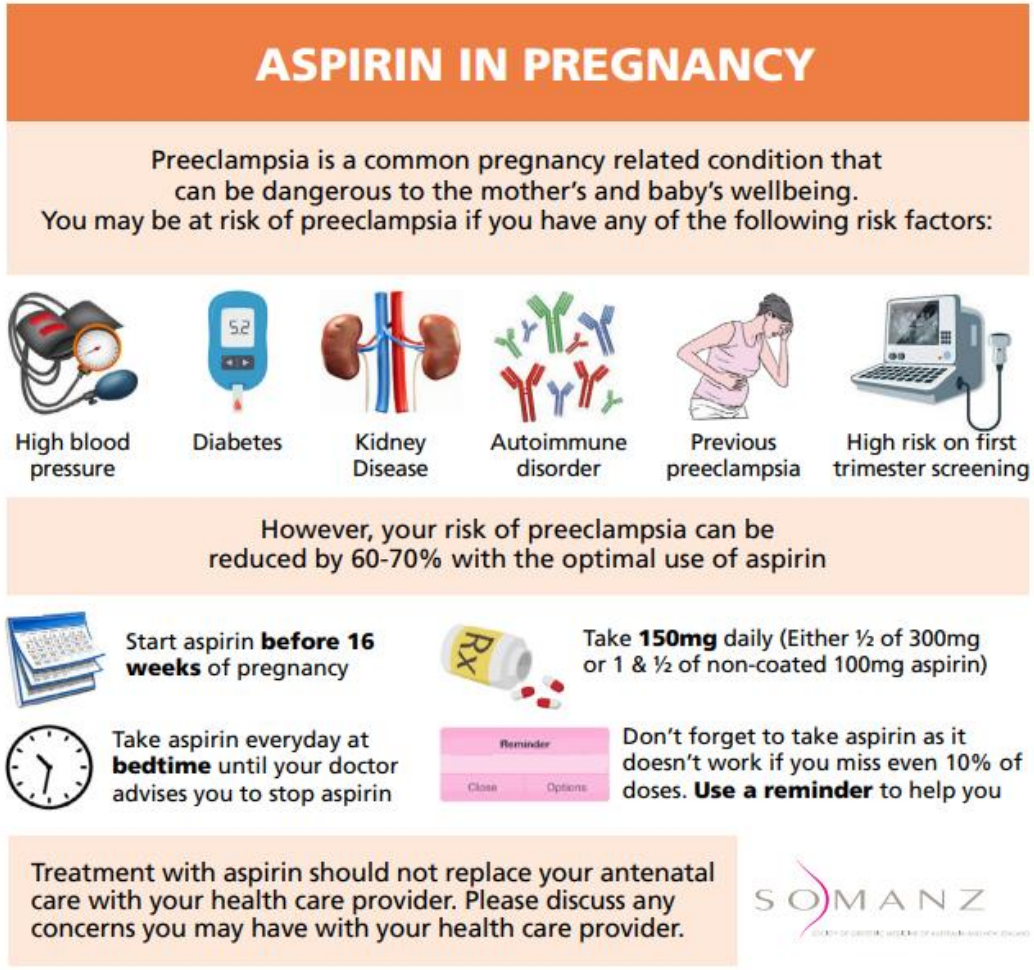
Factors identified as 'High Risk' for developing preeclampsia	
1 or more risk factors	Previous hypertensive disorder during prior pregnancy
	Chronic kidney disease or kidney impairment
	Multi-fetal gestation
	Pre-existing chronic hypertension
	Pre-existing Type 1 or Type 2 diabetes mellitus
	Autoimmune disorders e.g. systemic lupus erythematosus, anti-phospholipid syndrome
Factors identified as 'Moderate Risk' for developing preeclampsia	
2 or more risk factors	Advanced maternal age (>40)
	Obesity (BMI≥35)
	Nulliparity
	Family history of preeclampsia
	Interpregnancy interval of 10 or more years
	Assisted reproduction technologies
	Systolic blood pressure >130mmHg and/or diastolic blood pressure >80

	'High-risk' factors (any one)	**'Moderate-risk' factors** (two or more)
Prior pregnancy history	Prior pre-eclampsia	Prior placental abruption Prior stillbirth Prior fetal growth restriction
Demographics	Pre-pregnancy BMI > 30 kg/m^2	Maternal age >40 years
Pre-existing medical conditions	Chronic hypertension Pre-gestational diabetes mellitus Chronic kidney disease (inc. kidney transplanted women)† Systemic lupus erythematosus/ antiphospholipid antibody syndrome†	
This pregnancy	Assisted reproductive therapy‡	Nulliparity Multifetal pregnancy

Preventative strategies - Aspirin

- Initiation of **aspirin** in women at high risk of developing preeclampsia, **prior to 16 weeks'** gestation, is strongly recommended. (1B)
- The **dose of 150mg/day** of aspirin is strongly recommended. (1B)
- The use of **bedtime** aspirin is conditionally recommended. (2C)
- **Cessation** of aspirin between **34 weeks'** gestation and birth is conditionally recommended. (2B)

