Diabetes Case Studies
Antepartum
Higher Risk

Patient	Janine is a 32 year old with Type 1 DM, poorly controlled with Lantus and Humalog. She presents with a complaint of not feeling well since last night, pressure and discomfort in the upper right abdomen, nausea.
Current Pregnancy	G 1 P 0 at 28 weeks
History of Present Illness	• Proteinuria of 2+ and 3+ protein during antenatal visits • Polyhydramnios • States fasting blood sugar on fingerstick was 300 this morning
EFM	• Variability--moderate • Baseline—140 bpm • Accelerations—absent • Decelerations—absent • Toco—no contractions
Vital signs	Time: 0900 • T 37 C • HR 83 • RR 16 • BP 134/85

a) What are your questions for this patient?

- What time did you last check your blood sugar and give yourself insulin? What was your blood sugar then? What type of insulin was it, and how many units did you take? Any vomiting, shortness of breath, visual changes, dysuria, vaginal bleeding, leaking fluid, what have you eaten recently, and how long ago?
- Why? Differential diagnosis: hyperglycemia, ketoacidosis, UTI, gastrointestinal disorder
- What was your highest blood sugar? When was that? What have your blood sugar trends been?

b) What are your priorities for care?

- Stabilize blood sugar, hydrate, monitor fetus. Blood glucose is 503.
- Why? What could happen? With vomiting, she could develop ketoacidosis.

c) What is your plan for next steps in care?

- Patient education to re-assure her about fetal status with moderate variability, and reasons for 24-hour urine and importance of stable blood glucose
- Why? To encourage cooperation and to reduce her anxiety

d) What orders can you anticipate?

- Admit for observation; POCT blood sugar; urine to lab for ketones, glucose, protein, blood; pre-eclampsia labs; potassium and bicarbonate levels; 24-hour urine; serial BP monitoring; continuous fetal monitoring; IV insulin drip.
- Close communication with MD. Begin fluid resuscitation when ordered – up to 6-8 liters of fluid.

- Why? Possible organ dysfunction related to diabetes (kidney function, pre-eclampsia labs), assess fetal wellbeing due to possible placental perfusion problems.

e) What findings or changes would make your worry?

- Hyperglycemia and/or hypoglycemia, minimal FHR, vomiting
- Why? Sustained, minimal FHR could indicate poor placental perfusion related to hyperglycemia; vomiting and dehydration could lead to ketoacidosis with negative fetal consequences

f) What findings would make you call the provider immediately?

- Hyperglycemia, hypoglycemia, vomiting, FHR showing recurrent late decelerations
- Lab report indicating ketoacidosis
- Why? Patient might need transfer to ICU if she has ketoacidosis

g) What findings could wait until the provider makes rounds?

- Minimal FHR variability less than 1 hour, nausea without vomiting