

A Summary of Chinese Guidelines on Diagnosis and Management of Hyperglycemia in Pregnancy (2022)

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Abstract

Hyperglycemia is one of the most common complications women encounter during pregnancy, and is associated with a higher incidence of short- and long-term health risks for both the mother and offspring. In 2022, the Maternal-Fetal Medicine Committee of the Chinese Society of Obstetrics and Gynecology, Chinese Medicine Association, worked with the Chinese Society of Perinatal Medicine and the Professional Committee of Gestational Diabetes Mellitus of the Chinese Maternal and Child Health Association to update the Guidelines for the diagnosis and management of hyperglycemia in pregnancy in China. The aim was to further standardize the management of hyperglycemia in pregnancy from the aspects of screening, diagnosis, monitoring, treatment, and prevention of gestational diabetes mellitus, and consequently to further improve the health of mother and child.

Keywords: Hyperglycemia; Pregnancy; Diabetes, gestational; Guideline

Introduction

Hyperglycemia is one of the most common complications women encounter during pregnancy. It includes different types of abnormal glucose metabolism and is clearly associated with increased risks for the mother, fetus, and neonate, including macrosomia, birth injury, cesarean section, preterm delivery, and hypertensive disorders of pregnancy, as well as an increased risk of long-term metabolic syndrome in mothers and offspring. With rapidly changing socioeconomic conditions and lifestyles, and continuous adjustment of the birth policy, the occurrence of hyperglycemia in pregnancy (HIP) is on the rise in China. Standardized management beyond pregnancy can effectively break the links between hyperglycemia and adverse maternal and fetal outcomes as well as the future health risks to mother and offspring; moreover,

it is a key step in diabetes mellitus (DM) prevention under the holistic concept. Therefore, providing guidance to standardize the clinical management for screening, testing, treatment, and care of women with HIP in China is imperative, and contributes to the promotion of clinical and basic research in this field.

In 2022, the Maternal-Fetal Medicine Committee of the Chinese Society of Obstetrics and Gynecology, Chinese Medicine Association worked with the Chinese Society of Perinatal Medicine and the Professional Committee of Gestational Diabetes Mellitus of Chinese Maternal and Child Health Association to update the Guidelines for the diagnosis and management of HIP in China. The update was based on the previous two editions of the guidelines along with the most recently published high quality evidence-based clinical research, with the aim of providing clinicians with concise, evidence-based, and contemporary recommendations with supporting data to encourage their use. The 2022 China HIP Guideline systematically reviewed the clinical problems in this field and sections were divided as follows: (1) classification and diagnostic criteria, (2) preconception counseling and preconception care, (3) nutritional therapy, (4) physical activity, (5) medical therapy, (6) monitoring of glucose and lipid metabolism, (7) maternal and fetal complications, (8) perinatal health care, (9) postpartum care and follow-up, (10) prevention. All the evidence levels and recommendation grades were classified using the Grading of Recommendations, Assessment, Development, and Evaluations system (GRADE). (GRADE A: evidence supported by good and consistent scientific evidence (supported by randomized controlled trials); GRADE B: evidence for limited or inconsistent literature support (lack of randomized controlled study support); GRADE C: evidence-based primarily on expert opinion).

The purpose of the brief summary of the 2022 China HIP Guideline was to provide a synopsis of only the recommendations from the full guideline, and make some updates

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Table 1**Recommendations made by the Chinese Guideline on Diagnosis and Management of Hyperglycemia in Pregnancy (2022).**