- Universal aspirin in low-risk nulliparous women is conditionally recommended against. (2B)
- Counselling on the use of aspirin in pregnancy is recommended to improve adherence to aspirin in pregnancy. (PP)



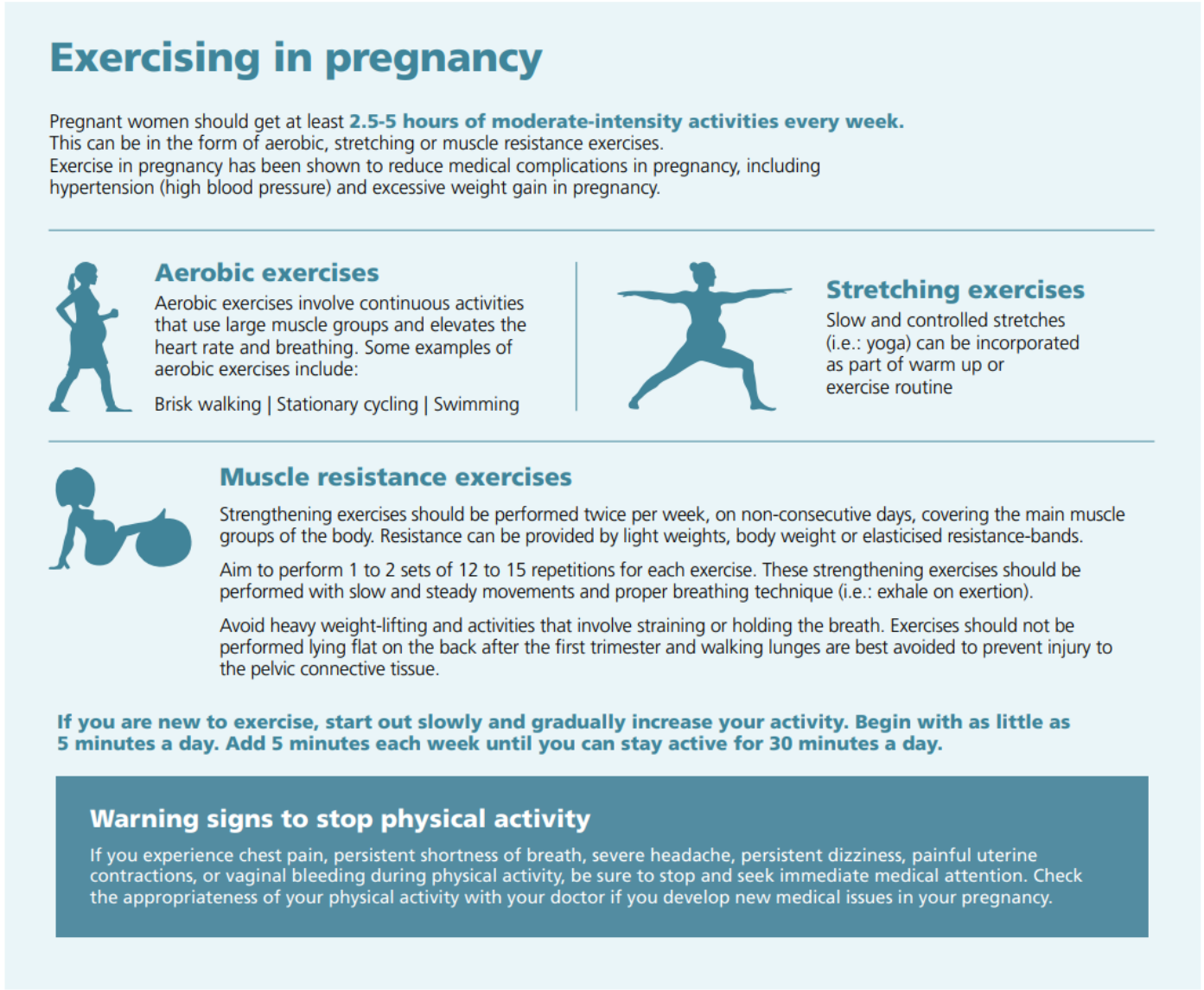
Preventative Strategies – other pharmaceuticals

- Calcium
  - The use of **supplemental calcium** is strongly recommended in pregnant **women with low dietary calcium intake** (<1g/day) for the prevention of preeclampsia, preterm birth, and gestational hypertension. (1C)
  - Assess dietary calcium intake prior to recommending oral calcium supplementation (PP)
  - Consider assessing serum corrected calcium in those taking calcium oral supplementation(to ensure the absence of hypercalcemia). (PP)
- Others **NOT** recommended:
  - Omega-3 lung chain polyunsaturated fatty acids
  - Vitamins C, D & E, Garlic, Magnesium, Progesterone, Statins, Metformin.
  - Clopidogrel, LMWH (if no thrombophilia or APLS)

