OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Diabetes: Gestational Diabetes Mellitus (GDM) [NEW 2026]

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate Staff
Scope (Area):	WNHS Obstetrics and Gynaecology Directorate clinical areas at KEMH and OPH

This document should be read in conjunction with the Disclaimer.

Contents

Aim

This guideline outlines the recommended care at Women and Newborn Health Service (WNHS) for women who have been diagnosed with GDM.

Background

The rising prevalence of Gestational Diabetes Mellitus (GDM) in Western Australia has led to significant adverse outcomes for both women and their babies. GDM is one of the most prevalent complications of pregnancy in Australia with just over 19% of all pregnancies in 2020 – 2022 complicated by GDM. Studies indicate that GDM contributes to a growing public health burden, perpetuating a transgenerational cycle of diabetes and related health issues. However, achieving optimal glycaemic control can substantially mitigate these adverse outcomes.

Women at risk of GDM, but not screened, experience a 44% greater risk of late stillbirth than those not at risk. Accurate GDM screening is important for pregnancy, and mothers' and babies' long-term health. Women diagnosed in time can be supported to optimise their pregnancy outcomes.

Scope/Responsibilities

The management of GDM requires a multi-disciplinary approach. This includes midwifery-led care, obstetric team care, dietitians, Obstetric Physicians, Diabetes Educator Midwives. Where required, insulin/medication stabilisation should be undertaken through the WNHS Diabetes Service. All clinical staff at WNHS are expected to be familiar with and apply this guideline when caring for women living with GDM.

Diabetes in pregnancy/obstetrics

Diagnostic criteria for GDM from 75g Oral Glucose Tolerance Test (OGTT)

The current Australasian Diabetes in Pregnancy Society (ADIPS) guidelines for the diagnosis of Gestational Diabetes Mellitus (GDM) on OGTT are a venous plasma glucose (PG) level of:

Fasting venous PG ≥ 5.3mmol/L
1-Hour venous PG ≥ 10.6mmol/L
2-hour venous PG ≥ 9.0mmol/L

The diagnosis of GDM is made if one or more of above values are recorded.

Criteria for overt Diabetes in Pregnancy (DIP)

Overt DIP should be diagnosed at any gestation if one or more of the following criteria are met:

FPG ≥ 7.0 mmol/L or 2hPG ≥ 11.1 mmol/L following a 75 g two-hour OGTT;

HbA_{1c} ≥ 6.5% (≥ 48 mmol/mol); and/or

Random plasma glucose ≥ 11.1 mmol/L in the presence of clinical signs or symptoms indicative of hyperglycaemia.

Screening in pregnancy

Screening process

The diagnosis of diabetes in pregnancy will include those women with previously undiagnosed abnormalities of glucose tolerance, as well as women with glucose abnormalities related to the pregnancy alone.

Women with pre-existing diabetes **are not** screened for GDM.

