

## **CAPSULE COMMENT**

### **Women and Diabetes**

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Diabetes is a demanding illness for both men and women. Complications like blindness, renal disease, amputations, myocardial infarction and stroke can happen no matter the patient gender. Women, like men, can prevent these dreaded complications through reaching evidenced based goals for A1C, LDL and blood pressure. But there are some unique issues to consider for women.

**Polycystic Ovary Syndrome (PCOS)** occurs in 5 to 10% of women between ages 12 and 45. These women have varying degrees of the metabolic syndrome and type 2 diabetes. The principal features are anovulation, irregular menses, hirsutism and insulin resistance. The severity of the syndrome varies among affected women. Their infertility responds to metformin and other fertility agents. Once pregnant they are at increased risk for gestational diabetes and diabetes throughout life.

**Sexual Health Problems** are common in diabetes. Women with diabetes have a 33% increased incidence of vaginal dryness, yeast infections, vaginal tightness (vaginismus), difficulty reaching orgasm and discomfort with sexual activity. Many of these issues result from the hyperglycemia induced diminished blood flow to vessels and nerve endings in the vaginal area. Women are not comfortable discussing these issues and clinicians are not asking enough questions about sexual health. Addressing these issues with women may help them better understand their diabetes and motivate them to adhere to treatment.

**Gestational Diabetes (GDM)** affects up to 10% of all pregnancies. If the hyperglycemia is not recognized and properly treated, it can lead to adverse outcomes for the mother and the fetus. The diagnosis of GDM is made after a 75 gram glucose load when any of the following plasma glucose values are exceeded:

- Fasting 92 mg/dl
- 1 hour 180 mg/dl
- 2 hour 153 mg/dl

Screening is usually conducted between 24 and 28 weeks for all pregnancies, but earlier screening can be considered for patients who have a BMI > 30, physical inactivity, first degree relative with diabetes, high risk ethnicity (e.g. African American, Latino, Native American, South Asian, Pacific Islander), past pregnancy with GDM or baby over 9 pounds, hypertension, HDL <35, acanthosis nigricans, and an A1C of 5.7 or higher.

Screen any of your patients who may be considering pregnancy. Lifestyle changes are effective in 80% of GDM. These changes can be started before conception if at high risk. Once pregnant, insulin and or oral medications may be added. One of the advantages of Metformin during pregnancy is the effect on the baby. Babies born to mothers who take Metformin have more subcutaneous fat than visceral fat. This may lessen the chance of insulin resistance, metabolic syndrome and diabetes as the baby grows older.

Over 50% of women with GDM go on to develop diabetes. If a woman has two of any of the following she has an 86% chance of developing diabetes postpartum:

- BMI>30
- Insulin therapy
- Diagnosed before 24 weeks
- 1 hour glucose >200

Unfortunately, most women are not receiving screening after they have GDM. Family Physicians can play a major role in this screening. Any of your patients with a history of GDM deserve at least an A1C every two to three years. If a patient is in one of the high risk categories (two of the above), A1C should be obtained yearly.