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Failure to diagnose: gestational diabetes

Case histories are based on actual medical negligence claims, however certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved. Medical negligence claims involving an allegation of 'failure to diagnose' account for up to 50% of claims against general practitioners. This article examines a case in which there was a failure to diagnose and appropriately manage gestational diabetes.

Case history

The patient, 28 years of age, attended her general practitioner for the management of her first pregnancy. The patient was uncertain of the date of her last menstrual period. An ultrasound performed on 22 July 2005 gave an estimated date of confinement (EDC) of 10 December 2005 (with a margin of error of +/- 7 days). In September 2005, at approximately 28 weeks gestation, a urinalysis revealed glucose +++. A 50 g oral glucose challenge screen revealed a glucose level of 10.5 mmol/L which was significantly elevated. A formal glucose tolerance test, performed on 10 October 2005, was abnormal, with a 2 hour reading of 8.5 mmol/L. At this time, it was noted that the patient had a strong family history of diabetes. The GP advised the patient to 'watch her diet' but did not recommend any additional interventions or monitoring. Routine urinalysis continued to reveal glucose +++.

An induction was planned for 13 December 2005 but the patient presented to hospital with a fetal death in utero on 10 December 2005. The baby weighed 4900 g. A postmortem examination showed signs of macrosomia and the foot length and other measurements indicated a gestation of 40+ weeks. This was despite the fact that the GP had not at any antenatal visit measured the fundal height as being larger than gestation and therefore had no indication of fetal macrosomia.

The patient subsequently wrote to the GP and asked that he pay for the cost of the baby's funeral. The patient alleged that the GP had failed to diagnose and appropriately manage her gestational diabetes. The patient believed that the failure to appropriately manage her diabetes had led to the death in utero. The GP forwarded the patient's letter to his medical defence organisation (MDO). The MDO sought an expert peer opinion from an independent GP obstetrician.

- the EDC appeared to have been incorrect and induction was actually planned past term, rather than at 38 weeks gestation.

Based on the expert report, the GP's MDO decided to settle the patient's claim on the basis of a Deed of Release. The patient was advised to obtain her own independent legal advice. The claim finally settled in the amount of \$5000, representing the cost of the baby's funeral and some additional out-of-pocket expenses.

Discussion and risk management strategies

Gestational diabetes can be defined as carbohydrate intolerance of variable severity with onset or first recognition during pregnancy. It has been estimated that gestational diabetes occurs in 2–9% of all pregnancies. Women with gestational diabetes are a heterogeneous group and may include those with unrecognised pre-

The GP expert report confirmed that there were deficiencies in the care provided by the GP. In particular, the GP expert expressed concern that:

- the patient had definite gestational diabetes which was diet controlled but not monitored appropriately
- there was a significant degree of macrosomia which was not recognised by the GP

existing noninsulin dependent diabetes (type 2) and also a small number with insulin dependent diabetes. Universal screening during pregnancy is recommended.

The Australasian Diabetes in Pregnancy Society recommends that:

- the screening test for gestational diabetes should be performed at 26–28 weeks gestation. Positive results are: 1 hour venous plasma glucose level ≥ 7.8 mmol/L after a 50 g glucose load (morning, nonfasting); or 1 hour venous plasma glucose level ≥ 8.0 mmol/L after a 75 g glucose load (morning, nonfasting)
- confirmation of diagnosis after a positive screening test: a 75 g oral glucose tolerance test (fasting) with a venous plasma glucose level at 0 hours of ≥ 5.5 mmol/L and/or at 2 hours of ≥ 8.0 mmol/L
- patient education is very important and a team approach, if available, is beneficial. Glycaemic control needs to be monitored. Self monitoring of blood glucose level is the optimal method
- dietary therapy is the primary therapeutic strategy, with insulin added where required to achieve the minimum goals for glycaemic control: fasting blood glucose < 5.5 mmol/L, 1 hour postprandial < 8.0 mmol/L or 2 hour postprandial < 6.7 mmol/L.¹

Recent studies have confirmed that appropriate treatment of gestational diabetes reduces serious perinatal outcomes (defined as death, shoulder dystocia, bone fracture and nerve palsy) and may also improve the woman's health related quality of life.²

Conflict of interest: none.

References

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2. Crowther CA, Hiller JE, Moss JR, et al. Effect of treatment of gestational diabetes mellitus on pregnancy outcomes. *N Engl J Med* 2005;352:2477–86.