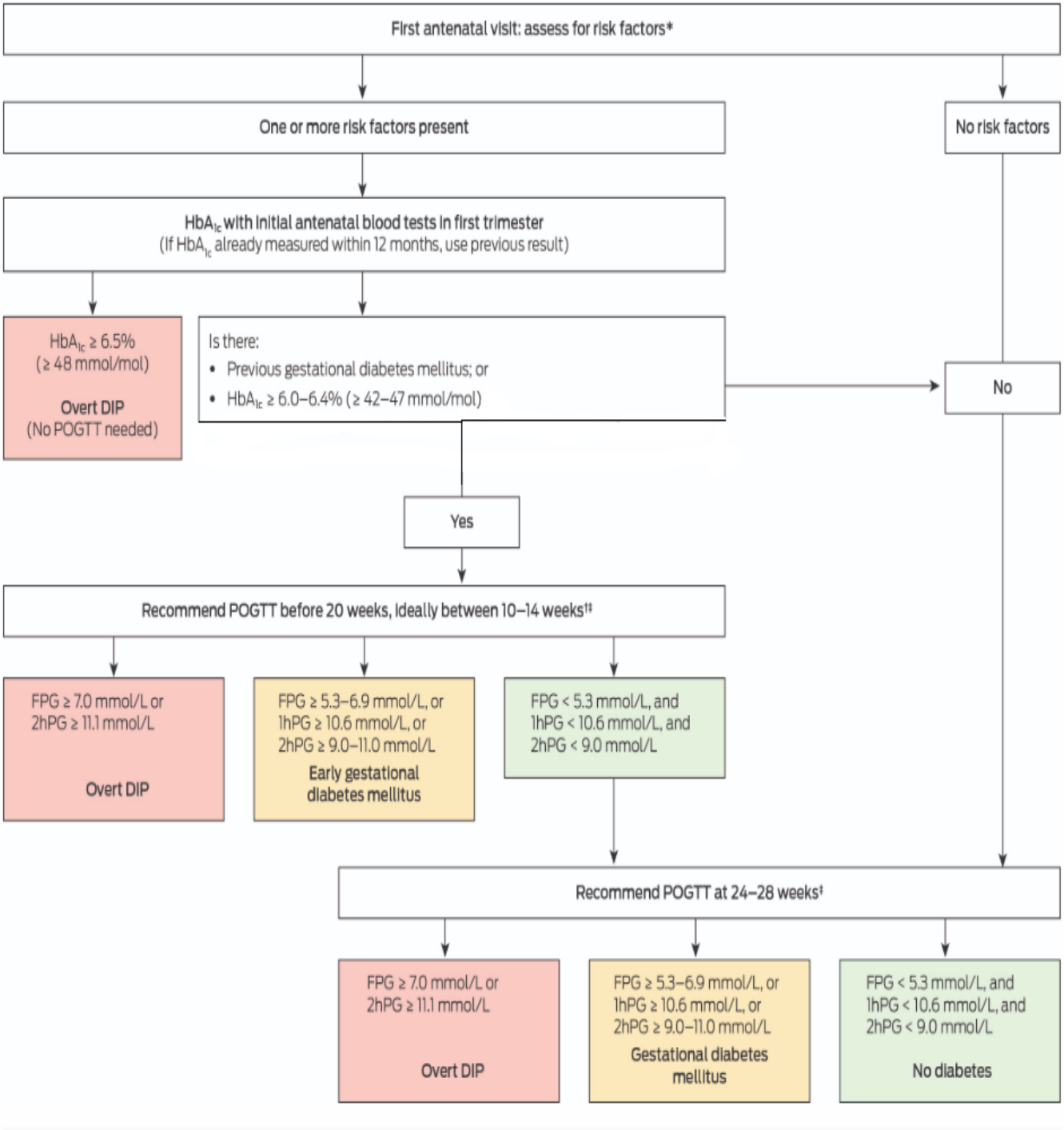
Risk factors

Risk factors for GDM

Offer screening as early as possible if a woman has any of the below see flow chart ADIPS 2025 criteria screening

- Previous GDM
- Maternal age ≥ 30 years
- Family history of Diabetes Mellitus (1st degree relative with DM including a sister with GDM)
- Obesity, especially if Body Mass Index (BMI) > 35kg/m²
- Hypertension prior to 20 weeks
- Previous macrosomia (baby with birth weight more than 4000g)
- History of unexplained stillbirth/perinatal loss
- Multiple pregnancy- Twins or higher
- Hypothyroidism
- Previous baby with congenital abnormalities
- Polycystic ovarian syndrome
- Medications: corticosteroids, antipsychotics

ADIPS 2025 criteria screening



Source: ADIPS 2025; adapted to align with WNHS model of care

1hPG = one-hour plasma glucose; 2hPG = two-hour plasma glucose; BMI = body mass index; DIP = diabetes in pregnancy; FPG = fasting plasma glucose; HbA_{1c} = glycated haemoglobin; POGTT = pregnancy oral glucose tolerance test. * See Box 2. † POGTT (i.e. 75 g two-hour oral glucose tolerance test) not recommended before ten weeks' gestation but should be before 20 weeks' gestation. ‡ See main text for options when POGTT is not tolerated or declined

