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SWEET SUCCESS: A NEWSLETTER for DIABETES AND PREGNANCY

Beyond the Numbers: Aspects of Family Counseling

Charlene Canger, MFT, LCSW

Counseling Parents about Newborn's Diabetes Risk

Diabetes is a unique chronic illness where the majority of care and responsibility occurs in the home. The family as a whole, rather than health care professionals, is the "management team" of the disease. Adhering to a philosophy of diabetes as a family disease is often useful when counseling parents about an increased risk for diabetes in their newborn (1). Increasing the overall family's understanding about lifestyle changes that benefit the children and adults. The whole family is seen as the focus of intervention with comprehensive education about

behavioral changes that positively influence glycemic control (2). Coordinating and educating the family's pediatrician about diabetes risk is another preventative measure with long-term positive implications in disease management.

Psychological impact of fetal imaging technology and parental response

Conveying what often are dire findings from prenatal ultrasound to concerned parents requires provider skill for this difficult task. Test results confront parents with life altering decisions about anomalies that are either

Continued on page 6

Sweet Success Express 2007: Charting a Course for Excellence

Predictors of Cesarean Delivery K. Berkowitz, MD

Cesarean sections are often employed to reduce the risk for birth injury and stillbirth, in women with diabetes during their pregnancies. The use of insulin alone doubles the cesarean sections rate, even when well controlled. The rate has historically been approximately 32% with diabetes. There has been an overall trend up in cesarean sections nation wide, not just in women with diabetes. The national cesarean section rate used to be 17% but it has recently increased to 30.2%.

In women with diabetes during their

pregnancy suspicion of macrosomia is one of the main reasons for a planned cesarean section. Other reasons are pre-eclampsia, ante and intrapartum testing abnormalities, labor progression abnormalities, and fetal heart rate assessment.

Overall the **stillbirth** rate in the diabetic population is 1-3%. In the normal population, and in women with DM with FBS under 90 the rate is 0.5%-0.7%. Twice weekly modified NST decreases the stillbirth rate to 0.4-0.8%. Clinically what we see are NST, BPP or modified AFI (NST with fluid measurements). The modified

Continued on page 3

What Are Normal Glucoses During Pregnancy? And Should It Be Our Goal?

Leona J. Dang-Kilduff, RN, MSN, CDE

In 2001 Parretti et al., followed non-obese and non-diabetic women's blood glucose values. She found that they had an average third trimester glucose level of 74.7 mg/dl (± 5.2). Interestingly the mean glucose value increased from 71.9 (± 5.7) to 78.3 (± 5.4). Not surprisingly 1 hour post-meal blood glucose elevations correlated closely with the increasing size of the baby.

Yogev et al., followed both obese and non-obese women without diabetes, with a continuous glucose monitoring system. Normal weight women demonstrated a mean fasting of (75 ± 12) and mean post-meal blood glucose of 110 (± 16). This profile gave a mean average of 83.7 (± 18). Most women also peaked their blood glucose at 70 minutes (± 13) from the beginning of the meal, not 60 minutes or 120 minutes. Obese women had slightly higher values. Fasting mean values were 73.2 (± 9) and the mean post-meal values were 117.6 (± 8). the overall mean was 84.2 (± 16). The post-meal peak was also delayed in obese women to an average time of 88.0 minutes (± 31). These differences, in glucose values, and length of time that BGs remain elevated, may explain why obesity alone increases the birth weight of offspring.

Gonzalez-Quintero et al., in 2007 looked at average blood glucose and complications of GDM. In women with the least complications the average FBS was 82.9 ± 7.3 verses, women with poorer control and outcomes, the FBS was 97.3 ± 11.4 mg/dl. Post-meals values were separated by meal. Breakfast values in women with the least complications, had an average BG at 1 hour post-meal of 114.3 ± 10.7 mg/dl verses women with poorer outcomes, the BG was 128.7 ± 14.8 mg/dl. Lunch values in women with the least complications had an average BG of 117.4 ± 10.4 verses women with poor control (and outcomes) the FBS was 130.5 ± 14.8 mg/dl. Dinner In women with the least complications the average FBS was 119.3 ± 9.9 verses women with poor control (and outcomes) the FBS was 132.3 ± 15.4 mg/dl. The values that are related to women with the worst outcomes were within the acceptable control range presently recommended by the American Diabetes

Association and the Sweet Success diabetes and pregnancy programs.

