Mother suffering from uncontrolled gestational diabetes delivers a healthy baby, a typical case of High Risk Pregnancy

Patient Name: Arunima Saha Age: 31 yrs

Medical Team: Dr. Sankar Das Mahapatra (Consultant-Gynae & Obs), Dr. Amit Dey (Critical Care Specialist), Dr. Paromita Srimani (Registrar-Gynae & Obs), Dr. Bibartan Saha (Consultant-Radiologist), Dr. Aniruddha Bhattacharyya (Consultant-Endocrinologist), Dr. Sumita Saha(Consultant-Paediatrics & Neonatology)

A 31 yr old pregnant housewife was brought to the Emergency Dept. of our hospital in the year 2010, with no foetal movements. She had undergone antenatal check up in some other clinic. USG revealed Intrauterine Foetal Death (IUFD) of the baby and it was delivered vaginally. The lady was found to be overtly diabetic with a fasting blood sugar level of 250 mg/dl and a post-prandial blood sugar level of 385 mg/dl. She was discharged after bringing her diabetes under control.

She came to the OPD of our hospital for follow up, again with very high levels of sugar. She was obese weighing 89 kg and BMI>40. She was properly counselled for reduction of body weight and strict control of diabetes for safe delivery of a healthy baby in future. She was prescribed daily dose of Folic acid along with oral hypoglycemics. She was also educated that gestational diabetes is associated with multiple congenital anomalies of the foetus and sudden unexplained foetal death. Next pregnancy was advised after 2 years but the lady again conceived after 1 year.

She was treated for diabetes in our High risk pregnancy clinic, to keep

her euglycemic throughout the first trimester of her pregnancy and minimize the chances of foetal congenital anomaly. Quadruple marker test and serial foetal scan was performed to rule out congenital anomaly. The mother was very compliant and she regularly attended antenatal clinics. She developed polyhydramnios in the second trimester. Foetal anomaly scan to rule out any spinal defect and foetal echocardiography to rule out any cardiac anomaly were performed. As the patient was obese, oral drugs were not totally effective in controlling diabetes and she required high doses of insulin. In order to do so, she was admitted to the hospital during 34th week of her pregnancy. Strict CBG monitoring and foetal monitoring by CTG was regularly done as our expert team was cautious about sudden IUFD in this pregnancy profile. At around 37th week, one Sunday she complained of pain in abdomen and slow foetal movements. She was rushed to the OT for emergency caesarean section and she delivered a healthy baby of 3 kg. Our Neonatal team took care of the baby. Post delivery, maternal blood sugar level was within normal limits and no insulin was required. Both mother and child were discharged from the hospital in stable condition after five days. Her post natal follow up confirmed fasting and post prandial blood sugar level to be within normal limits. It is obvious that a healthy baby can be delivered in high risk cases too, if the expecting mother gets registered at a safe and well equipped healthcare centre from very early stages of pregnancy or even before.