Obstetric and midwifery staff responsibilities

- Provide education on the purpose, timing and process of the GDM screening and issue pathology request form at the appropriate time, based on clinical observation and risk assessment.
- Inform women of the implications of GDM, including potential changes to birthplace, increased ultrasound surveillance and the need for blood sugar management.
- Advise on diagnostic criteria for GDM and refer them to the Diabetes Service via e-referral within 48 hours of receiving results.
- Diabetes Service will triage referrals and offer women the next available GDM class with Diabetes Midwifery Staff and a dietitian.
- Inform women that education sessions are primarily group-based, with regular weekly classes available in English, and interpreter-supported sessions as required.
- Offer referral to Aboriginal Liaison Officer (ALO) and Aboriginal Health Liaison Support Services (AHLSS) for all women and families who identify as Aboriginal or Torres Strait Islander to support culturally appropriate care and care coordination.
- Consider shared care models between Ngangk Maawit Mia (AMGP) and Diabetes Service, where appropriate, to support coordinated and culturally safe management.
    - For further guidance on supporting Aboriginal women, refer to Working with Aboriginal families – Allied Health

Alternative Screening When OGTT is Declined

If a woman declines an OGTT, discuss and offer alternative screening options where appropriate:

- FPG testing;
- Self-monitoring of blood glucose (SMBG): The woman may purchase a glucometer at her own expense and monitor her blood glucose levels for one week. Monitoring must include:
    - Fasting blood glucose levels; and
    - Two-hour postprandial levels after main meals.

Blood glucose results should be reviewed by the midwife or obstetric team. Use the current ADIPS targets for reference:

- Fasting: ≤ 5.3 mmol/L
- 2-hour postprandial: ≤ 6.7 mmol/L

Diagnosis of GDM may be considered If:

- The fasting blood glucose is ≥ 5.3 mmol/L; or
- Home glucose monitoring results exceed ADIPS recommended targets,

Medication management before GDM Screening

- Cease metformin at least 1 week prior to screening. Do not perform OGTT while the patient is taking metformin, as results will be unreliable.
- Do not conduct GDM screening in women currently on a short course of prednisolone or within 4 days of having antenatal steroids for fetal lung maturation, as results may be affected.

Late testing for Diabetes in Pregnancy

Repeat OGTT in the third trimester (after 28 weeks) is recommended if there is a strong suspicion of diabetes (e.g., large for gestational age [LGA], polyhydramnios, fetal macrosomia, or glucosuria). However, an OGTT is not advised after 33+6 weeks. For concerns or if GDM has not been investigated, consult the Diabetes team for further guidance.

Screening for GDM after bariatric surgery

- Perform diabetes screening in the first or early second trimester and repeat in the third trimester.
- Be aware that women with prior bariatric surgery may not tolerate a 75 g oral glucose load due to risk of dumping syndrome.
- If OGTT is not tolerated or contraindicated, use alternative screening methods:
  - FPG
  - HbA1c
- Select screening method based on clinical context and patient tolerance.

Key points

- Assess ability to tolerate OGTT based on type and timing of bariatric surgery (see below)
- Consider early FPG Test can for initial screening
- Request additional fetal growth scans if there are concerns for LGA

OGTT after Bariatric Surgery

Tolerance of OGTT varies depending on the type and timing of bariatric surgery:.

Type of Bariatric Surgery	Tolerance of the OGTT	
Lap Band/Orion Balloon	Most women tolerate the OGTT well	
Gastric Sleeve	Less than 12-18 months since surgery	OGTT may be poorly tolerated
	More than 12-18 months since surgery	OGTT normally well tolerated
Bypass surgery	Most women CANNOT tolerate the OGTT	

Recommended Screening Approach for Women Unable to Tolerate OGTT After Bariatric Surgery

Gestation	Test	Diagnosis
Booking visit (all women)	Fasting Plasma Glucose	≥ 5.3 – Diagnostic of GDM
24-28/40 if previous FBGL was normal	Repeat Fasting Plasma Glucose	≥ 5.3 – Diagnostic of GDM
If at any gestation after 28/40 baby is showing signs of being LGA, women will need an extra growth scan.	Random finger prick BGLs at clinics. PAGE Dietitian or Diabetes Educator Midwife if RBGLs are >6.7.	