In 1991 Langer et al., noted that blood glucose targets could be too low and result in small babies. They monitored blood glucose before and 2 hours after meals. Average whole blood glucoses of 87 mg/dl resulted in SGA babies. This research demonstrates that there is a lower threshold where glucoses can be too low for normal fetal growth.

So are the Sweet Success recommendations too high? Maybe? Or maybe not? The blood glucose control that is presently recommended fasting and pre-meal of 65-100 mg/dl and post-meals of 110-135 mg/dl still result in complications due to abnormal blood glucose control. What level of glucose control is needed? And is intervening at lower levels going to produce the desired reduction in complications? Will it be too cost and time prohibitive? I don't want every client utilizing medication for glucose control that may have minimal affect. Yet, if that were my baby, what would I want?

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Sweet Success Express 2007: Charting a Course for Excellence

Continued from page 1

NST decreases the incidence of incidence of oligohydramnios from placental failure. Placental failure is one of the main causes of stillbirth. Induction of labor should decrease the cesarean section rate. When an induction is planned practitioners must be careful to not cause iatrogenic prematurity from inaccurate dating. For every week before a woman's due date the risk of NICU admission doubles. Macrosomia rate is tied closely to post prandial blood glucoses.

Diet controlled women begin NST after 40 weeks. The stillbirth rate after 40 weeks is doubled. Women utilizing medications begin NST or modified BPP, at 32-34 weeks and as early as 26 weeks for vascular complications.

The **pre-eclampsia** rates triple with diabetes, HTN and obesity. Insulin resistance and excessive insulin stimulates vasoconstriction, and increases the Systolic BP, and effects smooth muscle and endothelium, and trans-membranous electrolyte pumps resulting in fluid retention and vasoconstriction. All of this leads to HTN. The increased rate of pre-eclampsia results in an increased cesarean section rate and often in preterm deliveries.

Shoulder dystocia and birth trauma risk is a major indication for cesarean section. Shoulder dystocia rates are 2-6 fold increase with DM during pregnancy (or 3-4%). Macrosomia 4000 - 4500 grams is 1-10%, or >4500 gram infant is 4-20%. Yet in women with diabetes during pregnancy, with 4500 gram infants, only 55% of the shoulder dystocia was identified. The infants of women with diabetes during pregnancy change their proportions even at lower body weights.

Cesarean sections are utilized to prevent birth trauma. Estimates of fetal weight by ultrasound can be up to 1 lb off. Leopolds maneuvers in a well-trained practitioner can be more accurate but this accuracy decreases in women that weight more then 90 Kilos (198lbs). CS for macrosomia results in 3-5% maternal complications. This is much higher then the incidence of birth injuries.

Induction in itself increases the cesarean section rate, even with cervical ripening or mechanical induction. Indications for induction are: abnormal fetal heart rate

or NST; pre-eclampsia, past due, suspected macrosomia, oligohydramnios, PROM, IUGR, and maternal health. Other indications for an induction include a mother's election or the availability of a specialized NICU team and unit.

Pediatric Obesity, Insulin Resistance and Disease Risk

Jamie Davis, PhD, RD

Obesity is on the increase. This is higher in ethnic populations verses Caucasian. Insulin resistance is higher in non-Caucasian populations and this is insulin resistance is exaggerated with obesity.

Obesity related diseases are metabolic syndrome, type 2 diabetes, PCOS (polycystic ovary syndrome), non-alcoholic fatty liver disease, and some cancers (such as breast and prostate). Factors that lead to insulin resistance are puberty, gestational diabetes, genetics, obesity (visceral fat), diet, activity, and ethnicity. Both blacks and Hispanics increase their insulin response and secretion of insulin, to compensate for insulin resistance. During puberty there is a 33% decrease in insulin sensitivity regardless of obesity level. Again obesity exaggerates this decrease in sensitivity.

The reduction of calorie intake alone has not worked. Both aerobic and strength training increases insulin sensitivity. The aerobic training program was for, 40 minutes for 5 days per week. The weight resistance training consisted of 40-60 minutes 2 times per week. A dietary intervention of decreasing the glycemic load has also been successful. This included reducing sugar and increasing fiber through education. The reduction in sugar improved both BMI and insulin secretion. Both dietary and activity interventions were successful.

