Promoting Healthy Beginnings

Fall 2015 Volume XVII Issue 1

A newsletter for health and human service providers published by:

Mohawk Valley Perinatal Network, Inc.
1000 Cornelia Street 2nd Floor
Utica, NY 13502
Phone: 315.732.4657
Fax: 315.732.5640
E-mail: info@newfamily.org
Web: www.newfamily.org

If you would like to contribute to our newsletter as a writer or with suggestions for future articles, please call, fax or e-mail the office.

Gestational Diabetes—Rates, Risks, Diagnosis and Treatment

Gestational Diabetes Mellitus (GDM) is an "impaired glucose tolerance with onset or first recognition during pregnancy". This type of diabetes is caused by a change in the way a woman's body responds to the hormone insulin during her pregnancy, and results in elevated levels of blood sugar, also known as blood glucose. Having too much sugar in your bloodstream causes serious problems for a woman and her baby, if left untreated. As the rates of obesity and type 2 diabetes rise in this country, so too, do the rates of GDM. With better up to date data on current rates of GDM and better treatment options, more can be done to understand GDM and lower prevalence in the future.

Rates

Because of discrepancies in the reporting of GDM by providers, the actual rates of GDM were unknown until recently. Depending on the population studied and the ways of gathering statistics on GDM, it was estimated, in past years, to be prevalent in 1%-14% of pregnancies in the U.S. per year. In June, 2014, the CDC published a study in *Preventing Chronic Disease*, which provided the most current GDM rates reported on birth certificates and the Pregnancy Risk Assessment Monitoring System (PRAMS), from 2007-2010. While the study has limitations, results indicated that GDM prevalence is as high as 9.2% in the U.S. (to read the article in full, visit http://www.cdc.gov/pcd/issues/2014/13_0415.htm).

Risks

A woman's risk of developing gestational diabetes is higher if she: is overweight, has had gestational diabetes before, has given birth to a baby weighing more than 9 pounds, has a parent, brother, or sister with type 2 diabetes, has prediabetes (meaning blood glucose levels are higher than normal yet not high enough for a diagnosis of diabetes) is African American, American Indian, Asian American, Hispanic/ Latina, or Pacific Islander American, or has a hormonal disorder called polycystic ovary syndrome (PCOS). Other risk factors include higher parity and advanced maternal age. To lower the chances of developing GDM, encourage women to lose extra weight and exercise more, *before* getting pregnant. Once a woman becomes pregnant, she should not try to lose weight.

Women who develop Diabetes during pregnancy are at a higher risk for pregnancy and delivery complications. If a woman's high blood glucose levels from GDM is not under control, her baby will also have high blood glucose. A baby's pancreas will have to make extra insulin to control the high blood glucose, and the extra glucose in baby's blood is stored as fat. Uncontrolled or untreated GDM can cause these problems for baby: being born with a larger than normal body (macrosomia) which can make delivery difficult and more dangerous for the baby, having low blood glucose (hypoglycemia) right after birth, having breathing problems (respiratory distress syndrome), or having a higher chance of dying before or soon after birth.

Article continued on Page 4...

Planned Parenthood Services and the Family Planning Benefit Program

Planned Parenthood Mohawk Hudson… Care. No Matter What.

At Planned Parenthood Mohawk Hudson, Inc. (PPMH) our mission is to provide quality health care, to educate individuals to make informed sexual and reproductive decisions, and to advocate for reproductive rights. PPMH provides quality, nonjudgmental reproductive medical care and supports those affected by sexual violence; promotes healthy sexuality through education; and advocates for reproductive justice. Our 10 licensed health care centers located in Oneida, Madison, Schoharie, Schenectady, Montgomery, Fulton, Warren and Saratoga Counties serve more than 20,000 women and men each year. Medical services provided by PPMH include annual exams, birth control, cancer screenings, pregnancy testing and counseling, abortion care, HIV testing, sexually transmitted infection testing and treatment, adoption and LGBTQ services.

