Diabetic Ketoacidosis in Pregnancy

Diagnosis of DKA:
   Initial STAT labs include
  • CBC with diff
  • Serum electrolytes
  • BUN
  • Creatinine
  • Glucose
  • Arterial blood gases
  • Bicarbonate
  • Urinalysis
  • Lactate
  • Serum ketones
  • Calculation of the Anion Gap
     serum anion gap = serum sodium – (serum chloride + bicarbonate)
  • Electrocardiogram

Treatment Protocol for Diabetic Ketoacidosis
DKA/HHS Pathway Phase 1 (Adult)

DKA Diagnostic Criteria:
- Blood glucose >250 mg/dl
- Arterial pH <7.3
- Bicarbonate ≤18 mEq/l
- Anion Gap Acidosis
- Moderate ketonuria or ketonemia
1. **Start IV fluids** (1 L of 0.9% NaCl per hr initially)
2. **If serum K+ is <3.3 mEq/L hold insulin**
   - Give 40 mEq/h until K ≥ 3.3 mEq/L
3. **Initiate DKA Order Set Phase I** (*In PREGNANCY utilize OB DKA order set)
4. **Start insulin** 0.14 units/kg/hr IV infusion (calculate dose)
   RN will titrate per DKA protocol

*PREGNANCY
- Utilize OB DKA order set Phase 1
- When glucose reaches 200mg/dL, Initiate OB DKA Phase 2
- Glucose goals 100-150mg/dL OB DKA Phase 2

**Look for the Cause**
- Infection/Inflammation (PNA, UTI, pancreatitis, cholecystitis)
- Ischemia/Infarction (myocardial, cerebral, gut)
- Intoxication (EtOH, drugs)
- Iatrogenic (drugs, lack of insulin)
- Insulin deficiency
- Pregnancy

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**IVF**
- Determine hydration status
  - Hypovolemic shock
  - Mild hypotension
  - Cardiogenic shock
  - Administer 0.9% NaCl (1.0 L/h) and/or plasma expander
  - Hemo-dynamic monitoring

**Insulin**
- Initiate and continue insulin gtt until serum glucose reaches 250 mg/dl. RN will titrate per protocol to achieve target.
- When sugar < 250 mg/dl proceed to DKA Phase II
  - *In PREGNANCY when sugar <200 proceed to OB DKA Phase II

**Potassium**
- If initial serum K+ is <3.3 mEq/L, hold insulin and give 40 mEq K+ per h (2/3 KCL and 1/3 KPO4) until K ≥ 3.3 mEq/L
- assess need for bicarbonate
- pH < 6.9
  - Dilate NaHCO3 (100 mmol) in 400 mL H2O with 20 mEq KCL. Infuse for two hours
  - Repeat NaHCO3 administration every two hours until pH > 7.0.
  - Monitor serum K
- pH > 7.0
- No HCO3

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**Bicarbonate**
- Assess need for bicarbonate
  - pH < 6.9
  - Dilate NaHCO3 (100 mmol) in 400 mL H2O with 20 mEq KCL. Infuse for two hours
  - Repeat NaHCO3 administration every two hours until pH > 7.0.
  - Monitor serum K

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**Determine hydration status**
- Evaluate corrected serum Na
  - Serum Na high
  - Serum Na normal
  - Serum Na low
  - 0.45% NaCl (4-14 ml • kg⁻¹ • h⁻¹) depending on hydration state
  - 0.9% NaCl (4-14 ml • kg⁻¹ • h⁻¹) depending on hydration state

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Updated 4/1/2023

Approved by Diabetes Steering Committee, MMC, 2015, Revised DKA Workgroup 1_2016
Phase 2: Blood sugar now less than 250mg/dL (*BS <200mg/dL in pregnancy)

If Anion Gap Elevated*

- Transition to **DKA Order Set Phase 2**
  - Discontinue Phase 1 insulin infusion order and DKA nursing titration protocol from phase 1.
  - Change to fixed dose insulin infusion at suggested rate of 2.5 units/hr (Adjust as needed for individual patient with typical dose range of 0.02 to 0.05 units/kg/hr based on drip rate and response in phase 1). **Do not** discontinue insulin therapy.
  - Start dextrose containing IV fluid such as D5 ½ NS and adjust dextrose to goal blood sugar 150-200. (*100-150mg/dL IN PREGNANCY)
  - Continue to check labs regularly.
  - Reevaluate for underlying causes and consider undetected stressors/illness.

