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**What neonatal complications should the pediatrician be aware of in case of maternal gestational diabetes?**

Mitanchez D *et al*. Neonatal complications and maternal gestational diabetes

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**Abstract**

In the epidemiologic context of maternal obesity and type 2 diabetes (T2D), the incidence of gestational diabetes has significantly increased in the last decades. Infants of diabetic mothers are prone to various neonatal adverse outcomes, including metabolic and hematologic disorders, respiratory distress, cardiac disorders and neurologic impairment due to perinatal asphyxia and birth traumas, among others. Macrosomia is the most constant consequence of diabetes and its severity is mainly influenced by maternal blood glucose level. Neonatal hypoglycemia is the main metabolic disorder that should be prevented as soon as possible after birth. The severity of macrosomia and the maternal health condition have a strong impact on the frequency and the severity of adverse neonatal outcomes. Pregestational T2D and maternal obesity significantly increase the risk of perinatal death and birth defects. The high incidence of maternal hyperglycemia in developing countries, associated with the scarcity of maternal and neonatal care, seriously increase the burden of neonatal complications in these countries.

**Key words:** Birth defects; Hypoglycemia; Respiratory distress; Preterm; Perinatal mortality; Type 2 diabetes; Obesity

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**Core tip:** Increased mortality and morbidity are historically attributed to neonates of diabetic mothers. A discerning analysis of the literature shows that these adverse outcomes are uncommon among infants born from “pure” gestational diabetes mellitus (GDM) mothers, well managed during pregnancy. Macrosomia is the predominant adverse outcome and the main factor linked to neonatal complications. Poor maternal glycemic control, especially in the context of maternal type 2 diabetes (T2D) and obesity increases the risk of all adverse neonatal outcomes, most strikingly the risk of perinatal mortality and birth defects. Developing strategies for screening and managing women with GDM must be encouraged notably in middle and low income countries and, also to limit the adverse effects on global health population in the future.

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**INTRODUCTION**

Gestational diabetes mellitus (GDM) is defined as a glucose intolerance of any degree with onset or first recognition during pregnancy. In high income countries, but also in middle and low income countries, because of the spreading of industrialized lifestyle, the incidence of obesity and type 2 diabetes (T2D) has dramatically increased, and subsequently the incidence of GDM[1].

In high-resource countries, progress has been made during the past fifty years regarding preconceptional care, screening and management of GDM. However, in low and middle-income countries, quality of antenatal care to detect and manage GDM, are often poorly available. As a consequence, the prenatal and neonatal burden of GDM may be paradoxically higher in these countries, although this point is not well documented[2].

Much of the currently available knowledge on the consequences of maternal diabetes on the offspring has been provided by studies on type 1 diabetes (T1D), while the risks related to GDM, which is much more frequent, need to be clarified in order to improve and to adapt neonatal management[3]. Moreover, extensive data suggest that the offspring of diabetic mothers is furthermore exposed to an increased risk of developing chronic, non-communicable diseases at adulthood[4].

Neonatologists are facing first-line this new epidemiologic setting. This review addresses the currently available knowledge on short term consequences of GDM in neonates and focuses on situations with increased risks of neonatal adverse outcomes.

**SHORT TERM OUTCOMES**

***Macrosomia***

Macrosomia is the most constant complication in GDM. The concept of excessive fetal growth is expressed either by the word “macrosomia” or by the expression “large for gestational age” (LGA). Macrosomia is defined by a birth weight (BW) of 4000 or 4500 g and more, depending on the authors. However, in this definition, gestational age (GA) is not taken into account. The term LGA corresponds to a BW ≥ 90th percentile or > +2SD (> 97th percentile) for GA. This definition allows premature newborns with excessive fetal growth to be identified. Macrosomia in newborns of diabetic mothers is characterized by excess body fat, an increased muscle mass and organomegaly, without increase in brain size.

The Pedersen-Freinkel’s hypothesis, expressed sixty years ago, suggested that fetal overgrowth is related to increased transplacental transfer of maternal glucose, which stimulates the release of insulin by fetal pancreatic beta cells[5]. Insulin is a major factor of fetal growth and it up-regulates the Insulin-like Growth Factor (IGF) system, subsequently leading to fetal macrosomia. According to this hypothesis, different studies have characterized the link between maternal glycemia and neonatal macrosomia or fat mass[6,7].

