THE CONSEQUENCES OF PREGNANCY ON THE HEALTH OF THE DIABETIC WOMAN

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In Type I, diabetics, a successful pregnancy is secured if proper control is achieved by insulin.

If this is not the case, pregnancy will induce a catabolic state in the mother. Without the proper amount of insulin, the metabolic realignments will not occur and the pregnant diabetic of type I will evidence ketonuria and glycosuria. Ketoacidosis might be a terminal event in that case. This sequence of events should be thought of in regions where the distribution of insulin and the application of health care are not optimal. If the treatment with insulin is appropriate, a woman with type I diabetes even associated with diabetic complications will not suffer any major hardship through the pregnancy. Background retinopathy will not tend to be aggravated if control is optimal. Proliferative retinopathy may take a turn for the worse however. Modern therapeutics with laser might be helpful. The evolution of nephropathy during pregnancy is essentially, control dependent also. Prognosis for the woman's health is good even for the ones who underwent a renal transplant provided normal blood glucose levels are achieved. However the women with diabetes of type I and coronary disease do not survive the pregnancy for more than several weeks.

In Type II, clinical diabetes may be triggered of by pregnancy and may give rise to clinical symptoms. Pregnancy may also disclose glucose intolerance without clinical symptoms in predisposed women. In population with a high prevalence of diabetes like the Nauru population, stillbirths will occur for 90% in the diabetic population disregarding the level of the post-prandial bloodsugar. The percentage of stillbirths was similarly divided amongst women who had bloodsugar levels 2 hours post glucose (50 g) between 140-150 mg/dl and the ones with 160 mg/dl or more. Hence the clinical importance of even minor elevation of maternal blood sugar which is associated with stillbirths. There is also a definite increased incidence of congenital malformation in the infants born to diabetic mothers. There is no clear evidence however that the percentage is the same in gestational and in overt diabetics. For the congenital malformations were more frequent when the diabetes had started at a young age was of longer duration and had to be treated with insulin because of diabetic symptomatology which was not always related to ketosis. Good diabetic control however reduced the incidence of congenital malformation even in patients with vascular complications. It indicates that the level of blood sugar elevation is a factor which influences the incidence of congenital malformation. This seems also confirmed by the fact that more infants are borne with congenital malformations from mothers who have a high haemoglobin Alc level before pregnancy than from mothers with close to normal levels.

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