If Anion Gap Normalized*

**Non-ICU Patients**

- **Desire to continue IV insulin?**
  - Yes
  - **Insulin Naïve?**
    - Yes
    - Consider total daily dose of 0.5 u/kg with 50% given as basal.
    - **Previously Under Good Control?**
      - Yes
      - Consider resuming home basal/prandial regimen.
      - Use past 6 hours of drip rate in phase 1 to estimate daily basal requirement. Reduce by 20% for safety. Order prandial insulin.
      - **Overlap IV infusion for 2 hours with basal dose.**
        - Order correctional insulin in addition on patients.
        - Advance diet as tolerated.
    - **No**
    - **Consider total daily dose of 0.5 u/kg with 50% given as basal.**
  - No
  - **Consider total daily dose of 0.5 u/kg with 50% given as basal.**

**Critical Illness (ICU)**

- **Change to Inpatient IV Insulin Protocol**
- **RN will titrate Insulin using IIP calculator.**
- **Discontinue D5 infusion if/when appropriate.**
- **Advance diet when able/appropriate, and if eating add prandial insulin.**

*Normal Anion Gap at MMC is 5-16 meq/L for the typical patient.

Approved by DKA Committee, MMC, 12/2015

Refer to Clinical Support Tools: IV Insulin or IV to SC Insulin Transition for further guidance.
## Diagnostic Criteria for DKA/HHS*

<table>
<thead>
<tr>
<th></th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>HHS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plasma Glucose</strong> (mg/dl)</td>
<td>&gt; 250</td>
<td>&gt; 250</td>
<td>&gt; 250</td>
<td>&gt; 600</td>
</tr>
<tr>
<td><strong>Arterial pH</strong></td>
<td>7.25 – 7.30</td>
<td>7.00 – 7.24</td>
<td>&lt; 7.00</td>
<td>&gt; 7.30</td>
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<tr>
<td><strong>Serum Bicarbonate</strong> (meq/l)</td>
<td>15 to 18</td>
<td>10 to &lt; 15</td>
<td>&lt; 10</td>
<td>&gt; 18</td>
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<tr>
<td><strong>Urine Ketones</strong></td>
<td>Positive</td>
<td>Positive</td>
<td>Positive</td>
<td>Small</td>
</tr>
<tr>
<td><strong>Serum Ketones</strong></td>
<td>Positive</td>
<td>Positive</td>
<td>Positive</td>
<td>Small</td>
</tr>
<tr>
<td><strong>Serum Osmolarity</strong></td>
<td>Variable</td>
<td>Variable</td>
<td>Variable</td>
<td>&gt; 320</td>
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<tr>
<td><strong>Anion Gap</strong></td>
<td>High Normal to Elevated</td>
<td>Elevated</td>
<td>Elevated</td>
<td>Variable</td>
</tr>
<tr>
<td><strong>Change in Mental Status</strong></td>
<td>Alert</td>
<td>Alert/Drowsy</td>
<td>Stupor/Coma</td>
<td>Stupor/Coma</td>
</tr>
</tbody>
</table>

*HHS = Hyperosmolar Hyperglycemic State  
*DKA = Diabetic Ketoacidosis  
*Normal Anion Gap at MMC is 5-16 meq/L for the typical patient.

Approved by Glycemic Steering Committee, MMC, 2015

### Additional Considerations for DKA/HHS

**Diet:** Patients should be kept NPO until their blood sugar is < 250mg/dl, their anion gap has normalized, and they are feeling well enough to eat. Once through the acute phase above, patients may be offered a diet and should have prandial insulin ordered as well.  
**Hyperglycemia:** In phase 1, the desired rate of decrease is approximately 50-75 mg/dl per hour. Adjust insulin infusion based on guidelines in DKA phase 1 protocol. Additional doses of subcutaneous insulin are discouraged.  
**Hypernatremia:** Most patients presenting with DKA will be mildly hyponatremic, but occasionally patients may present with significant hypernatremia. Additionally, those with HHS may frequently present with significant hypernatremia. Treatment in these patients should begin with reconstituting intravascular volume depletion with isotonic fluid such as NS or LR. Once adequately resuscitated in the acute phase, ½ NS or other hypotonic fluid should be used to address free water depletion (see phase 1 algorithm). Patients with significant hyperglycemia at presentation may experience a rise in serum sodium during treatment. That is expected and due to osmotic shifts that occur with reduction in hyperglycemia. In cases of patients presenting with significant hypernatremia initially, where serum sodium falls early on during treatment, there is increased concern for cerebral edema, and patients should be monitored more closely.  
**Hypokalemia:** Insulin should be held while potassium is administered for patients with significant hypokalemia (K< 3.3 meq/l) until potassium has normalized. Patients with hypokalemia should have q1h potassium levels in early phase.
Hypophosphatemia: Body stores of phosphate are significantly depleted in DKA. Most patients with DKA, however, will not require phosphate repletion. Severe hypophosphatemia (≤1 mmol/dl) though can be a medical emergency. Patients whose phosphate falls to this level should be treated with IV phosphate repletion. Periodic measurement of phosphate levels during the initial treatment of DKA is reasonable.