Recommendations	Level
Part 1 Classification and diagnostic criteria of hyperglycemia in pregnancy (HIP)	
HIP includes (1) pregestational diabetes mellitus (PGDM), (2) prediabetes, including impaired fasting glucose (IFG), and impaired glucose tolerance (IGT), (3) gestational diabetes mellitus (GDM), classified as A1 and A2. GDM A1 indicates GDM can be well controlled by lifestyle management (nutritional therapy and physical activity), while GDM A2 indicates GDM requiring medication.	
1-1 Fasting plasma glucose (FPG) screening is recommended for all pregnant women at their first prenatal visit to detect any missed diagnosis of diabetes mellitus (DM) before pregnancy. Pregnant women with a FPG ≥ 5.6 mmol/L before 24 weeks of gestation are diagnosed with IFG and require intervention and management. They do not need to undergo any further oral glucose tolerance tests (OGTT) during pregnancy.	Grade B
1-2 Health education and lifestyle management should be emphasized and strengthened for pregnant women with high risk factors for GDM.	Grade B
1-3 Hemoglobin A1c (HbA1c) is not recommended for routine DM screening during pregnancy. Pregnant women with an HbA1c of 5.7%–6.4% during the first trimester are at high risk of developing GDM.	Grade C
1-4 As FPG decreases consistently with rising gestational age from 4–6 to 24–28 weeks' gestation (Zhu, 2013); pregnant women with $5.1 \leq \text{FPG} < 5.6$ mmol/L during the first trimester should not be diagnosed with GDM. Such pregnant women should undergo OGTT during 24–28 weeks' gestation, or initially undergo FPG. If FPG ≥ 5.1 mmol/L, GDM can be diagnosed directly. If FPG < 5.1 mmol/L, OGTT should be performed (Hod, 2015).	Grade B
1-5 The diagnosis of GDM is based on "one-step" 75-g OGTT during 24–28 weeks' gestation. The plasma glucose threshold values of fasting, 1 h and 2 h after OGTT was 5.1, 10.0 and 8.5 mmol/L, respectively. When any of the plasma glucose values are met or exceeded, the diagnosis of GDM should be made.	Grade A
1-6 OGTT is recommended even if the first prenatal visit is after 28 weeks' gestation.	Grade B
1-7 Criteria for the diagnosis of PGDM during pregnancy is (1) FPG ≥ 7.0 mmol/L; and/or (2) random plasma glucose ≥ 11.1 mmol/L in the presence of classic symptoms of hyperglycemia or hyperglycemic crisis; and/or (3) HbA1c $\geq 6.5\%$. (The test should be performed in a laboratory using a method that is national glycohemoglobin standardization program certified and standardized to the diabetes control and complication trial assay). With regard to considering the use of 2-h plasma glucose post 75 g OGTT ≥ 11.1 mmol/L as one criteria for PGDM diagnosis, evidence from China of 75 women diagnosed with PGDM, according to a 2-h glucose value ≥ 11.1 mmol/L after 24 weeks' gestation, who underwent an OGTT from 6 weeks to 1 year postpartum. Only eight (10.7%) women were diagnosed with DM according to the postpartum OGTT value. Moreover, 25% of women had normal postpartum OGTT values (Wei, 2020). Thus, a 2-h glucose value ≥ 11.1 mmol/L in a 75 g OGTT during pregnancy may not be suitable for diagnosing PGDM in China. Such pregnant women are recommended to be managed as GDM patients, and postpartum OGTT should be performed to clarify if any patients should be diagnosed with DM.	Grade B
Part 2 Preconception counseling and preconception care	