The HAPO study showed a continuous, positive association between maternal glycemia, fetal hyperinsulinism and BW[8]. A linear and continuous relationship between body fat percentage in newborns, maternal glycaemia and fetal insulin levels has been found in this study[9]. More recently, other mechanisms that may also contribute to fetal overgrowth were evoked, like maternal metabolic environment and placental modifications[10]. In particular, maternal lipids availability and transport to the fetus may be enhanced in case of maternal diabetes [11].

Hence, all types of maternal diabetes are risk factors for macrosomia. As discussed below, macrosomia is *per se* a cause increased neonatal adverse outcome and this point emphasizes the importance of recognizing the excess of growth, even in preterm infants. Treatment of GDM significantly reduces the rate of macrosomia[12,13].

***Preterm birth***

A number of studies have reported an increased risk of preterm births in case of diabetes. However, data are not always available on the respective proportion of induced and spontaneous births, considering the increased maternal and fetal morbidity of diabetes during pregnancy. The benefits of early delivery to avoid fetal death or shoulder dystocia must be balanced against the morbidity linked to preterm birth, especially the respiratory morbidity.

The link between GDM and spontaneous preterm birth is still controversial. Hedderson *et al*[14] showed in a large cohort study that GDM was an independent risk factor for spontaneous preterm birth (RR =1.42 95%CI: 1.15-1.77)**.** On the other hand, Yogev *et al*[15] found that the rate of spontaneous preterm delivery was not increased in GDM compared to non-GDM patients. Nevertheless, both studies found a relationship between higher glucose values in the oral glucose tolerance test (OGTT) or higher mean blood glucose levels and preterm birth**.**

***Metabolic disorders***

**Hypoglycemia:** The link between macrosomia, increased cord C-peptide levels that reflects fetal insulin secretion, and neonatal hypoglycemia has long been known. The data collected by the HAPO study confirmed this relationship: neonatal hypoglycemia was strongly associated with elevated cord serum C-peptide levels[16]. The infant of a diabetic mother is at risk of transient hyperinsulinism, which prevents at birth the normal activation of metabolic pathways producing glucose and ketone bodies, and causes increased glucose consumption by tissues[17].

The exact incidence of hypoglycemia in case of maternal diabetes is difficult to assess due to the various definitions used for neonatal hypoglycemia in the literature. The rate of intravenously treated hypoglycemia was reported between 5 to 7% in two large studies[18,19]. Comparisons with the risk observed in healthy newborns are difficult also because monitoring of blood glucose at birth was different according to the mother was diabetic or not in most of the studies. At last, in many studies, blood glucose level in neonates is checked soon after birth, although the pathologic significance of low blood glucose levels immediately after birth, in the absence of specific symptoms, is still questioned. Indeed, an immediate fall in blood glucose concentration is observed after birth because of the interruption of placental supply, reaching a nadir between 1 and 2 h in healthy term infants[20]. Normal levels at this period cannot be distinguished from abnormal ones in asymptomatic infants and the incidence of hypoglycemia is likely to be overestimated[21]. From 3 h of age, blood glucose then rises spontaneously, even in the absence of any nutritional intake, due to the activation of metabolic regulatory pathways. Therefore, in the absence of abnormal clinical signs, the first blood glucose measurement is recommended after the second feed, which generally allows infants who cannot manage adequate early glucose homoeostasis to be identified[21].

There is currently no consensus on the indications for systematic glucose blood monitoring in asymptomatic infants born to diabetic mothers. It seems reasonable to consider that LGA or growth restricted infants (<10th percentile) born to diabetic mother may benefit from blood glucose concentration check at 3 to 6 h intervals during the first day of life. On the other hand, normal-grown infants of mothers with diet-controlled GDM should not be monitored[22].