For further information or advice, contact the Diabetes Service on 6458 2163. For other types of surgeries, please consult the Diabetes Clinical Midwifery Consultant (CMC) or Nurse Practitioner (NP).

Management when OGTT is not tolerated

- If vomiting occurs following glucose ingestion and the OGTT cannot be completed, offer:
  - FPG
  - HbA1c
- Diagnose GDM if FPG is above the diagnostic threshold.
- If HbA1c ≥ 6.0%, consider a trial of SMBG.
- SMBG should include a 4-point daily profile:
  - Fasting blood glucose
  - 2-hour postprandial levels after each main meal

- SMBG is to be undertaken at the patient's expense. Glucose monitors and testing strips are not supplied by WNHS Diabetes.

Pre-screening discussion / education for GTT

1. Explain to the woman that the OGTT is a diagnostic test for GDM and discuss the reasons for screening GDM.
2. Obtain verbal consent for the test.
3. Provide the following instruction:
   - Maintain usual carbohydrate intake for 2 days prior to the test. Fast from midnight before the test (water permitted).The test requires three venepunctures and takes approximately two hours.
   - At King Edward Memorial Hospital (KEMH) PathWest Pathology: A fasting blood glucose sample is taken first. If ≥ 5.3 mmol/L, the test is complete.
   - If fasting glucose is below threshold, consume a 75 g glucose drink within 5 minutes
   - Blood samples are taken at 1 hour and 2 hours post-glucose load
   - Mild nausea may occur during the test
   - If results are abnormal, referral to diabetes education and dietetic services will be arranged, including instruction on home blood glucose monitoring.
4. Provide a laboratory request form signed by an authorised clinician. Women may attend any laboratory for the test.
5. Advise the woman to book the test with a laboratory and follow site-specific instructions.

Referral to Diabetes Service

Refer patients for GDM education via e-referral (preferred for internal referrals), Central Referral Service (external referrals), fax (6458 2164), or email (KEMH.Diabetes@health.wa.gov.au). For enquiries, contact a diabetes educator on (08) 6458 2163.

Include results of all recent diabetes tests with the referral. Women with overt GDM in pregnancy should be referred via the same process. The triage diabetes educator will consult with the CMC or NP to determine the most appropriate model of care.

GDM education sessions

Key points

1. All women diagnosed with GDM and referred to the Diabetes Service should be offered gestational diabetes education promptly after diagnosis.
2. Diabetes education should be culturally appropriate and tailored to the individual needs of each woman, with interpreter-support available for those not fluent in English.

Lifestyle Modifications

Diet

Women with GDM should receive dietary education and review from a WNHS dietitian, either through group classes, individual consultations, or during antenatal clinic visits.

Exercise

Regular physical activity supports blood glucose management. Exercise should be incorporated into daily routines and, where possible, performed about 1 hour after meals.

GDM (on diet) self-blood glucose monitoring: Current ADIPS recommended targets (obstetrics)