2-1 Women with preexisting DM (type 1 diabetes mellitus, T1DM or type 2 diabetes mellitus, T2DM), prediabetes (IFG or IGT), or a history of GDM should plan their pregnancies and accept proper preconception counseling and disease severity assessment.	Grade A
2-2 Preconception counseling and assessment should include blood glucose levels, thyroid function, risk or severity of diabetic retinopathy, nephropathy, neuropathy, and cardiovascular disease.	Grade B
2-3 Women with preexisting DM and prediabetes should be provided with individualized medical nutritional counseling, lifestyle management, and health education.	Grade B
2-4 Elevated HbA1c levels in pre and early conception are associated with increased risk of congenital anomalies. It is recommended that a target of HbA1c $< 6.5\%$ should be achieved by DM women who are planning a pregnancy.	Grade A
2-5 For women planning a pregnancy, attention should be paid to the medications being taken, including hypoglycemic and antihypertensive drugs. Those that could potentially cause harm should be replaced. Low oral doses of folic acid or folate-containing multivitamin are recommended prior to conception.	Grade C
2-6 Women with preexisting diabetic retinopathy, nephropathy, neuropathy, and cardiovascular disease should have multidisciplinary consultations prior to conception to evaluate and adjust their condition.	Grade B
Part 3 Nutritional therapy	
3-1 Women with HIP should restrict their daily calory intake during pregnancy. During early gestation, daily calory intake should not be lower than 1600 kcal/d (1 kcal = 4.184 kJ), while in middle and late pregnancy, a daily calory intake of 1800–2200 kcal/d is advised. Those who are obese before pregnancy are advised to reduce their energy intake, but not to less than 1600 kcal/d in the first trimester and to increase it moderately in the second and third trimester.	Grade C
3-2 A carbohydrate intake of no less than 175 g per day during pregnancy is recommended, which should account for 50%–60% of the total daily calories, while for obese women this should be 35%–45%. Protein intake should be no less than 70 g per day. Saturated fatty acids intake should be no more than 7% of the total daily calories.	Grade A
3-3 Trans-fats should be limited. Fiber intake should be more than 25–30 g per day.	Grade B
3-4 It is recommended that women with HIP during pregnancy should arrange three regular meals and 2–3 extra snacks a day. The energy levels of breakfast, lunch, and evening meals should be 10%–15%, 30%, and 30% of the total daily energy intake, respectively, and the energy of each additional snack should account for 5%–10%.	Grade C
3-5 Adequate vitamin and mineral intake should be guaranteed. Foods rich in iron, folate, calcium, vitamin D, and iodine, including lean meat, poultry, fish, shrimp, dairy products, fresh fruits and vegetables, should be increased.	Grade A
3-6 Pregnant women should control their gestational weight gain during pregnancy based on their pre-pregnancy body mass index (p-BMI). Women with a normal p-BMI could gain 8.0–14.0 kg during pregnancy. However, women who are overweight or obese before pregnancy should have a lower gestational weight gain during pregnancy. The recommended weight gain during pregnancy for women who are overweight before pregnancy is 7–11 kg, and 5–9 kg for women who are obese before pregnancy.	Grade C

