A case of diabetic ketoacidosis in pregnancy
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Objective
Diabetic ketoacidosis (DKA) in pregnancy is rare, with an incidence of 1-3% compromising both the fetus and the mother when it does occur, resulting in a fetal mortality rates as high as 9% if undetected. Although antepartum diabetes screening, care and surveillance have greatly improved, DKA in pregnancy usually has delayed diagnosis, since it occurs at lower blood glucose levels than in non-pregnant women. We report a case of DKA in a pregnant woman with type 1 diabetes highlighting the management so that we can re-educate our colleagues on this rare condition.

Methods
We followed a 23 year old with type 1 diabetes who was non-compliant antenatally and during her DKA admission to delivery of her baby.

Results
Despite midwife efforts this patient was a poor attendee and at 28 weeks gestation, she was admitted with vomiting, abdominal pain, reduced fetal movements and a pathological CTG due to DKA. Under the guidance of the endocrine team and maternal medicine specialists she was stabilised and monitored with IV fluids, insulin infusion, replacement of electrolytes and antibiotics, then discharged. She re-presented at 34+3 with pre-eclampsia, hyperglycemia and polyhydramnios, in view of her poorly controlled diabetes she was induced at 35 weeks, resulting in delivery of a live female infant by caesarean section.

Conclusion
Management required a multidisciplinary approach, involving the obstetric, anaesthetic, HDU, diabetic and paediatric teams, ultrasonographers, psychologists and social services. DKA in pregnancy is an emergency requiring prompt and vigorous management and input from medical and obstetric teams. Management targets involve in-utero resuscitation and maternal stabilisation, hydration, and reversal of metabolic acidosis and hyperglycaemia. This was a complicated case with difficult management due to patient's poor attendance at antenatal appointments and poor compliance. This case illustrates the importance of counseling women with diabetes, strict surveillance of glucose levels, and how we need to manage the mother first, regardless of the fetal well-being. Aggressive management of the mother in this case helped to reduce the high perinatal mortality associated with DKA.