Handout

Hemoglobin A1c Targets[1,2]

• Before conception = 6.5%
• Early pregnancy = 6% to 7%
• Later pregnancy = 6% to 6.5%
• Less than 6% may be ideal, assuming this can be achieved without hypoglycemia.
Allow for individualization based on maternal risk of hypoglycemia.
Following conception, A1c is less reliable than self-monitoring blood glucose and should be used as a secondary measure of glycemic control.

Self-Monitoring Blood Glucose Targets[1,2]

• Fasting: ≤95 mg/dL (5.3 mmol/L) and either
    — One hour postprandial: ≤140 mg/dL (7.8 mmol/L); or
    — Two hours postprandial: ≤120 mg/dL (6.7 mmol/L).
• Women who are using insulin pumps or basal-bolus insulin regimens also should use preprandial testing.

Weight Gain Targets During Pregnancy[3]

• Prepregnancy BMI <18.5 = 28 to 40 lbs (1 lb/week during the second and third trimesters);
• Prepregnancy BMI 18.5 to 24.9 = 25 to 35 lbs (1 lb/week during the second and third trimesters);
• Prepregnancy BMI 25 to 29.9 = 15 to 25 lbs (0.6 lb/week during the second and third trimesters); and
• Prepregnancy BMI ≥30 = 11 to 20 lbs (0.5 lb/week during the second and third trimesters).

Nutrient Calculations[4,5]

• Energy = Estimated Energy Requirement (EER) for women aged 19 and older; adjusted for trimester
• First trimester EER = Nonpregnant EER + 0
• Second trimester EER = Nonpregnant EER + 340
• Third trimester EER = Nonpregnant EER + 452
• Protein = 71 g/day or 1.1 g/kg/day (calculated using prepregnancy weight)
• Carbohydrate = Minimum of 175 g/day
• Fat = No recommended Dietary Reference Intake or Adequate Intake
• Fiber = 28 g/day
• Sodium = Less than 2,300 mg/day
    — Individualize in women with preexisting hypertension

Physical Activity Guidelines[6]

• Women who aren’t physically active before pregnancy = At least 150 minutes (two hours and 30 minutes) of moderate-intensity aerobic activity per week.
• Women who are physically active before pregnancy = Continue same level of physical activity during pregnancy as before pregnancy.

• Discussion with a health care provider is recommended in case the need to adjust activity type or level over time is recommended.

References

1. American Diabetes Association. Management of diabetes in pregnancy. ***Diabetes Care***. 2017;40(Suppl 1):S114-S119.

2. American Diabetes Association. 13. Management of diabetes in pregnancy: Standards of Medical Care in Diabetes — 2018. ***Diabetes Care***. 2018;41(Suppl 1):S137-S143.

3. Institute of Medicine and National Research Council of the National Academies. Guidelines on weight gain & pregnancy. https://www.nap.edu/read/18291/chapter/1. Published 2013. Accessed November 9, 2018.

4. Reader DM, Thomas A. Pregnancy with diabetes. In: Mensing C, Cornell S, Halstenson C, eds. ***The Art and Science of Diabetes Self-Management Education Desk Reference***. 3rd edition. Chicago, IL: American Association of Diabetes Educators; 2014:683-718.

5. Wheeler ML, Dunbar SA, Jaacks LM, et al. Macronutrients, food groups, and eating patterns in the management of diabetes: a systematic review of the literature, 2010. ***Diabetes Care***. 2012;35(2):434-445.

6. Chapter 7: additional considerations for some adults. Health.gov website. https://health.gov/paguidelines/guidelines/chapter7.aspx. Updated November 8, 2018.