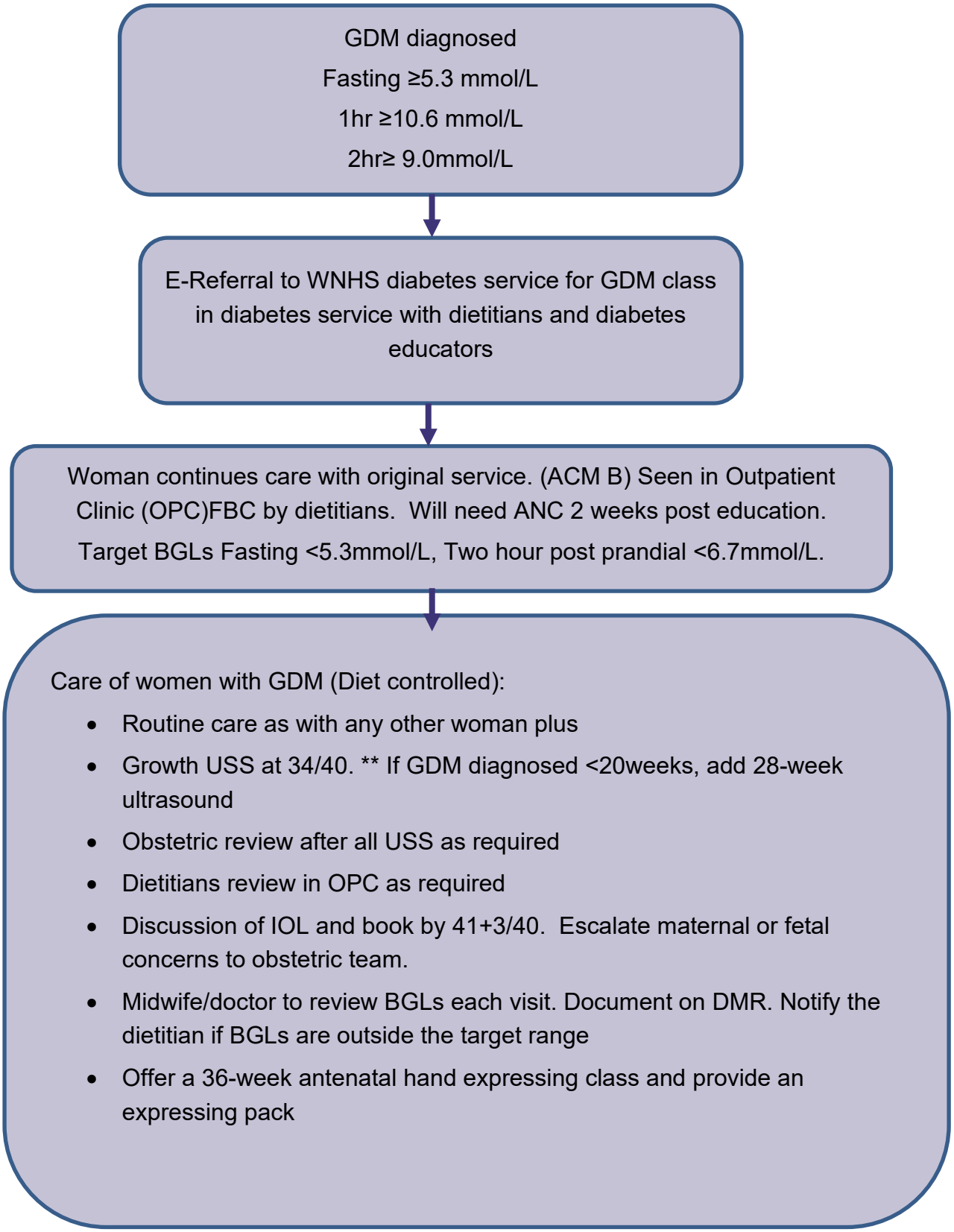
- Fasting ≤5.3mmol/L
- One hour post prandial ≤7.4mmol/L
- Two hours post prandial ≤6.7mmol/L

For GDM on insulin, see section below

GDM Follow up

- All antenatal healthcare professionals are responsible for reviewing BGLs in women with GDM.
- Dietitians will review BGLs at the initial antenatal clinic appointment after education and as needed.
- If BGLs are outside the target range, midwives or doctors should liaise with the dietitian for review during antenatal clinic (ANC) visits.
- Dietitians provide dietary recommendations and, if BGLs remain elevated despite dietary adjustments, will liaise with diabetes educators to arrange insulin initiation.
- When insulin is required, diabetes service midwives coordinate with the NP or physician to prescribe and dose insulin. Women are then scheduled to attend the next available insulin start class.