For newborns with no clinical signs, therapeutic intervention can be considered starting at a threshold value of 0.36 g/L (2.0 mmol/L). Early and frequent breastfeeding remains the key in preventing hypoglycemia, whatever the infant’s BW, as far as he/she is able to feed autonomously. Therefore, infants of diabetic mothers should be kept aside their mother, in the absence of significant complications requiring a transfer to a special care neonatal unit. Even in mildly or moderately symptomatic infants with low blood glucose levels, sustained breastfeeding, or eventually formula supplements should be tried first, provided a satisfactory clinical response is obtained[22]. In case the infant is unable to feed, an IV glucose supplementation (3-6 mg/kg/h) should be provided at constant rate of infusion, in order to avoid rebound hypoglycemia.

**Hypocalcemia:** Hypocalcemia can be defined by plasma calcium concentration below 2 mmol/L or ionized calcium concentration below 1.1 mmol/L, regardless of GA or BW. Transient neonatal hypocalcemia has been mainly reported in neonates of pregestational insulin dependent- diabetic mothers and may be partly related to maternal hypomagnesemia and subsequent fetal hypomagnesemia. The severity of hypocalcemia also appeared to be related to the severity of maternal diabetes, as calcium concentration in the neonates was negatively related to maternal HbA1c levels[23].

It seems that hypocalcemia is rarely of clinical significance, particularly in case of GDM, unless other complications are associated[24].

The mechanism is still unclear but seems to involve an abnormal calcium phosphorus metabolism during pregnancy with a decrease in calcium and vitamin D concentrations especially during the third trimester. Some studies have reported an association between GDM and low maternal vitamin D status, particularly with poor blood glucose control. Conversely, there are growing evidences that women who develop GDM are more likely to be vitamin D deficient[25]. Other factors like prematurity and perinatal asphyxia can contribute to low calcium levels[26].

Therefore, there is no indication to screen healthy baby for hypocalcemia and hypomagnesemia. When treatment is indicated, it consists to give oral vitamin D supplements and calcium gluconate orally or intravenously (40-60 mg/kg/day) and magnesium treatment according to plasma level.

**Hyperbilirubinemia:** Hyperbilirubinemia is more frequently observed in infants born to diabetic mothers. It is not a serious complication if non-toxic levels are diagnosed and treated, which is usually the case. The risk of nuclear icterus, the severe form of hyperbilirubinemia, is not reported in cases of diabetes as being more frequent. In the HAPO study, hyperbilirubinemia was weakly associated with maternal blood glucose levels[8]. Polycythemia could be one of the reasons, but additional mechanisms, such as preterm birth, poor liver conjugation are likely to be involved.

***Hematologic disorders***

It has been reported that infants of diabetic mothers may have polycythemia [hematocrit (Ht) higher than 65%]. Mechanisms evoked are reduced transplacental oxygen transport to the fetus and increased fetal oxygen consumption due to fetal hyperinsulinism. This may lead to fetal hypoxia and increased levels of fetal erythropoietin. However, no consistent correlation between plasma erythropoietin level and polycythemia has been reported in human. Increased insulin and IGFs levels can also increase red blood cells production. A strong positive correlation between maternal β-hydroxybutyrate levels and polycythemia was observed in a small observational study[27].

Normovolemic polycythemia seen in infants from diabetic mother can lead to hyperviscosity. Early symptoms are unspecific, feeding problems, plethoric aspect, acro-cyanosis, lethargy, hypotonia, respiratory distress, jitteriness and irritability, seizure (due to multiple cerebral infarcts), necrotizing entorolitis, hyperbilirubinaemia and hypoglycemia have all been found associated. Polycythemia may also favor deep vessels thrombosis. Hypoglycemia may be aggravated in infants from diabetic mothers in case of polycythemia, due to increased glucose consumption by the increased red cell mass. Partial exchange transfusion with saline solution should be performed in symptomatic infants according to the formula (volume exchanged in mL): (Ht-55)x weight (kg) x 80/Ht.

***Respiratory disorders***

The rate and the risk of respiratory distress syndrome (RDS) in cases of GDM cannot be accurately established, due to insufficient precise data[28]. In a recent study from the French birth cohort in 2011, including 474 614 births, the risk for neonatal respiratory disorders was slightly but significantly increased in case of GDM [OR adjusted on mother’s age and gestational age, 1.2 (1.1-1.3)] (personal data not yet published).

