

Figure. Screening for gestational diabetes mellitus (GDM): clinical summary of U. S. Preventive Services Task Force Recommendation.

Annals of Internal Medicine



**Screening for Gestational Diabetes Mellitus:
Clinical Summary of U.S. Preventive Task Force Recommendation**

Population	Pregnant Women Who Have Not Previously Been Diagnosed with Diabetes
Recommendation	Grade: I No recommendation due to insufficient evidence*
Risk assessment	<p>Women at increased risk for GDM include those who:</p> <ul style="list-style-type: none"> • are obese • are older than age 25 years • have a family history of diabetes • have a history of GDM • are of certain ethnic groups (Hispanic, American Indian, Asian, or African-American)
Rationale for no recommendation	<p>The current evidence is insufficient to assess the balance between the benefits and harms of screening women for GDM either before or after 24 weeks' gestation. Harms of screening include short-term anxiety in some women with positive screening results; inconvenience to many women and medical practices because most positive screening test results are probably false positive.</p>
Suggestions for practice	<p>Until there is better evidence, clinicians should discuss screening for GDM with their patients and make case-by-case decisions. The discussion should include information about the uncertain benefits and harms as well as the frequency and uncertain meaning of a positive screening test result.</p>
Screening tests	<p>If a decision is made to screen for GDM :</p> <p>The screening test most commonly used in the United States is an initial 50-g 1-hour glucose challenge test. If the result on the glucose challenge test is abnormal, the patient undergoes a 100-g 3-hour oral glucose tolerance test. Two or more abnormal values on the oral glucose tolerance test are considered a diagnosis of GDM.</p>
Screening intervals	<p>Most screening is conducted between 24 and 28 weeks' gestation. There is little evidence about the value of earlier screening .</p>
Other approaches to prevention	<p>Nearly all pregnant women should be encouraged to:</p> <ul style="list-style-type: none"> • achieve moderate weight gain based on their prepregnancy body mass index • participate in physical activity

For a summary of the evidence systematically reviewed in making these recommendations, the full recommendation statement (including a summary of research gaps), and supporting documents, please go to www.preventiveservices.ahrq.gov. *The current evidence is insufficient to establish the balance of benefits and harms for screening for gestational diabetes mellitus, either before or after 24 weeks' gestation.

Table 1. What the U.S. Preventive Services Task Force Grades Mean and Suggestions for Practice*

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer/provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer/provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer/provide this service only if other considerations support offering or providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

* USPSTF = U.S. Preventive Services Task Force.

Table 2. U.S. Preventive Services Task Force Levels of Certainty Regarding Net Benefit

Level of Certainty*	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: the number, size, or quality of individual studies inconsistency of findings across individual studies limited generalizability of findings to routine primary care practice lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: the limited number or size of studies important flaws in study design or methods inconsistency of findings across individual studies gaps in the chain of evidence findings that are not generalizable to routine primary care practice a lack of information on important health outcomes. More information may allow an estimation of effects on health outcomes.

* The U.S. Preventive Services Task Force (USPSTF) defines *certainty* as “likelihood that the USPSTF assessment of the net benefit of a preventive service is correct.” The net benefit is defined as benefit minus harm of the preventive service as implemented in a general primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.