Antenatal GDM Flow Chart



GDM management in WNHS ANC (including Osborne Park Hospital [OPH]/Midwifery Group Practice [MGP]/ Community Midwife Program [CMP])

- Review BGL diary at each ANC visit and document in the DMR.
- Refer to dietitian if:
  - 3 or more fasting BGLs ≥5.3 mmol/L, or
  - 3 or more 2-hour postprandial BGLs ≥6.7 mmol/L for the same meal.
- If fasting BGLs are elevated, provide "Tips and Tricks" checklist.
- Refer to Diabetes Educator if:
  - BGLs are not consistently recorded.
  - Further GDM advice is required.
  - There are clinician concerns regarding GDM management.
- Consult with Diabetes Educator if:
  - Multiple BGLs not recorded.
  - Woman has GDM questions that clinician cannot answer.
  - Clinician has any concerns or questions relating to GDM management.

Pharmacological Management of GDM

- Consider pharmacological therapy based on:
  - Degree and pattern of hyperglycaemia (fasting and/or postprandial)
  - Gestational age
  - Fetal growth (e.g. LGA, macrosomia, SGA, abdominal circumference, AFI)
  - Maternal BMI
  - Individual circumstances (e.g. preferences, barriers to insulin use)
- Use clinical judgement to determine the most appropriate therapy
- Initiate insulin as first line treatment when lifestyle and dietary measures do not achieve target BGLs
  - Use rapid-acting insulin for postprandial hyperglycaemia
  - Use long-acting insulin nocte for fasting hyperglycaemia
- Consider metformin where insulin is declined or not suitable
  - Discuss risks and benefits prior to initiation
  - Discuss the importance of strict normoglycaemia during pregnancy (refer to TGA database safety statement)
  - Provide patient resources MotherToBaby fact sheet where appropriate

Insulin education

- Provide insulin education through the WNHS Diabetes Service group classes.

- Arrange individual education where required based on clinical need.
- Education is delivered by trained midwives and Diabetes Educators.

Glycaemic Targets (Insulin Therapy)

The aim is to achieve and maintain BGLs within site-specific target ranges.

Note: Targets are determined locally, as ADIPS does not specify insulin treatment targets.

Target BGLs:

- Fasting: ≤5.1 mmol/L
- 1-hour postprandial: ≤7.4 mmol/L
- 2-hour postprandial: ≤6.7 mmol/L

Follow up

- Review BGLs weekly by the Diabetes Service.
- Women are to submit BGLs weekly via email to the GDM inbox.
- Diabetes Service is to review BGLs and respond accordingly
- If BGLs are not received:
  - Send SMS and email request and document in DMR.
  - If no response, notify ANC and add a WebPAS note for follow-up at next visit.
  - Contact next of kin if unable to establish contact.
- Diabetes Service to manage insulin adjustments.
  - Diabetes Educators are authorised to adjust insulin by up to 6 units.
  - Discuss larger dose adjustments with NP or physician.

Antenatal Care for Women with GDM Not Requiring Pharmacological Therapy

- Women remain under their original model of care unless a change in comorbidities requires transfer to a specialised clinic.
- Women may continue care with their known midwife.
- Schedule obstetric review at 38 weeks to discuss mode and timing of birth.

Antenatal Care for Women with GDM Requiring Pharmacological Therapy

- MGP 4/5 is an all-risk model; women may remain under this model with Diabetes Service support as needed.
- Women commencing insulin before 30 weeks (Family Birth Centre care) are transferred to the general obstetric clinic, with insulin titration managed by the WNHS Diabetes Service.

- Women commencing insulin after 30 weeks follow a shared-care model between their MGP midwife and the Diabetes Service, with birth in the hospital labour and birth suite.
- Women in the WNHS Midwifery Antenatal Postnatal Service (MAPS) program remain in this model with an obstetric review at 38 weeks to discuss mode and timing of birth.
- All fetal growth scan results must be documented and plotted on growth charts. Any abnormal growth patterns should be discussed with the obstetric team to establish an ongoing care plan.
- Women starting insulin at OPH will be transferred to WNHS for ongoing antenatal care. The WNHS Diabetes Education Team adjusts insulin weekly, and women are provided with Diabetes Service contact details.
- Women who started insulin at peripheral or regional hospitals and will deliver at WNHS are referred to the WNHS Diabetes Service. Insulin is managed per WNHS protocols, and women are referred to the general obstetric clinic.