It is generally recognized that, besides RDS, infants born to diabetic mothers are exposed to increased risk of transient tachypnea of the newborn. This is more likely to happen after caesarian section due to delayed reduction of alveolar fluid at birth and when the infants have macrosomia. This was clearly showed in infants of T1D mothers[29].

Diabetes, but also maternal body mass index (BMI), is associated with a higher risk of persistent pulmonary hypertension (PPH). However, other independent risk factors like macrosomia and caesarean deliveries might be in the causal pathway between diabetes, overweight and PPH[30].

***Cardiac disorders***

**Hypertrophic cardiomyopathy:** Fetuses exposed to maternal hyperglycemia and hyperinsulinism, are prone to develop hypertrophic cardiomyopathy. It primarily affects the interventricular septum, but can extend to the myocardium in more severe cases[31].

Myocardial hypertrophy has been reported in both pregestational diabetes and GDM with a wide range of frequencies (between 25 to 75% of infants born to diabetic mothers)[32,33]. The incidence was lower in case of pure GDM comparing to pregestational diabetes[34]. The most recent studies showed that good maternal glycemic control does not entirely prevent interventricular septum hypertrophy and minor fetal cardiac function impairment, regardless of the type of diabetes[35,36]. Although myocardial hypertrophy is associated with an overall decrease in ventricular compliance and an increase in contractility of the left and right ventricles, it is most often asymptomatic. It can sometimes lead to severe morbidity and mortality, according to the severity and the extension of cardiac hypertrophy. Major septal hypertrophy can lead to subaortic stenosis and secondary mitral insufficiency. It is usually considered that heart hypertrophy resolves anatomically within few months. However, the long term effect of diabetic cardiomyopathy on heart function remains to be elucidated.

**Cardiac malformations:** Some data supports that GDM carries a small but significantly increased of congenital defects (ORs between 1.1 and 1.3), but it is much lower than in women with pregestational diabetes[37]. The malformations described are similar to those reported in pregestational diabetes, especially cardiovascular defects and anomalies involving the musculo-skeletal and central nervous systems[38,39].

The most commonly reported cardiac malformations include transposition of the great arteries, double outlet right ventricle, truncus arteriosus, hyploplastic left heart syndrome and ventricular septal defects[40].

Antenatal ultrasounds play an important role in monitoring fetal cardiac anatomy and function. Antenatal diagnosis of cardiac malformation is helpful to decide the place of birth when specific neonatal cardiologic care is needed. Babies of women with GDM should have an echocardiogram in the presence of clinical signs at birth associated with congenital heart malformations (cyanosis, murmur) or cardiomyopathy (heart failure).

***Neurological impairments***

Infants of diabetic mothers are prone to neurologic impairments, mainly due to perinatal asphyxia, birth traumas and metabolic disorders.

**Perinatal asphyxia:** Increased risk of perinatal asphyxia has been reported in diabetic pregnancies in a number of studies. The risks of perinatal asphyxia are increased in case of macrosomia, particularly when there is a shoulder dystocia[28,41]. Impaired fetal environment characterized by fetal hypoxia has also been evoked as a contributing factor.

However, in cases of GDM, the incidence of perinatal asphyxia, defined by a 5-min Apgar score < 7, was very low (1%-2%) in a study including more than a thousand neonates of GDM mothers[18]. In another study, umbilical arterial pH < 7.2 was about 15% in GDM group, comparable to the non- diabetic group[42]. In both studies, the incidence was not influenced by the treatment of maternal diabetes.

**Metabolic disorders:** Glucose is the main energy substrate for the brain. In newborns, hypoglycemia can lead to the situation where brain energy metabolism cannot be sustained. The consequences of low blood glucose levels depend on the availability of other substrates, such as lactate and ketone bodies also used by the brain to provide energy. These alternative substrates are not routinely measured, and the normal threshold values are unknown. Their availability also depends on the clinical and nutritional status of the infant.