**Glucometers:** Use of POC glucometers is the standard of care for all inpatient settings. In the ED and L&D, hourly venous blood glucose via DKA panel should be used as principal method of glucose measurement, and glucometers utilized only as a fail safe for concern of hypoglycemia or when venous specimen cannot be obtained. All patients in DKA/HHS should have hourly blood glucose monitoring while on an insulin infusion. As always, if POC glucose is registering >500mg/dL, hourly lab venous glucose will need to be ordered and utilized for insulin infusion titration. If any concerns exist regarding accuracy of POC testing, obtain a STAT lab venous blood glucose.

**Phase 2:** Once a patient’s glucose has dropped to less than 250mg/dl, a patient is considered to have passed through the initial phase of treatment (Phase 1). However, patients who continue to have an elevated anion gap (>16 meq/l) due to ongoing ketoacidosis (and not another etiology) should be continued on IV insulin therapy until the anion gap has normalized. During this phase, considered Phase 2, patients should continue to have hourly blood glucose monitoring. In order to keep their sugars stable, patients should be given a dextrose infusion for a target blood sugar range of 150-200 mg/dl. The rate of dextrose and concentration of dextrose should be adjusted as needed, but most importantly is that IV insulin should not be discontinued. The exact rate of insulin infusion may be a patient specific decision based on the rates in phase 1. However, the typical dose range in Phase 2 is 0.02 to 0.05 U/kg per hour, and 2.5 units per hour is a reasonable suggested infusion rate. Once their anion gap has closed, they may be transitioned to subcutaneous insulin (with 1-2 hour overlap with the IV infusion) or continued on IV insulin titrated using the standard inpatient insulin protocol if desired.

**Special Populations:** Certain patients who are undernourished, or pregnant may have only mild hyperglycemia in the context of DKA, but have marked anion gap elevation from significant ketoacidosis. In these patients treatment should continue as it would normally with the focus of normalizing glucose, and continuing IV insulin until the anion gap has normalized (see phase 2 above). *Pregnancy requires tighter control, initiate OB DKA Phase 1 until BG 200mg/dL, then maintain BG 100-150mg/dL on IV insulin utilizing OB DKA Phase 2 until anion gap normalized.

DKA and the Fetus
- After viability all patients should be monitored continuously for both fetal heart rate and contractions.
- Betamethasone and corticosteroids should be avoided.
- Fetuses exposed to maternal acidosis may show decreased variability and late decelerations. Ominous patterns will typically convert with correction of the maternal metabolic acidosis.

Approved by DKA Committee, MMC, 2015
Even when fetal status is questionable during the phase of therapeutic volume and plasma glucose correction, emergency cesarean section should be avoided.

If a reasonable effort has been expended in correcting the maternal metabolic disorder and the fetal status remains a concern, delivery should not be delayed.

For help call Medicine On-Call Doctor

**Diabetic Ketoacidosis**

- Diabetic ketoacidosis (DKA) in pregnancy is a medical emergency for both the mother and fetus.
- Pregnant patients with Type I diabetes are at increased risk.
- Incidence and morbidity of this complication is about 2%.
- The rate of intrauterine fetal death is about 10%.
- Precipitating factors are pulmonary, urinary or soft tissue infections, poor compliance, and unrecognized new onset of diabetes.
- Severe DKA threatens the life of both the mother and the fetus.
- Fetal well being is in jeopardy until maternal metabolic homeostasis is reestablished.
- High levels of plasma glucose and ketones are readily transported to the fetus, which may be unable to secrete sufficient quantities of insulin to prevent DKA in utero.
- DKA evolves from inadequate insulin action and functional hypoglycemia at the target tissue level. This leads to increased hepatic glucose release but decreased or absent tissue disposal of glucose.
- Glucose lacking tissues release ketone bodies, and vascular hyperglycemia promotes osmotic diuresis. The diuresis causes profound vascular volume depletion and loss of electrolytes.
- The release of stress hormones (ie. catecholemines, glucagon, growth hormone and cortisol) further impairs insulin action and contributes to insulin resistance.
- The cycle of dehydration, tissue hypoglycemia, and electrolyte depletion can lead to multisystem collapse, coma, and death.
- Early in illness, hyperglycemia and ketosis are moderate. If hyperglycemia is not corrected, diuresis, dehydration, and hyperosmolality follow. Pregnant patients in the early stages of ketoacidosis respond quickly to appropriate treatment of the initiating cause, (eg. broad-spectrum antibiotics), additional doses of regular insulin and volume replacement.
- Patients with advanced DKA usually present with typical findings:
- Hyperventilation
- Normal or obtunded mental state (depending on severity of acidosis)
- Dehydration
- Hypotension
- Fruity odor to the breath
- They may have abdominal pain, and vomiting may be prominent
- Hyperglycemia (glucose >200 mg/100mL)
- Serum ketones of 1:4 or greater