Diabetes, Obesity, Gastric Bypass: Care During Pregnancy

Kathleen Berkowitz, MD

Treatment of obesity before a pregnancy is recommended to decrease the associated co-morbidities, and reduce the risk for birth defects, and reduce obesity and diabetes risk in the offspring. Gastric bypass surgery has become more common, especially in women of reproductive age. The types of surgeries are: restrictive (making the stomach smaller),

Continued on page 4

Sweet Success Express 2007: Charting a Course for Excellence

Continued from page 3

mal-absorptive, or both. It is recommended that conception be delayed until weight loss is stabilized. This usually takes 12-18 months. During this time a woman is producing large amounts of ketones and mal-absorbing multiple nutrients. A woman also becomes more fertile with weight loss. Depending on the type of surgery mal-absorption maybe chronic. Nutritional issues and psychological adjustments are also occurring during the first 12-18 months post surgery. If pregnancy occurs before weight stabilizes there is an increased incidence IUGR and stillbirth. Other risk are a 30% increase in hemorrhage rate, 5% ICU admissions in the 1st month after surgery, 1-2% mortality, 30% experience gallbladder flares, and many need nutritional supplementation.

These women should have preconception or intraconception and early pregnancy care. Baseline CBC, iron, albumin, vitamin B, calcium and phosphorous levels are recommended. Vitamins should be gel caps to assist with absorption. Gastric banding may require active management. Women that have had gastric bypass surgery should never use glucola for diagnosis of GDM. Periodic capillary blood glucose monitoring is recommended. These women have delayed gastric emptying. This may mean a delayed peak in post-meals and it also increases the risk of aspiration during labor.

Pregnancy and the Pump Maribeth Inturrisi, RN, MSN, CDE

Insulin pump provides less variation, more predictable absorption, reduces hypoglycemia. With complications such as gastro paresis a combo bolus (portion up front and over time) or square wave (spread out over time) can be utilized for the delayed emptying. Glucose sensors can now communicate with insulin pumps and be utilized to tighten control more rapidly.

Diabetes and Pregnancy: Legal Risk and Hazards Robbie Pepas, CNM, MN, JD

Negligence is a deviation from the accepted standard of care, which places a person at risk. Malpractice is a professional negligence when the conduct fails to meet the legal standard of care and someone is

damaged as a result. The elements of a lawsuit are duty (actions are compared to others in similar situation), breach of duty (failure to perform to the standard), causation (connection between action and injury) and damages (actual loss). With diabetes and pregnancy most are due to birth injury and then birth defects, and perinatal morbidity and mortality. Did the treatment and evaluation a woman received meet the standard of care for a woman with diabetes during pregnancy? Were goals met? If not what was done? What was the estimated fetal weight? Based on ACOG recommendations should this woman have been induced or cesarean sectioned? Or was she induced with poor lung maturity and/or poor dating?

Translating Psychosocial/ Behavioral Findings to Practice

Leonard Jack, Jr. PhD, MSc

Individual factors consist of food and activity. Individual food factors are preferences, body weight, childhood eating patterns, food preparation skills, nutrition knowledge, etc. Activity is related to physical fitness, time, knowledge, resistance to sweat, individual preferences, safety, etc. **Institutional factors** again are food at work, church, school, lack of health facilities, fitness opportunities, etc. The next layer is **Community factors**. These are fast food, lack of supermarkets or lack of choices, food cost, crime, recreation areas, physical structure of neighborhood, etc. **National/ Industry/ Policy factors** include marketing, food assistance, food supply, zoning, physical education policies, urbanization, transportation... Each of these impacts our health. Education and changing individual behavior is not enough. This is an individual, institutional, community and national issue. Change occurs through education and change, and with repetition of an activity. Diabetes Educators need to address diabetes at all levels, this includes individual, institutional, community and national issues. Individual issues include psychosocial factors that impact diabetes self care but community, institutional and national issues also affect health. For example, a lack of fresh fruits and vegetables will limit nutrition options.

Continued on page 5

Sweet Success Express 2007: Charting a Course for Excellence

Continued from page 4

Psychosocial Counseling strategies reviewed were to first frame the teaching to match the patient's perceptions. This means incorporating beliefs and concerns. Next, fully inform patients of the purpose of interventions and when to expect effects. Suggest small changes and be specific. It is easier to add a behavior rather than eliminate an old one. Link new behaviors with old behaviors to increase acceptance and incorporation into lifestyle. Use the power of the profession and get an explicit commitment. Use a combination of strategies, use staff and referrals.

Diabetes--Pre-term labor--Childhood Caries: The Dental Connection

Diane Limbo, RN, CPNP

Poor dental health increases the incidence of preterm delivery, pre-eclampsia, and IUGR. Due to this dental health should be assessed and addressed during before and during pregnancy.