For infants presenting with clinical signs compatible with hypoglycemia, like apnoea, hypotonia, jitteriness, apathy, hypothermia, tremors and seizures, treatment must ensure that blood glucose levels remain above 0.45 g/L (2.5 mmol/L). An IV bolus dose of glucose (150-200 mg/kg) should be administered urgently, followed by a constant rate infusion. It is necessary to check that thereafter blood glucose concentrations stabilize within normal ranges (20). In case of clinical signs, Cornblath *et al*[43] have suggested that the Whipple triad should be fulfilled: a low blood glucose concentration; signs consistent with hypoglycemia; and resolution of signs and symptoms after restoring blood glucose concentrations to normal values. Therefore, if symptoms persist despite adequate treatment, other causes should be investigated, since these symptoms are not specific.

Symptoms from hypocalcemia are similar to those observed in hypoglycemia, but usually present later, between 24-72 h of life[31]. Then, blood calcium concentration should also be measured in the presence of symptoms suggestive of hypocalcemia.

**Brachial plexus injuries:** The spinal cord is vulnerable to birth trauma with symptoms related to palsies of the brachial plexus.

The most common type of brachial plexus injury, also called Erb’s palsy, involved the cervical roots C5 to C7. The infant presents with internally rotated arm and flexed wrist. The second most common type called total plexus palsy involves cervical roots C5-C8 and sometimes thoracic root T1. The infant presents with a flaccid and insensitive arm and with clawed hand. Paralysis of the hemi-diaphragm is also observed when phrenic nerve is involved, leading to respiratory insufficiency and requirement of mechanical ventilation[44].

Incidence of brachial plexus palsy in newborns of diabetic mothers is low, between 0.2 and 3%. As a consequence, the risk could not be accurately measured[28].

**Poor suckling:** It has been shown in the early nineties that maternal GDM may impair neonatal behavior, leading to lethargy and hypotonia related to delayed neural maturation. More recently, poorer suckling patterns were found at day 3 only among infants of insulin-managed GDM mothers, but not in the diet-managed mothers[45]. This study confirmed some degree of neurologic immaturity during the early neonatal period.

***Digestive impairment***

Apart from the difficulties to feed because of poor suckling pattern, neonates of diabetic mothers may also exhibit neonatal small left colon, a cause of functional lower intestinal obstruction that can mimic Hirschsprung disease. The pathophysiology is unknown but it is significantly associated with maternal diabetes. The treatment is always conservative as long as intestinal perforation does not happen. Contrast enema is both diagnostic (abrupt transition zone at the splenic flexure) and curative, promoting the evacuation of meconium relieving the intestinal obstruction[46].

**FACTORS THAT INFLUENCE THE SEVERITY OF NEONATAL ADVERSE OUTCOME IN GDM**

The adverse neonatal outcomes described above are not constant in all cases but they are significantly influenced by the quality of maternal care and by maternal health. Furthermore, most of these complications are more likely to happen in macrosomic infants.

***Maternal conditions and neonatal outcomes***

**Impact of maternal blood glucose levels and pregestational T2D on neonatal outcomes:** Perinatal death, malformations and prematurity are mainly influenced by maternal glucose levels. As discussed above, there is also a linear relationship between glucose maternal level and the frequency of macrosomia[8]. Furthermore, the analysis of the risk of fetal malformation and perinatal death in case of GDM shows that undiagnosed pre-pregnancy T2D has a substantial impact on these serious perinatal complications.

There is a relationship between the malformation rate and maternal fasting blood glucose level[39,47]. This risk also increases with maternal BMI, and when GDM is diagnosed during early pregnancy[48,49]. Most major malformations occur very early in gestation during the embryonic stage. In diabetic pregnancies, they are attributable to unstable periconceptional glycemia. Maternal hyperglycemia results in excess glucose metabolism in the developing embryo that may alter various molecular chain reactions: (1) altered cell lipid metabolism, notably the production of prostaglandin E2 involved in the patency of the ductus arteriosus in utero[50]; (2) high glucose levels induce an excess production of reactive oxygen species which has been shown to cause oxidative stress and subsequently increase the risk for fetal malformations, notably neural tube defect [51]; and also (3) high glucose levels induce the activation of many proteins involved in apoptotic cell death, including members of the caspase families[52]. Although data on the molecular basis of diabetic embryopathy have improved during the last years, mechanisms are still incompletely understood[53].

