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Hyperglycaemia in Pregnancy: Postpartum Referral Pathways for TBH

1. Purpose

To standardise postpartum follow-up and referral pathways for patients with type 1 diabetes mellitus (T1DM), type 2 diabetes mellitus (T2DM), gestational diabetes mellitus (GDM), and hyperglycaemia first diagnosed in pregnancy, ensuring timely identification of persistent dysglycaemia and provision of appropriate ongoing care.

2. Definitions

4.1 True Gestational Diabetes (GDM): Hyperglycaemia first diagnosed in pregnancy *not* meeting criteria for overt diabetes.

4.2 Overt Diabetes in Pregnancy: Patients who met any of the following diagnostic criteria during pregnancy:

- Fasting plasma glucose ≥ 7.0 mmol/L, or
- 2-hour glucose > 11.0 mmol/L, or
- HbA1c ≥ 6.5%

3. Postpartum Follow-Up Pathways

3.1 Patients with True Gestational Diabetes

Follow-up location: Local primary care clinic / community health centre

Investigations and timing:

- 6 weeks postpartum (or nearest visit): HbA1c (purple-top tube)
- Next scheduled visit (e.g. 10-week immunisation visit): Fasting finger-prick glucose, Review HbA1c result

*Referral process: D*ischarge with the standardised postpartum GDM referral letter (Addendum 1) to facilitate appropriate testing and interpretation at local clinics. Register (online link) as 'GDM referred out'.

Discharge counselling: Emphasise high risk of future T2DM. Advise postpartum screening, annual screening if normal, and risk of recurrence in future pregnancies.

3.2 Patients with Overt Diabetes in Pregnancy

Follow-up location: Postpartum Diabetes Clinic; C7B Department of Endocrinology, Tygerberg Hospital

Booking process: Use departmental online booking link. Ideal review interval: 6–12 weeks postpartum, subject to clinic capacity.

Discharge counselling: Inform patients to be nil by mouth on clinic day to allow OGTT if indicated. Babies are welcome at clinic visits.

3.3 Patients with Type 1 Diabetes (T1DM)

Follow-up location: C7B Department of Endocrinology, Tygerberg Hospital

Booking process: Registrar for special care liaises for postpartum booking. Interval is individualised; booking via Vula to Endocrinology on-call.

Discharge counselling: Warn of brittle glycaemic control in early postpartum period. Insulin requirements may increase gradually. Frequent review and subspecialist follow-up at Tygerberg Hospital are required.

3.4 Patients with Type 2 Diabetes (T2DM)

Follow-up location: Local community health centre (CHC).

Booking process: Please complete the TTO for the patient as a referral script (triplicate version) with a note there that the patient is referred to local CHC for diabetes care. Prescribe max 2 repeats of the medication to allow timely review of glycaemia by CHC doctor.

Discharge counselling: Reinforce importance of lifestyle modification and glycaemic control to prevent target organ damage. Stress optimisation of glycaemia prior to future pregnancies.

4. Responsibilities

Discharging clinician:

- Identify the correct postpartum pathway
- Ensure appropriate referral documentation is provided
- Counsel patients regarding follow-up requirements and fasting instructions where applicable

5. Queries, Escalation and Audit

For clinical or administrative concerns related to postpartum diabetes follow-up, please contact:

Dr Deidré Mason (dmason@sun.ac.za)

6. Addenda

Table 1: Postpartum Pathway summary

Addendum 1: GDM Referral.

AUTHORISED BY:		DATE EFFECTIVE: 20.04.2026
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COMMITTEE RESPONSIBLE:	D Mason, GS Gebhardt, A Coetzee	REVIEW DATE: 19.04.2028

Postpartum Follow-Up Pathway: Hyperglycaemia in Pregnancy

Patient Group	Follow-Up Location	Investigations & Timing	Booking / Referral Process	Key Counselling Points
True Gestational Diabetes (GDM)	Local primary care clinic / community health centre	6w postpartum: HbA1c Next visit (e.g. 10-week immunisation): Fasting finger-prick glucose, review HbA1c	Discharge with standardised postpartum GDM referral letter and register online as 'GDM refer out'.	High risk of future T2DM; importance of postpartum and annual screening; recurrence risk in future pregnancies
Overt Diabetes in Pregnancy	Postpartum Diabetes Clinic, C7B Endocrinology, Tygerberg Hospital	6–12 weeks postpartum: OGTT if indicated	Online departmental booking link for Endocrinology.	Nil by mouth on clinic day; OGTT may be required; babies welcome at clinic
Type 1 Diabetes Mellitus (T1DM)	C7B Endocrinology, Tygerberg Hospital	Individualised follow-up; frequent review initially	Registrar for special care liaises, booking via Vula to Endocrinologist on-call	Brittle glycaemic control early postpartum; insulin needs may rise; subspecialist follow-up required
Type 2 Diabetes Mellitus (T2DM)	Local community health centre (CHC)	Ongoing review at CHC	TTO referral script (triplicate) with note of referral; max 2 repeats of medication	Lifestyle modification and glycaemic control essential; prevent complications; optimise control before next pregnancy

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REFERRAL LETTER

Gestational Diabetes

Local Follow-Up at 6weeks Postpartum

Patient Name & Surname:

Folder Number: DOB:

Discharge Date:

_____

Dear Sister

Thank you for including a glucose test for this patient at her routine 6-week postpartum visit.

She had gestational diabetes during pregnancy. After delivery, blood sugar levels often return to normal. However, some women may still have high blood sugar, and all are at increased risk of developing type 2 diabetes in the future (about 50% within 5–10 years).

Please perform a glucose test 6 weeks after delivery and refer the patient if the result is abnormal.

Management Algorithm

6 weeks after delivery (or nearest visit): Take blood for HbA1c (purple-top tube).

Next visit (e.g. 10-week immunisation visit):

- Do fasting finger-prick glucose
- Review HbA1c result.
- Use the highest result to guide management:

Diagnostic Category	Fasting Finger Prick Test	HbA1c Result	Management
Normal	<5.6mmol/l	<5.7%	Tell the patient her blood sugar is *normal.* Explain she still has a higher risk of type 2 diabetes. Encourage a healthy diet and lifestyle. **Arrange yearly diabetes screening at local clinic.**
Pre-diabetes	5.6 – 6.9mmo/l	5.7 – 6.4%	Tell the patient she has *pre-diabetes.* Explain she is at high risk of type 2 diabetes. Reinforce diet and lifestyle advice. **Refer to the clinic in 6 months for repeat testing and to consider metformin.**
Diabetes	≥7.0mmol/l	≥6.5%	Tell the patient she has diabetes. **Refer to the nearest clinic for:** ✓ Diet and lifestyle counselling ✓ Medical assessment ✓ Treatment as needed

Your support in early identification of diabetes plays an important role in protecting long-term maternal health — thank you.

TBH1277