CGM in Gestational Diabetes

An emerging paradigm shift: better visibility, mixed outcome evidence, and unresolved GDM-specific percentage targets.

Four trials, different questions

GRACE · LGA primary endpoint

375 randomized; 345 with primary data. LGA: 6/170 (4%) CGM vs 18/175 (10%) SMBG; OR 0.32 (95% CI 0.10–0.87). SGA: 19% vs 13%; OR 1.59 (0.86–2.99). Funding: Dexcom. Open-label, missing outcome data, and low event counts limit certainty.

DipGluMo · Composite perinatal endpoint

302 randomized; 299 after early withdrawal; 297 with primary data. Events: 56/154 (36%) vs 50/143 (35%); adjusted OR 1.02 (0.63–1.66). Comparator: SMBG six times daily. Funding: University of Bern / Swiss Diabetes Foundation. Null result does not establish equivalence. Correction: control TAR in Table 4 = 2.3%.

Steady Sugar · TIR 63–140 mg/dL

128 randomized; 120 with CGM data. TIR: 88.6% (95% CI 82.5–94.3) vs 87.4% (79.1–93.9), p = 0.37. Both groups had CGM-informed care. Secondary LGA: 4/80 vs 7/38; NICU: 18/80 vs 17/38. Multiple comparisons and delivery exclusions limit interpretation. Funding: Dexcom.

Valent · TIR 60–140 mg/dL

111 randomized (74 / 37). TIR: 93 ± 6% vs 88 ± 14% (mean ± SD), p = 0.027. A treatment-difference CI is not supplied in the abstract. Single-center glycemic trial, not definitive evidence of neonatal benefit. Funding: Dexcom.

Targets require population labels

Blood glucose: fasting <95 mg/dL; either 1-hour postprandial <140 or 2-hour <120. These are treatment goals, not diagnostic OGTT thresholds.

T1D pregnancy CGM: TIR 63–140 mg/dL >70%; TAR >140 <25%; TBR <63 <4%; TBR <54 <1%. Routine GDM/T2D percentage targets remain unresolved.

Chukwuma Onyeije, MD / OpenMFM · September 7, 2026 · Clinical review pending

Connect the trace to a decision

Assess symptoms and device context first. A discrepant pair may matter now, while many reference pairs are needed to assess overall accuracy. Follow device instructions and meter-confirmation guidance.

Review fasting and meal-specific patterns alongside TIR. A high overall TIR can coexist with clinically relevant timing-specific elevations. HAPO supports a glucose–risk association, not a CGM dosing algorithm.

Evidence synthesis: Gautam pooled 11 GDM RCTs; Yang pooled 21 GDM studies of mixed design. Their outcome estimates are not interchangeable. Balaji's search ended in January 2025, before several major trial reports.

Implementation: Agree on selection, training, backup supplies, costs, review frequency, and contact responsibility. Evaluate benefit alongside hypoglycemia, SGA, burden, and access.

Selected references

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Targeted literature check: September 7, 2026; not a systematic search. Educational synthesis, not an individualized dosing protocol. Full references and study details appear in the companion HTML presentation.