

## **Diabetes in pregnancy: time to focus on women with type 2 diabetes**

We read with interest the article by Murphy et al,<sup>1</sup> highlighting poor pregnancy outcomes experienced by women with type 2 diabetes in England, Wales and the Isle of Man. Sadly, we are a long way off the 1989 Saint Vincent declaration<sup>2</sup> for women with diabetes in pregnancy to experience outcomes approximating those of the background population. NICE guidance recommends pre-pregnancy care for women with pre-existing diabetes,<sup>3</sup> yet in practice programs are poorly attended by women with type 2 diabetes. Uncertainty persists around responsibility for care, with a lack of training and knowledge amongst health workers.<sup>4</sup> Consequently, most women with type 2 diabetes in the UK enter pregnancy without the ability to self-monitor their blood glucose, unaware of HbA1c targets to minimise congenital abnormalities, and (sometimes) taking medications harmful for pregnancy. In our experience, women struggle escalating from no glucose monitoring to the intensive management required in pregnancy to prevent poor outcomes.

We must challenge the status quo if we hope to improve pregnancy outcomes for women with type 2 diabetes. With more people diagnosed with type 2 diabetes in their 20's and 30's, community-based services need to incorporate the priorities of younger people. Preconception care needs a major rethink, with education and financial support for primary care providers. As part of the recommended annual diabetes review, we call for a structured preconception assessment to be performed for every woman with type 2 diabetes of reproductive age. Incorporation of this into the General Medical Services contract Quality and Outcomes Framework (QOF)<sup>5</sup> for diabetes care would improve accountability. This approach takes the responsibility of preconception care seeking away from the woman herself, given that pregnancy is unplanned in more than 50% of women. To be equitable, programs need to be available in different languages and sensitive to the psychological and social challenges many women living with type 2 diabetes experience. Digital solutions, such as NHS-supported Apps, could provide support and information between annual appointments. For women with complex medical needs, timely review by an obstetric physician or diabetologist should be prioritised.

Education addressing broader reproductive health issues (including fertility and contraception choices), the importance of preconception folic acid, safe medications for pregnancy, weight loss support, HbA1c targets, and support for self-monitoring of blood glucose, could improve the health of all younger women with type 2 diabetes, benefitting more than just pregnancy outcomes.

## **References**

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