Exercise in pregnancy

- **Moderate intensity exercise**, in the form of aerobic, stretching and/or muscle resistance exercises, for a total of **2.5-5 hours a week**, as recommended as part of routine pregnancy wellbeing has the added benefit of reducing the risk of hypertensive disorders of pregnancy. (2D)

- Exercise regimen should be commenced early in the pregnancy. (PP)



Exercising in pregnancy

Pregnant women should get at least **2.5-5 hours of moderate-intensity activities every week.**
This can be in the form of aerobic, stretching or muscle resistance exercises.
Exercise in pregnancy has been shown to reduce medical complications in pregnancy, including hypertension (high blood pressure) and excessive weight gain in pregnancy.

Aerobic exercises

Aerobic exercises involve continuous activities that use large muscle groups and elevates the heart rate and breathing. Some examples of aerobic exercises include:

Brisk walking | Stationary cycling | Swimming

Stretching exercises

Slow and controlled stretches (i.e.: yoga) can be incorporated as part of warm up or exercise routine

Muscle resistance exercises

Strengthening exercises should be performed twice per week, on non-consecutive days, covering the main muscle groups of the body. Resistance can be provided by light weights, body weight or elasticised resistance-bands.

Aim to perform 1 to 2 sets of 12 to 15 repetitions for each exercise. These strengthening exercises should be performed with slow and steady movements and proper breathing technique (i.e.: exhale on exertion).

Avoid heavy weight-lifting and activities that involve straining or holding the breath. Exercises should not be performed lying flat on the back after the first trimester and walking lunges are best avoided to prevent injury to the pelvic connective tissue.

If you are new to exercise, start out slowly and gradually increase your activity. Begin with as little as 5 minutes a day. Add 5 minutes each week until you can stay active for 30 minutes a day.

Warning signs to stop physical activity

If you experience chest pain, persistent shortness of breath, severe headache, persistent dizziness, painful uterine contractions, or vaginal bleeding during physical activity, be sure to stop and seek immediate medical attention. Check the appropriateness of your physical activity with your doctor if you develop new medical issues in your pregnancy.

Longterm consequences of preeclampsia

- Women should be **informed** of the **long-term risks** associated with preeclampsia, gestational hypertension and chronic hypertension and the importance of postpartum follow up **prior to discharge** from hospital (PP)

- Women should be **reviewed by a health care provider within 1 week of discharge** from hospital to ensure stable blood pressure post discharge and titrate medications accordingly. (PP)

- At **3-6 months postpartum**, a follow up review of
  - blood pressure (consider a 24-hour blood pressure monitor if not previously done),
  - urine protein assessment (uACR and/or uPCR),
  - BMI and metabolic profile (fasting blood glucose and fasting cholesterol assessment)
- **Interventions** for any abnormalities (i.e. further investigations, specialist referral, weight management, lifestyle changes, smoking cessation) should be discussed. (PP)

- A **yearly follow up** of blood pressure, urine protein assessment, BMI and metabolic profile should be considered in identifying early abnormalities in the first 5-10 years postpartum (PP)

- At every review, women should be **opportunistically screened** for postpartum depression and anxiety. The Edinburgh Postnatal Depression Scale (EPDS) can be used as an initial screening tool . (PP)

- At every review, women should be counselled on the risk of preeclampsia and gestational hypertension in **subsequent pregnancies** and the i**mportance of pre-conception medical optimization**, **contraception** (where indicated) and risk minimization strategies (i.e.: prophylactic aspirin). (PP)

< 6 weeks postpartum

- Blood pressure assessment
- Non-steroidal anti-inflammatory avoidance (where possible)
- Adherence to antihypertensives
- Screen for features of postpartum depression and/or anxiety. The Edinburgh Postnatal Depression Scale (EPDS) can be used as an initial screening tool

3-6 months postpartum

- Blood pressure assessment with a 24-hour blood pressure monitor where possible
  - Consider further assessment for a secondary hypertension screen +/- specialist review if blood pressure remains ≥130/80mmHg (ABPM), ≥140/90mmHg (clinic blood pressure assessment) or if remains on antihypertensives
  - Encourage lifestyle measures if BP is noted to be persistently > 120/80mmHg
- Assess for normalisation of abnormal laboratory-based results
  - Consider further assessment +/- specialist review for persistently abnormal renal function, urine microalbumin to creatinine ratio (uACR), urine protein to creatinine ratio (uPCR), liver function or haematological parameters.
- Screen for features of postpartum depression and/or anxiety
  - Consider a combination of non-pharmacological and pharmacological intervention
- Metabolic screen: BMI, fasting cholesterol and fasting blood glucose level assessment
  - Consider a combination non-pharmacological and pharmacological interventions in addressing abnormal metabolic features
- Discuss future pregnancies: importance of pre-conception care and early preeclampsia prophylactic intervention (i.e: aspirin, regular exercise, dietary +/- supplemental calcium)
- Discuss contraception where relevant (where there is need for medical optimisation) prior to next pregnancy)
- Explain future cardiovascular, metabolic and renal risk factors.