Barriers to dental health are culture, people with disabilities have competing needs to oral health, and may have health issues that decrease saliva or increase oral bacteria. Saliva protects teeth and has antibacterial enzymes and immunoglobulins. So saliva also works against bacterial growth and provides for remineralization. Primary teeth are formed by the 7th week of pregnancy and the permanent teeth are formed by 3-4 months. Risk factors for disease process are bacterial load, frequency of fermentable sugars, reduced saliva (e.g. dehydration). Protective factors are fluoride and remineralization, anti-bacterial agents, saliva and sealants. Bacteria can invade and infect cells in the mouth. This leads to proinflammatory chemicals. This results in antibodies and macrophages. This then increases the inflammatory response.

Pregnancy hormones by 2 months cause changes in the gums and make them more susceptible to disease. Gastric issues of pregnancy, such as vomiting may also affect oral health.

Early childhood caries are a result of infectious disease process caused by acquired bacteria in the infant's mouth. Oral health begins as an infant. Prevention for children include, Good nutrition, good hygiene, avoid drugs and embellishments and begin

dental care at approximately 1 year of age. This includes not letting milk pool in the infant's mouth. Once an infant has teeth their teeth need to be cleaned. Dental hygiene includes brushing 2 times per day, flossing, washing/rinsing, fluoride products, and protection such as sealants and mouth guards for sports.

Preconception Care: Project for Teens with Diabetes

Denise Charron-Prochownik, PhD, CPNP

This talk emphasized the need to begin preconception counseling early, with the onset of puberty and to reintroduce this concept at every provider contact. Two thirds of women have unplanned pregnancies. In a study of 16-21 year olds with type 1 DM, 63% don't ever remember discussing diabetes and its affects with pregnancy. Only 10% said they received preconception information. Of these 40% were sexually active. With the average age of first sexual intercourse at a mean of 15.7 years old. Ranging from 14-18 years old. In a study that asked women with type 2 DM, ages 13-21 found that 100% of these women said they knew nothing about preconception care. The preconception care program was in 3 phases. The first phase is awareness counseling. The second phase was to plan for a pregnancy (>6 months before). The third phase was in-depth preconception care (<6 months before attempting conception). This program is based on a book and DVD that is being distributed by the American Diabetes Association, written by D. Charron-Prochownik et al. In their last study they found that this program was accepted, informative, and easy to use and follow. They also saw that these women need both the introduction and annual boluses to maintain their knowledge level. Young teen girls were sexually active and engaging in high-risk behaviors that could result in unplanned pregnancies.

In a survey of health care providers they found that most did not initiate preconception care with adults and all were unprepared to introduce this topic with teens. This is now offered providers for 5.0 hours of CME/CEUs through the University of Pittsburgh web site.

Continued on page 6



Sweet Success Express 2007: Charting a Course for Excellence Continued from page 5

Tsunami-Earthquake-Hurricane: Disaster Management Diabetes and Pregnancy Robbie Prepas, CNM, MN, JD

Women with chronic disease like diabetes in pregnancy are disproportionately adversely affected by disasters and public policy does not reflect this. Most first responders and emergency organizations are not prepared for maternal child populations and especially with special needs. Women with diabetes in pregnancy are at greater risk of complications associated with their pregnancies. The medical needs of women with DM with pregnancy are predictable and consistent with the community need before a disaster. It is critical to keep mother and infants together. Breastfeeding and re-lactation or wet nursing maybe mandatory. There is increased stress, depression, psychosis, and PTSD. Sanitation and food are also issues to address. Lessons from Katrina are that crisis counseling staff and health worker burn out and post-traumatic stress surfaced, credentialing of volunteers was a problem. People wanted to help but not way of verifying their

professional status was in place. Coordination of efforts was poor. Volunteers were not directed to where their skills were needed. And last were unanticipated needs such as oxygen, apnea monitors, specialty formulas, prescriptions and mental health needs. At the web site dmat.org anyone interested in being part of a disaster management assistance team can find out how they can participate. The changed environment in a disaster is what limits access to normal medical care. The FDA has a web site now for switching between insulins. That site is <http://www.fda.gov/cder/emergancy/insulin.htm>. JDRF has a Diabetes emergency checklist on their web site.

Due to the lack of recourses and plans, for women with DM during pregnancy, we may wish to address this issue with our women so they are not left in a precarious situation in the event of a disaster.

Beyond the Numbers: Aspects of Family Counseling *Continued From Page 1*

incompatible with life or will irrevocably alter their child's and their family's future.