	GDM Diet	GDM-Pharmacological treatment	Overt GDM
Ultrasound Surveillance	• 32-34 week Growth & wellbeing scan • 28 week USS if diagnosed prior to 20 weeks	• 32-34 weeks growth and wellbeing • 3-4 weeks post growth velocity • If increased or decreased velocity re- scan minimum 2 weekly	• 28/32/36 week scan followed by obstetric review • Increase frequency of USS if concerns over fetal growth
Timing of Birth	• In line with timing of birth guidelines – routine care	• In line with timing of birth guidelines • Plan birth at 39+0 to 39+6 if well controlled, if there are concerns including sub-optimal control or macrosomia plan birth 38+0 to 38+6	• In line with timing of birth guidelines • Plan birth at 39+0-39+6 if well controlled, if there are concerns including sub-optimal control or macrosomia plan birth 38+0-38+6
Mode of Birth: • Consider offering IOL/CS if clinically indicated due to fetal size or additional obstetric complications • Woman to be at the centre of mode of birth discussion to ensure informed decision making. • Limited evidence to support offering or not offering IOL prior to 39/40 gestation			

Breastfeeding and Antenatal Expressing

- WNHS Lactation to provide breastfeeding education and support from 30 weeks' gestation
- Offer women with GDM the option to begin antenatal expressing from 36 weeks' gestation (36+0), according to standard practice and eligibility

Timing of birth

- Refer to the Clinical Guideline Labour and birth: Planned birth timing (indications and gestations for booking induction of labour and caesarean section) for further instruction

Intrapartum / postpartum: GDM (including planned IOL / caesarean)

Key points

1. Most women with GDM, whether on insulin or not, do not require insulin during labour or caesarean section.
2. For women on insulin or oral hypoglycaemic agents undergoing induction of labour (IOL) or caesarean section, intrapartum and postpartum BGL and insulin management plans must be discussed and documented in the DMR.
3. Develop and document an individualised intrapartum pharmacotherapy plan in consultation with the woman. This plan is to be documented in DMR and the woman's handheld record.
4. Ensure informed consent and shared decision-making.
5. If insulin infusion is required for unstable BGLs, consult KEMH physicians regarding the need for concurrent glucose infusion.

Pharmacotherapy and Birth – Clinical Guidance

GDMi General Principles

Intrapartum Considerations

1. Induction of Labour (IOL)

- IOL in primiparous women may extend over 2–3 days.
- Halve the nighttime dose of long-acting insulin the evening prior to a planned artificial rupture of membrane to reduce the risk of maternal hypoglycaemia during labour
  - Bishops Score < 7 (cervical ripening required):
    Reduce the long-acting insulin dose by 50% on the night cervical ripening is commenced in the LBS
  - Bishops Score ≥ 7 (no cervical ripening required):
    Advise the woman to reduce the long-acting insulin dose by 50% at home on the night prior to admission to LBS for ARM ± oxytocin

- Continue short-acting insulin if the woman is eating; omit if not eating.
- Monitor BGLs every 4 hours until established labour, then every 2 hours.

2. Elective Caesarean Section (C-section)

- Halve the dose of long/intermediate-acting insulin the night before surgery.
- Discuss insulin adjustments during pre-admission appointments and continue counselling at all subsequent antenatal visits.
- Midwives and MWDEs are responsible for reinforcing this information.
- 2 hourly BGLs whilst fasting.
- Monitor BGLs for 24 hours post-birth.

3. Emergency C-section

- Monitor maternal BGLs post-birth for 24 hours.

4. Spontaneous Labour Onset

- Continue short-acting insulin if the woman is eating; omit if not.
- Consider the effects of long/intermediate-acting insulin given the night before as these may contribute to maternal and neonatal hypoglycaemia.
- Monitor BGLs every 4 hours until established labour, then every 2 hours.
- Offer food as soon as possible post-birth.
- Monitor BGLs for 24 hours post-birth.