Yearly review

- Reassessment of metabolic, cardiovascular and renal risk factors (BP, weight, lipid and glycaemic profile, urine protein analysis)
- Discuss future pregnancies: importance of pre-conception care and early preeclampsia prophylactic intervention (i.e. aspirin, regular exercise, dietary +/- supplemental calcium)
- Explain future cardiovascular, metabolic and renal risk factors

SOMANZ Hypertension in Pregnancy Guideline 2023

The **SOMANZ Hypertension in Pregnancy Guideline 2023** represents a comprehensive update of the previous 2014 version and has been approved by the National Health and Medical Research Council (NHMRC) under section 14A of the National Health and Medical Research Council Act 1992, reflecting its alignment with NHMRC's clinical practice guideline standards.

Developed with academic rigor, the guideline adheres to NHMRC's Guideline for Guidelines and employs the 'Grading of Recommendations Assessment, Development, and Evaluation' (GRADE) approach. It encompasses thirty-nine recommendations across eight sections, addressing key aspects such as screening, prevention, diagnosis, and management of hypertensive disorders in pregnancy.

Updates based on the latest data include recommendations on combined first-trimester screening for identifying women at risk of preeclampsia and sixteen preventative interventions. The

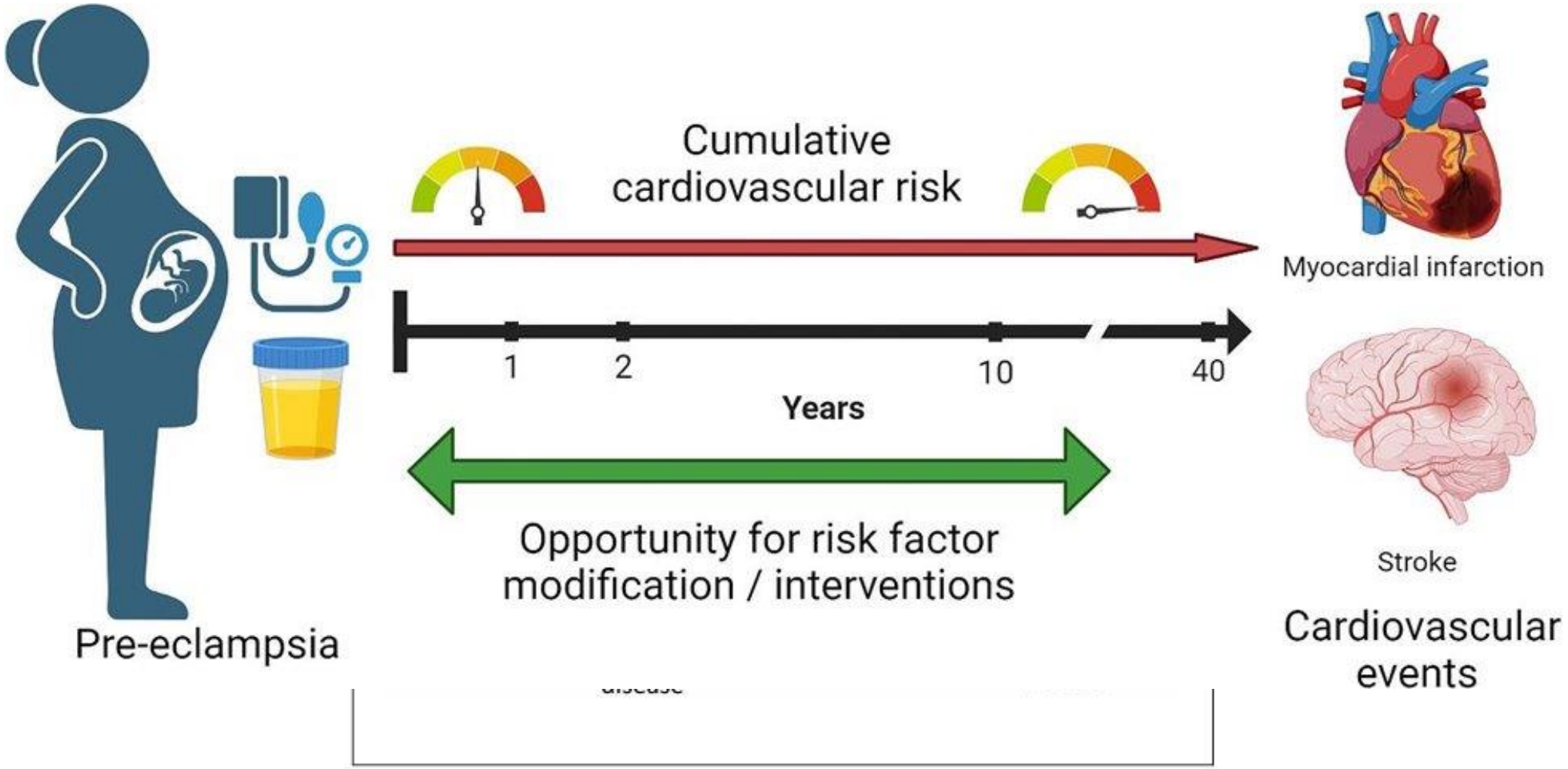
Guideline Documents

- **SOMANZ Hypertension in Pregnancy Guideline 2023**
- **Executive Summary of Recommendations SOMANZ HIPG 2023**
- **Top 10 Points for Clinicians from the SOMANZ HIPG 2023**
- **Top 10 Points for Women and Families from the SOMANZ HIPG 2023**
- Summary of the SOMANZ Hypertension in Pregnancy Guideline 2023 is accessible through the **Wiley Online Libray** (Open Access)**.**

Flowsheets for Health Care Providers +

Patient Information Sheets +

RISK


Cumulative
cardiovascular risk
1
2
10
40
Years
Opportunity for risk factor
modification / interventions
Pre-eclampsia
Myocardial infarction
Stroke
Cardiovascular
events

FIGO
International Federation of Gynecology and Obstetrics
the Global Voice for Women's Health

Pregnancy Passport

Postpartum Health Record

Risk indicators

Have you had any pregnancy

- Preeclampsia ☐ Y
- Gestational hypertension ☐ Y
- Gestational diabetes ☐ Y
- Placental abruption ☐ Y
- Preterm birth (<37 weeks) ☐ Y
