Insulin stacking leads to hypoglycemia, he warned. “You have to remember and remind patients about overcorrection with too much insulin too soon before the insulin they have taken has played out.” Dr. Gabbe said insulin levels increase in pregnancy, but changes can vary for each woman. To help with the adjustment, he advised teaching the patient that:

- One unit of short-acting insulin will lower her blood glucose level by approximately 30 mg/dL.
- Ten grams of carbohydrate will elevate her blood glucose by about 30 mg/dL.
- One unit of short-acting insulin will cover approximately 10 g of carbohydrates.

He recommended the short-acting insulins lirgowo and aspart for pregnant patients; these can be injected or used with an insulin pump. He said there are concerns but not much experience with the long-acting insulin glargine in pregnancy. Insulin pumps offer many advantages. Along with eliminating the need for multiple injections, they provide a continuous basal rate, which reduces the risk of mean glucose excursions and hypoglycemia. They also allow a more flexible lifestyle.

But the pumps also have disadvantages. They require excellent compliance, intensive glucose monitoring, and can produce hyperglycemia if mechanical problems occur. Pump failure increases the risk of ketoacidosis, and there is the potential for infection at the insertion site. It also “costs $340 more per month to use a pump vs. multiple injections,” he said.

Whatever method is used, Dr. Gabbe said diet is critical as well. Patients should have three meals and three snacks each day. Another concern is hypoglycemia unawareness, which could be exacerbated by intensive insulin therapy during pregnancy. Determine if the patient has hypoglycemia unawareness; review and adjust her diet, insulin, and exercise; and teach family members to treat hypoglycemia, Dr. Gabbe said.

“Does all of this really make a difference?” he asked rhetorically. “Yes, it does—having a baby that grows normally and behaves normally in the nursery.”