In addition to high quality, affordable health care services, PPMH staff provides education and attends numerous health fairs providing valuable information to members of the community. Education staff provide medically accurate, non-judgmental programs, on such topics as sexual reproduction/ health; puberty; healthy relationships; birth control and STI's to the community, at no cost. PPMH provides comprehensive sexual health education for youth through the implementation of evidence-based programs. These programs align with the NYS Core Standards for Health Education and have been shown to reduce high-risk behaviors with youth who participate in these programs. This grant initiative also increases access to family planning services; expands opportunities to build life skills; and works to advance a local community effort to improve the living environment for adolescents. If you or anyone you know is interested in learning more about our education programs please visit our website, listed below.

PPMH has staff that are trained as New York State Certified Application Counselors to enroll individuals and families in commercial health insurance, including Medicaid and Child Health Plus, through the Affordable Care Act. In addition, staff is trained to enroll individuals in the Family Planning Benefit Program (FPBP). The FPBP is a public health insurance program for New York State residents who seek family planning services, but may not be able to afford them. It is intended to increase access to confidential family planning services and to enable women and men of childbearing age, including teens, to prevent and/or reduce the incidence of unintended pregnancies. Patients can apply for FPBP in the office at time of their appointment. This program can be used in conjunction with commercial health insurance to assist with co-pays and/or deductibles. Title X (the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health service) allows us to discount most services for any individuals who qualify. PPMH also accepts most commercial insurances and Medicaid. PPMH is dedicated to providing affordable, accessible healthcare to all.

Planned Parenthood Mohawk Hudson is always accepting new patients and we are happy to announce that we are now providing same day, next day appointments.

Check us out at:
Web: www.planonit.org

Article provided by Melissa Arcuri, Community Educator, PPMH

Local Planned Parenthood Locations:

PP Utica Health Center: 1424 Genesee Street, Utica, **Phone:** (315) 724-6146

PP Rome Health Center: 111 East Chestnut Street, Suite 205, Rome, **Phone:** (315) 337-8584

PP Oneida Health Center: 603 Seneca Street, Suite 5, Oneida, **Phones:** (315) 363-3950

ACOG Releases New Recommendations on Early Pregnancy Loss

April 21, 2015

Washington, DC — Early pregnancy loss, or miscarriage, is a tragic yet common event, occurring in approximately ten percent of all clinically recognized pregnancies. Because of this, obstetrician-gynecologists must be prepared to care for patients and offer the full range of options for the management of early pregnancy loss, according to new guidelines from the American College of Obstetricians and Gynecologists (the College). The recommendations on "Early Pregnancy Loss" are presented in a Practice Bulletin released today by the College.

Most pregnancy losses occur in the first trimester, hence the importance of the new guidelines. According to the Practice Bulletin, approximately 50 percent of all cases of early pregnancy loss are due to fetal chromosomal abnormalities, and the most common risk factors are advanced maternal age and prior early pregnancy loss. The risk for miscarriage for women aged 20 to 30 years is between nine and 17 percent; this rate increases sharply from 20 percent at age 35 years to 40 percent at age 40 years and 80 percent at age 45 years.

"These recommendations serve to help guide providers in making appropriate decisions, as well as aide in counselling our patients. This Practice Bulletin, in particular, will help ob-gyns in better dealing with a common and yet emotionally devastating situation for pregnant women—early pregnancy loss," stated Jeffrey M. Rothenberg, MD, Chair of the College's Committee on Practice Bulletins—Gynecology, the Committee responsible for the new document.

Since there is overlap of common symptoms of early pregnancy loss with other obstetric conditions, including normal gestation, ectopic pregnancy, and molar pregnancy, it is important to distinguish early pregnancy loss from other early pregnancy complications prior to initiating treatment. The Practice Bulletin recommends a combination of a thorough medical history, physical examination, ultrasound and a pregnancy hormone blood test in order to make a highly certain diagnosis.

Once an early pregnancy loss is diagnosed, there are three accepted management options: expectant management, medical treatment or surgical evacuation. Studies have demonstrated that all three options result in complete evacuation of pregnancy tissue in most patients and serious complications are rare. Patients should be counseled about the risks and benefits of each option. In women without medical complications or symptoms requiring urgent surgical evacuation, treatment plans can safely accommodate patient preferences.