- Fetal growth restriction ☐ Y
- Stillbirth/intrauterine death ☐ Y

What you can do to reduce such risk

Stay active by exercising at least 150 minutes per week

Breastfeed as long as possible

Aim to have the best body weight

Get at least 6 hours of sleep regularly

Eat a diverse diet rich in colourful fruits and vegetables, including nuts and seeds; and reduce salt, fats and sugar intake

See your primary care provider for routine appointments

Live smoke-free

Consider suitable contraception method(s), space your next pregnancy at least 12 months apart, seek help from your provider to optimise your health before the next pregnancy and seek early attention when you become pregnant

Pregnancy after Bariatric Surgery

Introduction

- Maternal obesity is linked to multiple complications in pregnancy.

- ~2/3 of patients undergoing Bariatric surgery are women of childbearing age - improves fertility.

Shekelle PG, Newberry S, Maglione M, Li Z, Yermilov I, Hilton L, Suttorp M, Maggard M, Carter J, Tringale C, Chen S. Bariatric surgery in women of reproductive age: special concerns for pregnancy. Evid Rep Technol Assess (Full Rep). 2008 Nov;(169):1-51.

- Roux-en-Y gastric bypass was associated with more obstetric complications than Sleeve Gastrectomy.

Osiakwan SE, Jones KS, Reddy SB, Omotosho P, Skertich NJ, Torquati A. Pregnancy and birth complications among women undergoing bariatric surgery: sleeve gastrectomy versus Roux-en-Y gastric bypass. Surg Obes Relat Dis. 2025 Apr;21(4):509-515. doi: 10.1016/j.soard.2024.11.012.

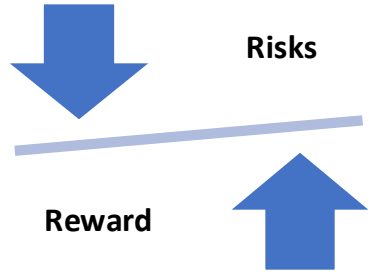
- Following bariatric surgery, pregnancy should be delayed by at least **12-18 months** due to ongoing weight loss and a discussion about contraception had.

- Pregnancy after bariatric surgery –
  - **Lower risk** of GDM, HDP and LGA
  - **Higher risk** of SGA and nutritional deficiencies

Harriet D Morgan, Amy E Morrison, Malak Hamza, Cathy Jones, Caroline Borg Cassar, Claire L Meek. The approach to a pregnancy after bariatric surgery, Clinical Medicine, Volume 25, Issue 1, 2025, 100275, ISSN 1470-2118.

Eccles-Smith J, Griffin A, McIntyre HD, Nitert MD, Barrett HL. Pregnancy and offspring outcomes after prepregnancy bariatric surgery. Am J Obstet Gynecol. 2025 May;232(5):485.e1-485.e9. doi: 10.1016/j.ajog.2024.08.044.

- A multifaceted and **multidisciplinary personalized approach** in recommended.