When confronted with the discovery of fetal abnormality, expectant parents are faced with an acute emotional trauma that can threaten their own functioning ability at the time, their developing role as parents, and their attachment to their future child. Prenatal diagnosis of malformations is widely accepted as beneficial for parents' postnatal psychological adjustment because they were prepared for the outcome (3). Yet other studies, even when controlling for other covariates, found prenatal diagnosis was a significant predictor of acute psychological distress in parents, especially mothers upon admission to a tertiary care center (4). Likewise, the remainder of the pregnancy can be fraught with underlying anxiety and uncertainty for parents as they struggle with perceived loss of control.

When parents made the decision to continue with the pregnancy they sought ongoing support from health care professionals who were able to respect their choice and help them maintain both a sense of hopefulness and normalcy. Their process of decision-making is a mix of medical information and support for their emotional needs from other parents, family and friends. Fear of health care professionals rejecting their choice is a common fear of parents and they experience much relief when met with acceptance and ongoing respect (5).

Women who make the decision to terminate a wanted pregnancy after results showing fetal abnormalities experience grief reactions similar to spontaneous pregnancy losses (6). Bereavement is often confounded by the choice involved, ambivalent feelings about screening,

Continued on page 7

Beyond the Numbers: Aspects of Family Counseling

Continued From Page 6

abortion, and disability. Parents are well aware they are making decisions for the future of their unborn child, their families, and themselves (7)

Guidelines for Counseling Parents Facing Negative Prenatal Ultrasound Findings

- Titrate the critical information of the ultrasound results with empathy and understanding for parental stress response and grief process
- Provide multiple prenatal consultations with parents whose overwhelming stress reactions may impede their ability to understand important information
- Coordinate timely with tertiary care center team (perinatologist, social worker, etc.) to ensure continuity of care for parents
- Respect and offer non-judgmental support for the parents' decision-making process if termination of pregnancy is an option (8)
- Attend to and validate the complexity of parents' reactions and emotional responses (9)
- Assess the available social supports for the parents and offer resources
- Refer to mental health professional (social worker, psychologist, etc.) if stress response is exacerbated by other familial psychosocial stressors interfering with its resolution.

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Mom worked very hard with DM 2 and had a perfect 6lbs 14 ounce, 19.5 inch baby girl!!

Conferences

Sweet Success: A Diabetes and Pregnancy Newsletter

Table of Contents

TOPIC	PAGE
-------	------

Beyond the Numbers: Aspects of Family Counseling	1,6-7
Sweet Success Express: Charting a Course for Excellence	1,3-7
What are Normal Blood Glucoses for Pregnancy? And Should These be Our Goal?	2
Conferences	8
Useful Web Sites	8

California Diabetes and Pregnancy Program

On the web at:
[www.llu.edu/llumc/
sweetsuccess](http://www.llu.edu/llumc/sweetsuccess)

January 22, 2008. Sweet Success Basic Training. Sacramento, CA. For more information call (916) 733-7053.

January 23-25, 2008. 28th Annual MCCPOP perinatal Potpourri: Reaching Out and Looking Forward. Monterey, CA. for more information go to mccpop.stanford.edu.

February 1-3, 2008. American Diabetes Association 55th Post Graduate Course. San Francisco, CA. for more information go to <http://professional.diabetes.org>.

February 6-7, 2008. Affiliate Training. Loma Linda University Children's Hospital, Loma Linda, CA. For information call Terry Kramer at (909) 558-3936.

March 5th (6:30 PM) or 6th (8:15 AM), 2008. Diabetes and Pregnancy Guest speaker Lois Jovanovic, MD. 1 CME. Please RSVP to the caldiabetes web site at: www.caldiabetes.org/events.cfm?#event_356

March 14-15, 2008. Comprehensive lactation care II: Honoring Cultural, Social and Physical Diversity. Berkeley CA. For information call Anne Garrett at (650) 573-29955 or Sue Wirth (510) 524-6917.

June 6-10, 2008. American Diabetes Association 68th Scientific Sessions. San Francisco, CA. For information go to <http://professional.diabetes.org>

August 6-9, 2008. American Association of Diabetes Educators 35th Annual Meeting. Washington, D.C. For more information go to <http://www.diabeteseducator.org/>

Useful Web Sites

Do your patients in California need help with their prescriptions. Go to the www.RxHelpforCA.org

Learn about domestic abuse and screening for it, as a professional. Go to www.endabuse.org/health. They have some wonderful materials for training staff and to use for your patients.

Diabetes information for you and your patients. Information from the latest diabetes news to recipes. <http://www.dlife.com/diabetes-news/>

California Diabetes and Pregnancy Program

