

BÖLÜM 13

GESTASYONEL DİYABET YÖNETİMİ

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Giriş

Gestasyonel diyabet, daha önceden diyabeti olmayıp ilk kez gebelik sırasında ortaya çıkan ve genelde gebeliğin sonlanması ile beraber sona eren karbonhidrat intoleransı olarak tanımlanmaktadır (1). Gestasyonel diyabetin sıklığı gittikçe artmakta olup, dünya genelinde yılda 20 milyon gestasyonel diyabetli anne bebeği doğmaktadır. Bu vakaların %90'ı Güney ve Güneydoğu Asya'da doğmaktadır(2).

Gebelik birçok komplikasyonları beraberinde getiren bir durumdur. Gestasyonel diyabet ise maternal ve fetal olumsuz sonuçları olan gebeliğin ciddi komplikasyonlarından biridir. Bu risklerden bazıları makrozomi, preeklamsi, fetal kardiyak problemler, ani fetal ölümdür. Klinisyenlerin bu noktadaki görevi gestasyonel diyabet tanısını koyabilmek ve tanı sonrası hiperglisemi kontrolünün sağlanmasından; gestasyonel diyabetin gebelik komplikasyonlarının yönetilmesinden sorumludur(3).

Gestasyonel Diyabet, spontan abort, fetal anormallikler, preeklamsi, fetal anomaliler, makrozomi, yenidoğan hipoglisemisi, neonatal respiratuar distress sendromu gibi spesifik komp-

likasyonları doğurabilmektedir. Ayrıca gebelik sonrası artmış obezite, hipertansiyon ve Tip 2 Diyabet gestasyonel diyabet komplikasyonları arasında sayılabilir(4, 5).

Klinisyenler gebelik, doğum ve doğum sonrası yönetimi planlamalıdır.

Gestasyonel Diyabetin Tanısı

Gestasyonel diyabette son zamanlar elde edilen kanıtlar sayesinde tanı için kullanılan gen tarama programları perinatal morbiditenin azalmasına direkt olarak etki etmiştir. GDM tanısında 20 yıldan uzun süredir bir Ad Hoc Consensus gen terapisinden türetilen derive kullanılmaktadır (8).

Biyokimyasal tarama gestasyonel diyabet açısından en riskli dönem olan 26 ila 28. Haftalar arası yapılmalıdır. Eğer erken haftalarda tarama yapıldı ve sonuç negatif çıktı ise de 24 ila 28. Haftalar arası tarama testi tekrarlanmalıdır. RANZCOG, 75 gram şeker ile yapılan 2 saatlik oral glukoz tolerans testini (OGTT) önermektedir. 1 saatlik açlık gerekmeden yapılan glukoz challenge test(GCT), sensitivite ve spesifitesinin düşük olması ve 3 gün yüksek karbonhidrat alımı sonrası yapılması nedenleriyle artık önerilmektedir (9).

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sülin duyarlılığı, doğum sonrası 1-2 hafta içinde gebelik öncesi seviyesine döner. İnsülin tedavisi alan kadınlarda emzirme döneminde, uyku düzensizliklerinde ve diyet programlarında, hipogliseminin önlenmesine özellikle dikkat edilmelidir (96).

LAKTASYON

Diyabetli annelerin tamamı, anne sütünün immünolojik faydaları düşünülerek emzirme yönünde desteklenmelidir. Aynı zamanda emzirme anneye uzun dönemde metabolik faydalar sağlayabilir. Ancak emzirme gece görülen hipoglisemi riskini artırabilir, insülin doz ayarlanması gerekebilir (97-98).

KONTRASEPSİYON

Prekonsepsiyonel olarak korunmadaki en büyük engel gebeliklerin çoğunluğunun plansız oluşudur. Diyabeti olan kadınlarda, önceden yapılan glisemik kontrol planlaması konjenital malformasyonların ve görülebilecek diğer risklerin azaltılmasında etkilidir. Bu nedenle çocuk doğurma potansiyeli bulunan diyabetli kadınlar aile planlaması yönünden bilgilendirilmeli i etkili ve sürdürülebilir kontrasepsiyon yöntemi planlanmalıdır. Bu doğum sonrası hemen planlanmalıdır. Diyabetli kadınlarda seçilecek kontrasepsiyon yöntemleri diyabetli olmayanlarla benzerdir. Uzun etkili ve geridönüşümlü olan kontrasepsiyon yöntemleri kadınlar için ideal olanlardır. Plansız bir gebelik riski; seçilecek doğum kontrol yönteminin riskine oranla daha ağır basmaktadır (99, 100).

Sonuç

Tüm gebelerde risk faktörü yok ise 24-28. haftalarda gestasyonel diyabetin fetal ve maternal komplikasyonlarından korunmak için oral glukoz tolerans testi (OGTT) yapılmalıdır. OGTT 75 gram olarak yapıp yükleme öncesi venöz kandan açlık glukozu bakılmalı ve yükleme sonrası

1. ve 2. saat glukoz bakılmalıdır. OGTT taraması için lojistik eksiklik olan yerlerde hbA_{1c} bakılması önerilmektedir. Eğer yüksek risk faktörü var ise gebeliğin erken döneminde OGTT 75 gr taraması yapılmalıdır. Fakat OGTT sonucu normal gelse bile 24-28. Haftalarda yine test tekrarlanmalıdır.

Kaudal regresyon, konjenital kardiyovasküler malformasyonlar, anensefali, mikrosefali gibi ciddi fetal embriyopatiler ve preeklamsi riskleri açısından diyabet tanısını koyup önlem almamızı sağlamaktadırlar. Profilaktik aspirin kullanımı hipertansif diyabetli gebelerde endikedir. Glisemik dengesizliğin yarattığı komplikasyonlardan korunmak için insülin dozları düzenlenmeli ve sıkı bir kan şekeri takibi yapılmalıdır.

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