Pre-conception care: Are we improving?

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Listening to the obstetric history of women who have had type 1 diabetes for many years, with heart-breaking tales of multiple miscarriages and stillbirths, reminds us that the care for women with diabetes has come a long way. Today, in most cases, the expectation for these women is that they will have a relatively normal pregnancy with a healthy baby delivered at the end of it, whereas years ago, women were often discouraged from getting pregnant because the outcome was so poor. However, despite the advances in care, the CEMACH report (2007) shows there is still room for improvement, with women with diabetes continuing to have a poorer obstetric outcome compared to women without the condition.

Recent NICE guidelines for the management of pregnancy in women with diabetes (NICE, 2008), along with standard 9 of the NSF for diabetes (DoH, 2001), give clear guidance about the service that should be available to women planning, and during pregnancy. Improving the chances of having a healthy baby without increasing the risk of worsening existing diabetes complications for the mother involves considerable effort from the woman herself and her diabetes team. In the accompanying article Jackie Webb describes the support women with diabetes are offered in the combined diabetes obstetric service at Heartlands Hospital, including a regular multidisciplinary pre-conception counselling clinic. However, she notes that despite the availability of these services, there continues to be an unacceptable number of miscarriages and stillbirths in women with diabetes attending the hospital.

She describes the shift of responsibility for preparing women for pregnancy. Traditionally, pre-conception care was managed by the hospital diabetes clinic as most women with diabetes of child-bearing age had type 1 diabetes. Type 2 diabetes used to be called mature-onset diabetes, and many women with the condition were middle-aged or older and had 'completed' their families. However, not only are more people developing type 2 diabetes, they are developing it at an earlier age. As people with type 2 diabetes are usually managed in primary care, the responsibility of giving pre-conception care to young women with type 2 diabetes lies firmly in primary care. Although the nGMS contract has improved diabetes care, as judged by attainment of the QOF indicators, pre-conception care is not included in the QOF and may be missed in the annual diabetes review.

Despite the availability of the pre-conception counselling clinic at Heartlands Hospital, most women with diabetes are already pregnant when they first access the diabetes obstetric clinic. If they have type 2 diabetes, they are likely to have dyslipidaemia and hypertension and may be taking potentially teratogenic medication such as statins and ACE-inhibitors. If this is combined with sub-optimal glycaemic control, it is not an ideal start to a pregnancy. The case for pre-conception counselling is unquestionable so why are not more women accessing it?

Although women should ideally plan their pregnancy, many do not. The catchment area for Heartlands Hospital contains some of the most deprived areas in the country (Birmingham East and North PCT, 2006), and the people living there may have poor literacy levels and disorganised lives – which the author believes may result in unplanned pregnancies. She notes that the hospital serves a large South Asian population, so there may be cultural and social reasons for avoiding attending a pre-conception clinic or delaying conception, as well as language barriers, for example.

One thing is clear from the article: preparing adequately for pregnancy is essential, especially if an individual has diabetes. Everybody involved in the education and management of diabetes should think 'pre-conception counselling' whenever they see a woman with diabetes of child-bearing age, and should certainly manage their diabetes care as if the woman is actively planning a pregnancy unless she is taking adequate contraception. ■