"Research has shown that women have strong and diverse preferences for how their early pregnancy loss is managed and report higher satisfaction when treated in accordance with these preferences. We believe clinicians who are prepared to offer all management options to their patients provide higher quality care," said Jody Steinauer, MD, MAS, Professor of Obstetrics, Gynecology and Reproductive Services at the University of California, San Francisco, and Director of the Managing Early Pregnancy Loss initiative, an educational website that provides e-learning, online resources, practice integration tools, and patient education material for evidence-based, patient-centered early pregnancy loss management.

Practice Bulletin #150, "Early Pregnancy Loss" is published in the May issue of Obstetrics & Gynecology.

Mohawk Valley Perinatal Network's Healthy Beginnings Newsletter is "Going Green" January 2016!

Do we have your email address? Please contact Kayleigh at kriesel@newfamily.org or 732-4657 X228 with your email address, if you would like to keep receiving our Newsletter. If email is not an option, please let us know, so we can continue sending paper Newsletters. Thank you!

mohawk valley perinatal network
Promoting Healthy Births and Healthy Families

1000 Cornelia Street
2nd Floor
Utica, NY 13502

Our Mission: *To improve birth outcomes and maternal, child and family health, facilitate collaboration among providers and community organizations and advocate for change.*

Gestational Diabetes Continued

A baby also might be born with jaundice, which is more common in newborns of mothers who had diabetes during their pregnancy. With jaundice, the skin and whites of the eyes turn yellow. Jaundice usually goes away, but the baby may need to be placed under special lights to help. Making sure baby gets plenty of milk from breastfeeding will also help the jaundice go away.

Women with GDM and the children of mothers with GDM have a higher risk for long-term health problems as well. These babies will be more likely to become overweight and develop type 2 diabetes as he or she grows up. Additionally, women who are affected by GDM have more than a 7-fold increased risk of developing type 2 diabetes 5 to 10 years after she delivers.

Diagnosis and Treatment

Most pregnant women have a glucose screening test between 24 and 28 weeks of pregnancy, which checks for gestational diabetes. The test may be done earlier if a pregnant woman has high glucose levels in her urine during routine prenatal visits or if she has a high risk for diabetes. If the results are above normal, she may need to have an additional oral glucose tolerance test. A doctor will use these test results to find out if a woman has gestational diabetes.

Treating gestational diabetes means keeping blood glucose levels in a target range. While working with her doctor, a woman will learn how to control her blood glucose by eating healthy, being physically active, and having insulin shots, if needed.

A woman's doctor may ask her to use a small device called a blood glucose meter to check her blood glucose levels on her own. A doctor will help her learn how to use the meter, how and when to prick her finger to obtain a drop of blood to check, and what her blood glucose target range is.

Takeaway

Encourage all women you know and work with to eat healthy and exercise *before* they get pregnant. The healthier a woman is before conception, the healthier she and her baby will be during and after pregnancy. If a woman is at a high risk for developing GDM and just became or is thinking about getting pregnant, encourage her to talk to her doctor about lowering her risks and being tested early for GDM. Also encourage her to talk to her doctor or a lactation counselor, during pregnancy, about breast-feeding. Breastfeeding helps give babies a healthy start in life, especially when they face other challenges early on in their life.

Sources for Diabetes Article:

National Institute of Diabetes and Digestive Kidney Diseases (2013 August). *What I Need to Know About Gestational Diabetes.* Retrieved from http://www.niddk.nih.gov/health-information/healt-topics/Diabetes/gestational-diabetes/Pages index.aspx#10

DeSisto, C.L.; Kim, S.Y.; & Sharma A.J. (2014, June 19). *Prevalence Estimates of Gestational Diabetes Mellitus in the United States, Pregnancy Risk Assessment Monitoring System (PRAMS), 2007 2010.* Retrieved from http://www.cdc.gov/pcd issues/2014/13_0415.htm