GDM on diet only

- Women controlled by diet alone rarely require insulin during labour.
- Monitor BGL every 2 hours if fasting or in established labour.
- Increase monitoring to hourly if BGL level exceeds 8 mmol/L.
- Contact the physician if BGL exceeds 8 mmol/L for two consecutive hourly checks.
- Check ketone levels if BGL exceeds 10mmol/L and contact the physician immediately.

Newborn Care – Infants of Women with GDM

Metabolic Considerations

- Neonatal insulin regulation may take 24–48 hours to stabilise.
- Hypoglycaemia (<2.6 mmol/L) is associated with adverse neurodevelopmental outcomes.

Feeding and Thermoregulation

- Encourage skin-to-skin contact and initiate breastfeeding within the first hour of life.
- Offer expressed breast milk (EBM) after breastfeeds, especially if antenatal expressing was undertaken.
- Encourage ongoing expression after feeds to support glycaemic stability.

Blood Glucose Monitoring

- Monitor pre-feed plasma glucose levels (PGL):
  - Prior to the second and fourth feeds.
  - First BGL should be done within 4 hours of birth (or as early as 60 minutes if coinciding with the second feed).
- Ensure feeds are no more than 3 hours apart to reduce risk of hypoglycaemia.

Note:
Infants of women with GDM are at increased risk of hypoglycaemia due to in-utero exposure to maternal hyperglycaemia. Close monitoring and proactive feeding support are essential in the first 24–48 hours. WNHS follows the CAHS neonatal guideline in LBS and postnatal wards-

See CAHS Neonatology Guideline Hypoglycaemia

Long-Term Follow-Up – Women with Prior GDM

Postpartum Screening and Contraception

- Recommend a 6–8 week postpartum OGTT.
- Repeat OGTT at least every 2 years thereafter.
  - The National Gestational Diabetes Register provides reminders to women and their GPs for follow-up diabetes screening.
- Discuss contraceptive options, and consider risks, benefits, and individual preferences: Refer to RANZCOG guidelines.

Cardiometabolic Health

- Consider the increased long-term risk of metabolic syndrome.
- Reinforce the importance of lifelong screening for:
  - Cardiovascular disease
  - Renal disease

Future Pregnancy Planning

- Encourage women to plan future pregnancies in consultation with their healthcare provider.
- Offer support and advice on interpregnancy and preconception weight management:
  - Each unit increase in BMI between pregnancies significantly raises the risk of recurrent GDM.
  - Weight loss in previously overweight or obese women can reduce the risk of GDM recurrence by up to 80%.
- Recommend:
  - Preconception diabetes screening
  - Preconception folic acid supplementation
  - Early glucose testing in subsequent pregnancies

Referral and Communication

- Provide timely written communication to the woman's primary care provider (e.g. GP), including:
  - Summary of maternal and neonatal outcomes
  - Details of diabetes management during pregnancy
  - Follow-up screening recommendations
- Promote healthy lifestyle practices including:

- A balanced diet
- Regular physical activity
- Weight maintenance or loss as appropriate

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Related WNHS procedures and guidelines

WNHS Obstetrics and Gynaecology guidelines

Diabetes

Working with Aboriginal families – Allied Health

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Version history

Version number	Date	Summary
1	April 2026	First version. Note- previously content for management of GDM was contained within guideline titled “Diabetes: In Obstetrics and Gynaecology” **Changes**: • Added new ADIPS table of changed Diagnostic criteria for GDM • Additional section added for women who decline GTT/late screening of GDM • Inclusion of definition of overt diabetes in pregnancy and addition of advice for women with Overt Diabetes in pregnancy • Timing of specific screening for GDM has been altered • Clarified plan regarding birth and management of diabetes medications for this period • Information included regarding the baby and breastfeeding

		• Contraception advice refers to RANZCOG guidelines • AN care planner for GDM on Tx adjusted • Additional information and link added for use of Metformin in pregnancy • Risk factors for screening of GDM updated as per ADIPS guidelines.

This document can be made available in alternative formats on request for a person with a disability.