IATROGENIC GESTATIONAL DIABETES: SHOULD WE CHANGE OUR APPROACH

IN WOMEN WHO TAKE ORAL CORTICOSTEROIDS?

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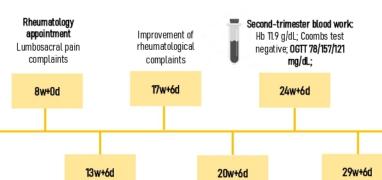


INTRODUCTION

Peripheral spondyloarthritis (SpA) refers to patients who present SpA features that are mainly or completely peripherical rather than axial. Besides extraarticular manifestations, symptoms of arthritis, enthesitis or dactylitis dominate the clinical presentation. Oral corticosteroids have an immunosuppressive and anti-inflammatory effect and can be used to treat these patients.

The literature has noted that synthetic corticosteroids increases the risk of adverse pregnancy and birth outcomes in women with autoimmune diseases, such as preterm birth, preeclampsia, and gestational diabetes mellitus (GDM). However, little data exist about the association between chronic low dose corticosteroid therapy during pregnancy due to maternal conditions and development of GDM.

PREGNANCY FOLLOW-UP



CASE REPORT



29-year-old women 3 Gesta 2 Para

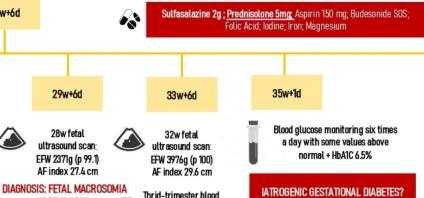
MEDICAL HISTORY

- SpA diagnosed in April 2022 with follow-up at our hospital;
- Controlled and unmedicated asthma:
- Supraventricular tachycardia under study;
- Overweight (IMC 29.3 kg/m²).

OBSTETRIC HISTORY

- September 9th, 2013 vaginal delivery newborn with 2510g;
- March 2nd, 2017 vaginal delivery newborn with 3550g.

- Diabetes Mellitus Grandmother:
- Arterial Hypertension Grandparentes;
- Behçet syndrome Uncle;
- Rheumatoid Arthritis Aunt.



MATERNAL-FETAL HOSPITALIZATION FOR SURVEILLANCE AT 35w+6d

normal; No visible malformations. Combined screening: Low risk

First-trimester fetal

ultrasound scan: NT 2.64mm:

Nasal Bones present; DV

T21;T18;T13.

First-trimester blood work: Hb 12.7 g/dL; Coombs test negative; Glucose 75 mg/dL; All serologic testing negative.

Second-trimester

fetal ultrasound scan: Biometrics appropriate to gestational age but near 95 percentile. No visible malformations. Cervical length 40mm.

28w fetal ultrasound scan: EFW 2371g (p 99.1) AF index 27.4 cm

HYDRAMNIOS

Pelvic heaviness and

hypogastric discomfort.

No complaints of

dyspnea or contractility



Thrid-trimester blood work: Hb 13 g/dL;

HbA1C 5.8% TSH 0,35; T4 0.95 All serologic testing negative

ADMISSION

Surveillance by the endocrinological team

Blood alucose values within the intended values.



36w fetal ultrasound scan: EFW 4796g (p100);



Fetal echocardiogram: Muscular ventricular septal defect. Difficult assessment due to maternal obesity



C-section at

36w+1d

HEALTHY MALE NEONATE: Weight: 4580 g; Length: 52.5 cm; Cephalic perimeter: 37 cm; Apgar index 8/9/10; pH arterial 7.11; Base deficit 8

ANATOMOPATHOLOGICAL REPORT OF THE PLACENTA



"Placenta of preterm pregnancy with increased weight (860g), balanced fetoplacental weight ratio and hyperspiral umbilical cord, in which the following stand out: delayed villous maturation, with a diffuse pattern; lowgrade fetal vascular malperfusion lesions with a global pattern (partial/intermittent obstruction); Presence of meconium pigment."

PUERPERIUM



DIABETES RECLASSIFICATION TEST: **NEGATIVE** (6 weeks post partum) 82 mg/dL; 103 mg/dL

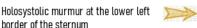


WORSENING OF RHEUMATOLOGICAL **COMPLAINTS** - Started biweekly Adalimumab



border of the sternum

NEONATOLOGY APPOINTMENT - FIRST MONTH



FETAL ECHOCARDIOGRAM Restrictive apical muscular ventricular septal defect Minimal restrictive ductos arteriosus Patent foramen ovale with shunt L-R

Right testicle in the inquinal canal

FOLLOW-UP AT PEDIATRIC CARDIOLOGY + PEDIATRIC SURGERY

CONCLUSION

Studies have found evidence that pregnant women who receive higher doses of corticosteroids are at a greater risk of developing GDM compared to those who receive lower doses. Additionally, the risk appears to be highest among women who receive corticosteroids for a period longer than four weeks. With this case, we should be aware that even minimal dose of corticosteroids could lead to adverse outcomes.. At the moment, there are no clear quidelines regarding the monitoring of blood glucose levels in pregnant women undergoing steroid therapy, but some studies strongly recommend checking casual blood glucose before and during treatment with corticosteroids. Therefore, steroid use should warrant more aggressive screening for GDM, above and beyond routine recommendations

ARRREVIATIONS