These clinical and physiopathologic data suggest that the increased risk of congenital defects in GDM reported in some studies is likely to be related to the inclusion of women with undiagnosed T2D in the GDM groups[54].

Unlike in pregestational diabetes, the increased rate of fetal deaths in the 2nd and 3rd trimesters of pregnancy is debatable in cases of GDM[55,56]. In a large cohort study, the rate of mortality was 16.2/1000 in the GDM group versus 12.5/1000 in the general population. Six weeks after delivery, women diagnosed with GDM were re-classified by a post-partum glucose tolerance test. Women having diabetes on post-partum test were considered as “newly presenting T2D”. When those women were excluded from the GDM group, perinatal mortality was 8.9/1000 in the “true” GDM group, which was similar to the general population. Mortality was the highest in the groups with T2D diagnosed before and after pregnancy (respectively, 39.1/1000 and 56.2/1000)[57]. These data demonstrated that the increased risk of perinatal death reported in case of GDM in some studies, seems to be attributable to undiagnosed T2D.

Prematurity is one of the leading causes of neonatal death. As discuss above, higher maternal glucose levels were observed in case of prematurity in GDM pregnancies. Furthermore, one of the main causes of induced preterm delivery is maternal pre-eclampsia which is more commonly associated with T2D pregnancies[58].

**Impact of maternal obesity in the complications of GDM:** Maternal obesity is associated with worse perinatal outcome even in glucose-tolerant women. Macrosomia is the main complication reported in overweight or obese women, independently of diabetes[59-62]. It is well recognized that neonates born to obese women, even if normal glucose tolerant, have increased fat mass[63]. As in GDM, increased adiposity at birth is related to maternal excess of glucose and lipids availability, and placental transfer to the fetus[11].

The risk of fetal and infant deaths are two to three times greater for women with preconceptional obesity, after excluding pregnancies affected by congenital anomalies or pregestational diabetes[64]. It was recently showed that even modest increases in maternal BMI were associated with increased risk of fetal death, stillbirth, and neonatal, perinatal, and infant death. The relative risk per 5-unit increase in maternal BMI ranged from 1.15 to 1.24[65]. Maternal obesity is also associated with an increased risk of a range of structural anomalies, with the higher risk for neural tube defects[66,67]. It is interesting to note that the risk of particular malformations such as omphalocele and diaphragmatic hernia is increased in obese pregnant women, but not in case of diabetes[68,69].

There is a tight link between maternal obesity and diabetes in pregnancy. Indeed, the risk of GDM increases with maternal BMI[70]. The overall population-attributable fraction of GDM related to overweight was estimated at 46.2%[71].

The benefit effect of treatment of diabetes on neonatal outcomes is lower in obese women, even if targeted levels of glycemic control are achieved. Furthermore, when GDM is untreated or poorly controlled, overweight and obese women have a higher risk of poor neonatal outcome, compared to normal weight GDM women[42,72].

The combination of GDM and obesity shows a greater impact on pregnancy outcomes than either GDM or obesity alone. This cumulative risk was shown for macrosomia, newborn percent body fat and birth trauma[73]. It was also reported for a composite neonatal outcome (BW > 4000 g, birth trauma, shoulder dystocia, hypoglycemia, or jaundice)[74].

***Effects of macrosomia on neonatal outcomes***

It has long been reported that the delivery of macrosomic infants is associated with a higher risk for adverse neonatal morbidity such as birth injury, respiratory distress and hypoglycemia. Macrosomia (BW > 4500 g), regardless of the cause, is also in itself a risk factor for asphyxia and perinatal death[75].

Macrosomia increases the risk of shoulder dystocia, regardless of the cause. In the study by Zhang *et al*[75], the risk of birth injury was the highest for infants with a birth weight 4500-4999 g and ≥ 5000 g, [ORs 2.4 (2.2-2.5) and 3.5 (3.0-4.2), respectively].

In the case of GDM, there is a particularly high risk of respiratory distress in newborns with a BW ≥ 4000 g, compared to those with a BW of less than 4000 g [OR = 3.1 (1.11-8.65)][76]. In the other study, the risk of respiratory complications increased with increasing BW ≥ 4000 g, irrespective of maternal diabetic status[22]. Furthermore, it seems that clinically significant hypertrophic cardiomyopathy without concomitant fetal macrosomia is rarely observed[40].