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Recommendations	Level
Part 4 Physical activity	
4-1 Regular exercise before and during pregnancy can significantly reduce the risk of GDM in pregnant women, especially in women who are overweight or obese before pregnancy. One randomized controlled trial in China showed that the risk of GDM in overweight and obese pregnant women was decreased by 45.8% with the introduction of 3 times/week cycling from early pregnancy (Wang, 2017). Moreover, regular exercise during pregnancy can improve the blood glucose compliance rate in women with GDM and reduce the risk of an adverse outcome for mother and offspring.	Grade A
4-2 Women with uncomplicated pregnancies should have moderate physical activity for 30 min per day on at least 5 days of the week.	Grade C
4-3 Aerobic exercise and resistance training activities are both acceptable physical activities during pregnancy.	Grade C
4-4 Patients on insulin therapy during pregnancy should take precautions against hypoglycemia during exercise.	Grade C
Part 5 Medical therapy	
5-1 It is recommended that pregnant women with PGDM switch to insulin therapy for glycemic control before or during early pregnancy. Paired rapid-acting with intermediate or long-acting insulin is recommended.	Grade B
5-2 For pregnant women with GDM whose blood glucose targets cannot be met by diet and/or physical activity, or who develop starvation ketosis following diet control, but have excessive glucose levels through increasing calory intake, should undergo timeous insulin therapy.	Grade C
5-3 The following forms of insulin are considered safe to be used during pregnancy: ultra-rapid-acting insulin, rapid-acting insulin, medium-acting insulin, and long-acting insulin.	Grade B
5-4 Insulin regimen should be formulated according to the results of blood glucose monitoring during pregnancy.	Grade B
5-5 Principles of addition and adjustment of insulin: insulin regimen should be individualized according to the results of each patient's blood glucose monitoring. According to the glucose targets combined with the weight of pregnant women, the adjustment of insulin should be based on the principle that every 2–4 U insulin reduces blood glucose by 1 mmol/L. Be alert to hypoglycemia when adding insulin to pregnant women with T1DM.	Grade C
5-6 For pregnant women with T2DM and GDM A2, insulin resistance needs to be considered, metformin can be added to reduce insulin resistance.	Grade C
5-7 The efficacy and near-term safety of metformin during pregnancy has been shown to be similar to that of insulin. If pregnant women are unable to use insulin (refuse to use insulin or are unable to safely inject insulin), metformin can be used instead.	Grade A
5-8 Metformin has been shown to cross the placental barrier, reaching fetal circulation. However, no obvious adverse effects of metformin on offspring have been found.	Grade B
5-9 Metformin is contraindicated in pregnant women with T1DM, hepatic and renal insufficiency, heart failure, diabetic ketoacidosis (DKA) and acute infection.	Grade B
Part 6 Monitoring of glucose and lipid levels in HIP women	
6-1 Pregnant women with hyperglycemia should use a micro blood glucose meter to monitor their fasting and postprandial blood glucose levels. Preprandial blood glucose level should also be monitored for pregnant women with PGDM, and those who use an insulin pump or basic insulin injection.	Grade B
6-2 Continuous glucose monitoring (CGM) helps to achieve an optimum level of HbA1c and reduce the risk of macrosomia and neonatal hypoglycemia in pregnant women with T1DM.	Grade B
6-3 CGM cannot replace self-monitoring of blood glucose to achieve optimum blood glucose control.	Grade C
6-4 Encourage and gradually standardize the application of minimally invasive, non-invasive, remote, and other new blood glucose monitoring technologies in pregnancy.	Grade C
6-5 For pregnant women with GDM A1 with good self-monitoring of blood glucose, the monitoring frequency should include fasting and postprandial blood glucose at least once a week, and GDM A2 should monitor fasting and postprandial blood glucose at least twice a week.	Grade C
6-6 PGDM (including T1DM and T2DM) whose blood glucose is not well controlled are recommended to conduct daily self-monitoring of blood glucose and record fasting, preprandial, and postprandial blood glucose. If blood glucose is well controlled, the monitoring frequency can be adjusted appropriately.	Grade C
6-7 Nocturnal blood glucose should be measured at the initial stage of insulin application during the onset of nocturnal hypoglycemia, when the dosage of insulin before sleep is increased but FPG is still poorly controlled.	Grade C
6-8 The optimal targets for blood glucose control in pregnant women with GDM or PGDM are: FPG <5.3 mmol/L, 1 h postprandial plasma <7.8 mmol/L or 2 h postprandial plasma <6.7 mmol/L, avoid a nocturnal blood glucose <3.3 mmol/L.	Grade B
6-9 Pregnant women with PGDM should monitor their HbA1c level at least once in the first, second, and third trimester of pregnancy.	Grade C
6-10 Pregnant women with GDM A2 should have their HbA1c evaluated before receiving medical therapy.	Grade C
6-11 For those without significant hypoglycemia during pregnancy, the HbA1c target in pregnancy is ideally less than 6%. However, the target can be appropriately relaxed to less than 7% if necessary to prevent hypoglycemia.	Grade B
6-12 Pregnant women with HIP should monitor their lipid levels. The level of serum lipids in pregnancy is higher than that in non-pregnancy, which is an adaptive change for mothers to give priority to the supply of nutrition to the fetus. However, an abnormal lipid level increase during pregnancy is associated with an adverse pregnancy outcome.	Grade C
6-13 The monitoring of thyroid function of pregnant women with HIP should be strengthened. At present, there is no unified standard for monitoring frequency. If conditions permit, it can be tested once in the first and second trimesters of pregnancy respectively.	Grade C
6-14 Urine ketone bodies should be timeously monitored during the treatment of HIP.	Grade C
6-15 When pregnant women with HIP have unexplained symptoms such as nausea, vomiting, or fatigue, complicated by hyperglycemia, they should be highly alert to the occurrence of DKA, and monitor their blood and urine ketone body levels.	Grade C
Part 7 Maternal and fetal complications	
7-1 If pregnant women with HIP have unexplained nausea, vomiting, fatigue, headache or even coma, they should be highly alert to the occurrence of DKA.	Grade B