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DOI: 10.1111/obr.12927

BARIATRIC SURGERY/PREGNANCY

WILEY obesityreviews

Pregnancy after bariatric surgery: Consensus recommendations for periconception, antenatal and postnatal care

Jill Shawe[1] | Dries Ceulemans[2,3] | Zainab Akhter[4] | Karl Neff[5] | Kathryn Hart[6] | Nicola Heslehurst[4] | Iztok Štotl[7] | Sanjay Agrawal[8] | Regine Steegers-Theunissen[9] | Shahrad Taheri[10] | Beth Greenslade[11] | Judith Rankin[4] | Bobby Huda[12] | Isy Douek[11] | Sander Galjaard[9] | Orit Blumenfeld[13] | Ann Robinson[14] | Martin Whyte[15] | Elaine Mathews[16] | Roland Devlieger[2,3,17]

Pregnancy considerations

- **Nutrient testing** – for ALL women as soon as possible, 1st trimester
  - FBC, iron studies, active B12, folate, thiamine, vitamins A, D & E.
  - Optional -
    - Cu – if persisting iron deficiency or on Zn supplements
    - Zn & Se – if deficiency suspected (eg. Gastric bypass).
    - Vitamin K and INR (malabsorptive procedures)
  - Repeat 'micronutrient screen' every trimester.

- **Gastrointestinal symptoms** -
  - Watch for things like postprandial hyperinsulinaemic hypoglycaemia (dumping syndrome), recurring vomiting, reflux disease, constipation or diarrhoea (esp. steatorrhoea) and upper abdominal pain.
  - **Constipation** is common –
    - Lifestyle intervention: ensure adequate hydration 6-8 glasses fluid/day), dietary fibre (25 35g/day) and physical activity.
    - May recommend bulk-forming laxative: e.g. Benefibre/wheat dextrin, Metamucil/psyllium husk, Fybogel/ispaghula husk).
  - Treat **dumping syndrome** with low GI carbohydrate (e.g. wholegrain crackers) with a source of protein and fat (e.g. peanut paste or cheese).

Appendix C: Suggested pregnancy nutrient and biochemical screening post bariatric surgery

Laboratory test		Pre conception	First trimester	2nd and 3rd trimester	Lactation (3 monthly)	Additional measurements/notes
Full blood count		✓	✓	✓	✓	
CHEM20*	Electrolytes Sodium, Potassium, Chloride, Creatinine, Chem Panel	✓	✓	✓		Order individual tests or if all required complete as part of a *CHEM20
	Albumin	✓	✓	✓	✓	
	Calcium	✓	✓	✓	✓	
	Magnesium	✓	✓	✓	✓	
	Phosphate	✓	✓	✓	✓	
	Liver function tests	✓	✓	✓	✓	
	Renal Panel	✓	✓	✓	✓	
Thyroid function—thyroid stimulating hormone (TSH)		✓	✓			At physicians' discretion Add on free thyroxine (FT4) if TSH abnormal
C Reactive Protein		✓	✓		✓	Baseline screen, then at physician's discretion. If systemic inflammation, risk of inaccurate plasma nutrient levels (e.g. vitamins A, B^6, C, D, selenium, zinc). Repeat after resolves
Iron studies		✓	✓	✓	✓	Includes ferritin and transferrin saturation
Vitamin D—25 OH		✓	✓	✓	✓	
Vitamin B_{12} (Cobalamin)		✓	✓	✓	✓	Folic acid supplementation may mask deficiency
Methylmalonic acid (MMA)		✓	✓	✓	✓	Sensitive index of vitamin B_{12} status At physicians' discretion
Folate (Serum)		✓	✓	✓	✓	
Zinc protoporphyrin		✓	✓	✓		
Vitamin A		✓	✓	✓	✓	
Retinol Binding Protein		✓	✓	✓	✓	
Vitamin B_1 (Thiamine diphosphate whole blood—THIAM)		✓				If repeated vomiting
Serum copper and ceruloplasmin			✓			Ceruloplasmin: copper carrying protein
Selenium			✓			
Vitamin E—Alpha-tocopherol (VITE)		If symptomatic anaemia or steatorrhea				
Vitamin B_6 (Pyridoxine)		If multiple or severe deficiencies				
Vitamin C		If deficiency suspected				

Queensland Health
Clinical Excellence Queensland

Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal **Clinical Guideline**

Obesity and pregnancy (including post bariatric surgery)

mater health

Guidelines for specific care management for maternal obesity including previous bariatric surgery

- Sensitive language to reduce weight stigma
- Sufficient resources (human and equipment)
- Local criteria for safe care provision
- Audit care

BMI classification (kg/m²)

Underweight	< 18.5
Normal	18.5–24.9*
Overweight	25.0–29.9*
Obese I	30.0–34.9*
Obese II	35.0–39.9
Obese III	> 40

*Variations for Asian background

GWG

Trimester 1	kg
All women	0.5–2.0
Trimester 2+3	kg/week
Underweight	0.5
Normal	0.4
Overweight	0.3
Obese	0.2