The analysis of the data collected by the HAPO study showed that neonatal hypoglycemia was strongly related to elevated cord C-peptide levels. High C-peptide levels are related to the importance of fetal hyperinsulinemia that favors fetal excess of growth. Therefore, infants with excessive size at birth are prone to develop hypoglycemia[16]. It was shown that when BW was ≥ 4000 g the risk of hypoglycemia increased, but the risk was higher when BW ≥ 4000 g was associated with maternal GDM[76]. In another study, the risk of hypoglycemia increased with increasing BW, irrespective of maternal diabetic status[77].

**SIZE OF THE BURDEN IN LOW INCOME COUNTRIES**

The prevalence of risk factors for diabetes during pregnancy are increasing all around the world because of increasing incidence of T2D and obesity and the shift of age at onset of diabetes to younger age groups. T2D is an occult disease that can remain undiagnosed, especially in young women of reproductive age. A recent study reported an estimated global prevalence of hyperglycemia in pregnancy worldwide of 170/1000 live births in 2013. A majority of cases occurred in low and middle income countries (91.6%). The prevalence varies widely around the world. The South-East Asia region had the highest prevalence with 23% of live births, followed by the Middle East and North Africa region with 22%[78].

A community-based prospective program in India, with universal screening for GDM, showed that the prevalence of GDM was 13.9%. The frequency varied widely across urban, semi-urban and rural areas, respectively 17.8%, 13.8% and 9.9%. The prevalence also varied according to maternal BMI. For BMI ≥ 25 mg/m2, the incidence was up to 28.4%, 23.8% and 16.1% in urban, semi-urban and rural areas, respectively[79].

A recent analysis of data from World Health Organization (WHO)’s Global Survey on maternal and perinatal outcomes in 23 developing countries described the prevalence of macrosomia, one of the main complications of maternal diabetes and obesity[80]. There was a large variation in the prevalence of babies with BW ≥ 4 kg, ranging from 0.5% in India, to 15% in Algeria. Maternal diabetes and increased gestational BMI were significantly associated with macrosomia in all regions. For example, in Algeria, where 15% of the babies had a BW ≥ 4 kg, 25% of the mothers were obese (BMI ≥ 30 kg/m2). In in Latin America countries, frequency of maternal obesity was more than 30% (Argentina, Mexico, and Paraguay).

It can then be estimated that the burden of neonatal complications is higher in developing countries than in high-income countries, because of the high incidence of maternal hyperglycemia and the absence of screening and treatment of maternal diabetes, and finally because of substandard neonatal care. This is probably even worst within the rural areas, because of limited financial and human resources.

**CONCLUSION**

It is indisputable that diabetes during pregnancy exposes the fetus and the neonates to increased adverse outcomes. These risks mainly depend on maternal health condition. Thus, awareness of maternal health prior and during pregnancy is essential to pediatricians to anticipate the severity of neonatal adverse outcome. Health systems in low income countries are often insufficiently structured to provide adequate screening and care to diabetic mothers. Such situations seriously increase the burden of adverse fetal and neonatal outcomes, probably still underestimated.

The current definition of GDM does not allow identifying pregestational diabetes from true GDM. The WHO recently proposed new criteria for the diagnosis and definition of hyperglycemia first detected in pregnancy which distinguishes the more serious diabetes in pregnancy from GDM[81]. This is a considerable advance as we say that risks of serious complications for fetuses and the neonates are much higher in true diabetes than in GDM. This will help to better understand the burden of hyperglycemia in pregnancy and its relationship with the growing prevalence of T2D. This will also probably allow in the future to determine precisely the risks linked to GDM compared to those linked to T2D. Such distinction will subsequently help better identifying risks in the neonatal period, but also later in life. Indeed, offspring of diabetic and obese women, or macrosomic infants, are more likely to be obese and to have diabetes and cardiovascular diseases in adulthood[3,4]. These long-term consequences of diabetes in pregnancy are going to be the burden of further generations.

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