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Recommendations	Level
7-2 When a random blood glucose level is higher than 11.1 mmol/L, blood and urine ketone bodies should be monitored. When ketosis occurs, blood gas analysis is recommended to make a clear diagnosis.	Grade C
7-3 Once the diagnosis of DKA is confirmed, a multidisciplinary consultation should be organized to control DKA with intravenous fluid infusion and continuous intravenous pumping of low dose insulin.	Grade B
7-4 Be alert to hypoglycemia during pregnancy; it is common in women with T1DM and T2DM.	Grade B
7-5 A random blood glucose of pregnant women with HIP should not be lower than 3.3 mmol/L.	Grade C
7-6 Monitoring of related infections should be strengthened in pregnant women with HIP.	Grade C
7-7 For PGDM with poor blood glucose control before pregnancy or in early pregnancy, prenatal screening of the fetus should be performed by ultrasound in the first and second trimester of pregnancy. Attention should be given to the development of the fetal central nervous system and heart. If conditions permit, a fetal echocardiography is recommended.	Grade C
7-8 Fetal growth is recommended to be assessed by dynamic monitoring after 20 weeks of gestation; for pregnant women with poor blood glucose control and insulin treatment, B-ultrasound should be performed every 4 weeks in the third trimester of pregnancy to identify fetal growth abnormalities early.	Grade C
7-9 Dexamethasone should be given to pregnant women with HIP to promote fetal lung maturation if there is a chance of preterm birth, and blood glucose monitoring should be strengthened. Routine invasive fetal lung maturity testing is not recommended.	Grade C
7-10 Women with HIP should have their amniotic fluid volume monitored by dynamic ultrasound. If excessive amniotic fluid is found, fetal structural anomalies should be excluded and the monitoring frequency of blood glucose should be increased.	Grade C
7-11 For pregnant women with GDM A1, fetal heart rate monitoring should be started from 36 weeks of gestation.	Grade C
7-12 For pregnant women with GDM A2 or PGDM, fetal monitoring should be started at 32 weeks of gestation. If other high-risk factors are combined, the monitoring of gestational age could be further advanced.	Grade C
Part 8 Perinatal healthcare	
8-1 For pregnant women with GDM A1 whose blood glucose is well controlled after diet and exercise intervention, it is recommended to deliver the fetus at 40–41 weeks of gestation.	Grade C
8-2 For pregnant women with GDM A2 who need insulin treatment and whose blood glucose is well controlled, it is recommended to deliver the fetus at 39–39 ⁺ ₆ weeks of gestation.	Grade C
8-3 For PGDM whose blood glucose is well controlled and without any other maternal and fetal complications, it is recommended to deliver the fetus at 39–39 ⁺ ₆ weeks.	Grade C
8-4 For PGDM with microvascular disease, poor blood glucose control or a history of adverse labor, the timing of pregnancy termination should be individualized.	Grade C
8-5 HIP itself is not an indication for cesarean section delivery, and the choice of delivery mode should be determined according to the health of mother and infant.	Grade B
8-6 When HIP is accompanied by severe microvascular disease or other obstetric indications, cesarean section is feasible.	Grade C
8-7 The indications for cesarean section can be appropriately relaxed if the blood glucose during pregnancy is not well controlled and if the fetal weight estimated by ultrasound is ≥ 4000 g, or if there is a history of fetal death or stillbirth.	Grade B
8-8 If insulin treatment is required during labor or the perioperative period, intravenous insulin should be used to avoid hyperglycemia or hypoglycemia.	Grade C
8-9 Blood glucose level must be measured every 1–2 h before surgery, and during delivery or surgery, and a low dose insulin intravenous drip should be maintained according to blood glucose levels.	Grade C
8-10 During the period before a normal diet is recovered after cesarean section, those women who used insulin during pregnancy should be given an intravenous infusion with a ratio of insulin to glucose of 1:6–1:4. At the same time, the blood glucose levels and urinary ketone bodies will be monitored to determine whether to use or adjust the amount of insulin according to the test results.	Grade C
8-11 If insulin is used during pregnancy, blood glucose monitoring should be carried out as soon as a normal diet is recovered after delivery. If blood glucose is obviously abnormal, insulin should be injected subcutaneously. After delivery, the dosage of insulin should be adjusted and reduced according to the blood glucose level.	Grade C
8-12 Newborns of mothers with HIP are high-risk infants for hypoglycemia. Routine neonatal care should be provided immediately after delivery, and hypoglycemia symptoms should be noted.	Grade A
8-13 The blood glucose level of the newborn should be monitored regularly, with the first monitoring time being after the first feeding (within 1.5 h after birth) and then once every 3–6 h before feeding within 24 h after birth.	Grade B
8-14 The optimal blood glucose monitoring targets for newborns are: blood glucose level within 4 hours of birth ≥ 2.2 mmol/L; blood glucose level within 24 h ≥ 2.6 mmol/L.	Grade B
Part 9 Postpartum care and follow-up	
9-1 All HIP women should be encouraged to breastfeed.	Grade B
9-2 GDM is associated with an increased risk for T2DM, and follow-up should be carried out for all GDM mothers.	Grade B
9-3 Women with a history of GDM should be screened at 4–12 weeks postpartum, using the 75 g OGTT. Women should also be tested every 1–3 years thereafter if the 75 g OGTT is normal. The diagnosis of diabetes should be according to nonpregnancy criteria.	Grade B
9-4 For women with pre-diabetes diagnosed during postpartum follow-up, lifestyle intervention and/or metformin should be initiated to prevent the occurrence of diabetes.	Grade A
Part 10 Prevention of GDM	
10-1 High risk factors of GDM include race and maternal factors; for example advanced age, overweight or obesity before pregnancy, excessive weight gain during pregnancy, polycystic ovary syndrome, family history of diabetes, history of GDM, delivery history of macrosomia, multiple pregnancies, and hypertensive disorder during pregnancy.	Grade C
10-2 The prevention of GDM includes diet, exercise, inositols, and vitamin D supplementation, which may play a role in the prevention of GDM.	Grade B

(Table 1). The overall goal was to inform overseas readers regarding the current guidelines used for the diagnosis and management of HIP in China. The complete reference for the full 2022 China HIP Guideline, used for grades and advice, can be found in the SDC file (<http://links.lww.com/MFM/A24>).

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Conflicts of Interest

None.

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