Total GWG

Singleton	kg
Normal	11.5–16
Overweight	7–11.5
Obese	5–9
Twin/triplet	kg
Normal	17–25
Overweight	14–23
Obese	11–19

Pre and inter-conception

- Comprehensive health assessment
- Discuss health impacts and options
- Consider referral to dietitian
- Aim to normalise weight
- Higher dose folic acid daily
- Personalised approach to weight concern and lifestyle
- Post BS: micronutrient supplements and monitoring
- Identify/optimise comorbidities (e.g. diabetes mellitus)

Antenatal

Assessment
- Comprehensive history (including past BS)
- Early antenatal booking-in
- Measure BMI pre-pregnancy and at 36 weeks
- Use correctly sized BP cuff
- If BS: micronutrient supplements/monitoring

Discuss
- Lifestyle options, healthy eating and physical activity
- GWG and consider weight gain chart use
- Implications for care (e.g. transfer of care)
- Greater inaccuracy early pregnancy screening

Refer as required
- Psychosocial wellbeing
- Mental health

Consider risk of
- Pre-eclampsia – low dose aspirin
- VTE and need for thromboprophylaxis

Elements | BMI (kg/m²)	25–29.9	30–34.9	35–39.9	> 40	BS
Higher dose folic acid		✓	✓	✓	✓
Multidisciplinary	✓	✓	✓	✓	✓
Additional bloods		✓	✓	✓	✓
Early GDM screen		✓	✓	✓	✓caution:OGTT
Additional USS			✓	✓	✓
Referrals					
Dietitian	✓	✓	✓	✓	✓
Obstetrician			Consult	✓	✓
Anaesthetic				✓	✓
Obstetric medicine					✓

Labour and birth

- If BMI > 40 kg/m²
  - Early assessment of IV access
  - Recommend CFM
- If prophylactic antibiotics, consider higher dosage
- Surveillance for shoulder dystocia/PPH
- Active third stage management

Postpartum

- Surveillance for airway compromise
- Early mobilisation
- Assess risk of VTE and consider thromboprophylaxis
- Additional support for breastfeeding
- Referral for ongoing healthy lifestyle support

Gestational diabetes (**GDM**) update – ADIPS 2025

Consensus statement

Australasian Diabetes in Pregnancy Society (ADIPS) 2025 consensus recommendations for the screening, diagnosis and classification of gestational diabetes

Arianne Sweeting[*,1,2], Matthew JL Hare[*,3,4], Susan J de Jersey[5,6], Alexis L Shub[7,8], Julia Zinga[9], Cecily Foged[7], Rosemary M Hall[10,11], Tang Wong[12,13,14], David Simmons[14,15]

What's new?

Overt diabetes in pregnancy (overt DIP) should be diagnosed at any time in pregnancy if one or more of the following criteria are met:

- fasting plasma glucose (FPG) ≥ 7.0 mmol/L;
- two-hour plasma glucose (2hPG) ≥ 11.1 mmol/L following a 75 g two-hour pregnancy oral glucose tolerance test (POGTT); and/or
- glycated haemoglobin (HbA1c) ≥ 6.5% (≥ 48 mmol/mol).

Irrespective of gestation, **gestational diabetes mellitus should be diagnosed** using one or more of the following criteria during a 75 g two-hour POGTT:

- FPG ≥ 5.3–6.9 mmol/L;
- one-hour plasma glucose (1hPG) ≥ 10.6 mmol/L;
- 2hPG ≥ 9.0–11.0 mmol/L

The Consensus recommendations for BGL targets are:

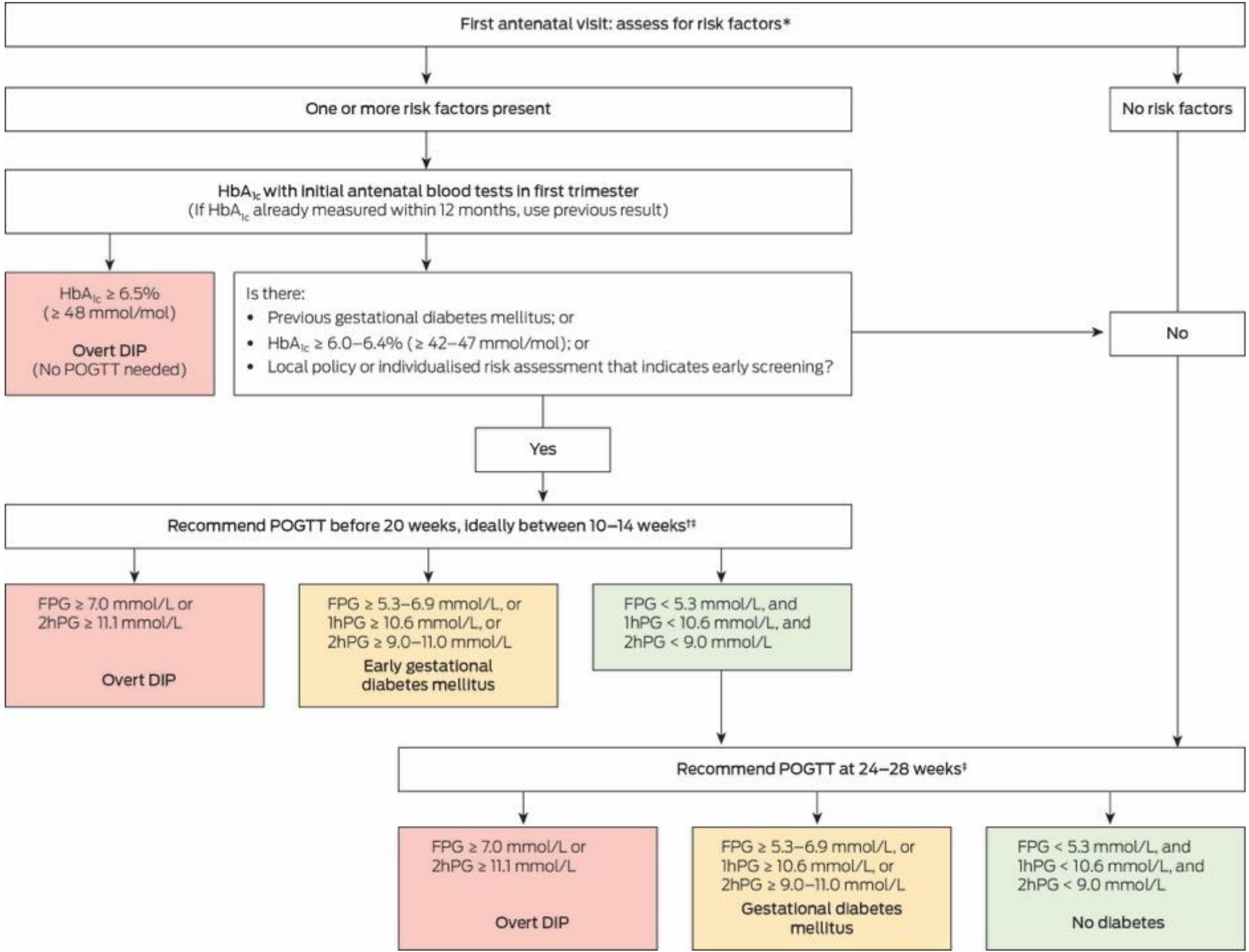
- Fasting—less than or equal to 5.2 mmol/L
- 1 hour after commencing meal—less than or equal to 7.4 mmol/L
- 2 hours after commencing meal—less than or equal to 6.7 mmol/L

Women with risk factors for hyperglycaemia in pregnancy should be advised to have the HbA1c measured in the first trimester.

- Women with HbA1c ≥ 6.5% (≥ 48 mmol/mol) should be diagnosed & managed as having overt DIP.

Before 20 weeks' gestation, and ideally between 10- & 14-weeks' gestation, if tolerated, women with a previous history of gestational diabetes mellitus or early pregnancy HbA1c ≥ 6.0-6.4% (≥ 42–47 mmol/mol), but without diagnosed diabetes, should be advised to undergo a 75 g two-hour OGTT.

All women (without diabetes already detected in the current pregnancy) should be advised to undergo a 75 g two-hour POGTT at 24–28 weeks' gestation.


First antenatal visit: assess for risk factors*
One or more risk factors present
No risk factors
HbA1c with initial antenatal blood tests in first trimester
(If HbA1c already measured within 12 months, use previous result)
HbA1c ≥ 6.5%
(≥ 48 mmol/mol)
Overt DIP
(No POGTT needed)
Is there:
• Previous gestational diabetes mellitus; or
• HbA1c ≥ 6.0–6.4% (≥ 42–47 mmol/mol); or
• Local policy or individualised risk assessment that indicates early screening?
No
Yes
Recommend POGTT before 20 weeks, ideally between 10–14 weeks†‡
FPG ≥ 7.0 mmol/L or
2hPG ≥ 11.1 mmol/L
Overt DIP
FPG ≥ 5.3–6.9 mmol/L, or
1hPG ≥ 10.6 mmol/L, or
2hPG ≥ 9.0–11.0 mmol/L
Early gestational diabetes mellitus
FPG < 5.3 mmol/L, and
1hPG < 10.6 mmol/L, and
2hPG < 9.0 mmol/L
Recommend POGTT at 24–28 weeks‡
FPG ≥ 7.0 mmol/L or
2hPG ≥ 11.1 mmol/L
Overt DIP
FPG ≥ 5.3–6.9 mmol/L, or
1hPG ≥ 10.6 mmol/L, or
2hPG ≥ 9.0–11.0 mmol/L
Gestational diabetes mellitus
FPG < 5.3 mmol/L, and
1hPG < 10.6 mmol/L, and
2hPG < 9.0 mmol/L
No diabetes

Thank You