

Diabete Gestazionale - Esiti Ostetrici e Salute Futura
Bonarcado, Sa Mola Hotel - 20 ottobre 2017

Documento FIGO (International Federation of Gynecology and Obstetrics) e linee guida internazionali

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The International Federation of Gynecology and Obstetrics (FIGO) Initiative on gestational diabetes mellitus: A pragmatic guide for diagnosis, management, and care[#]

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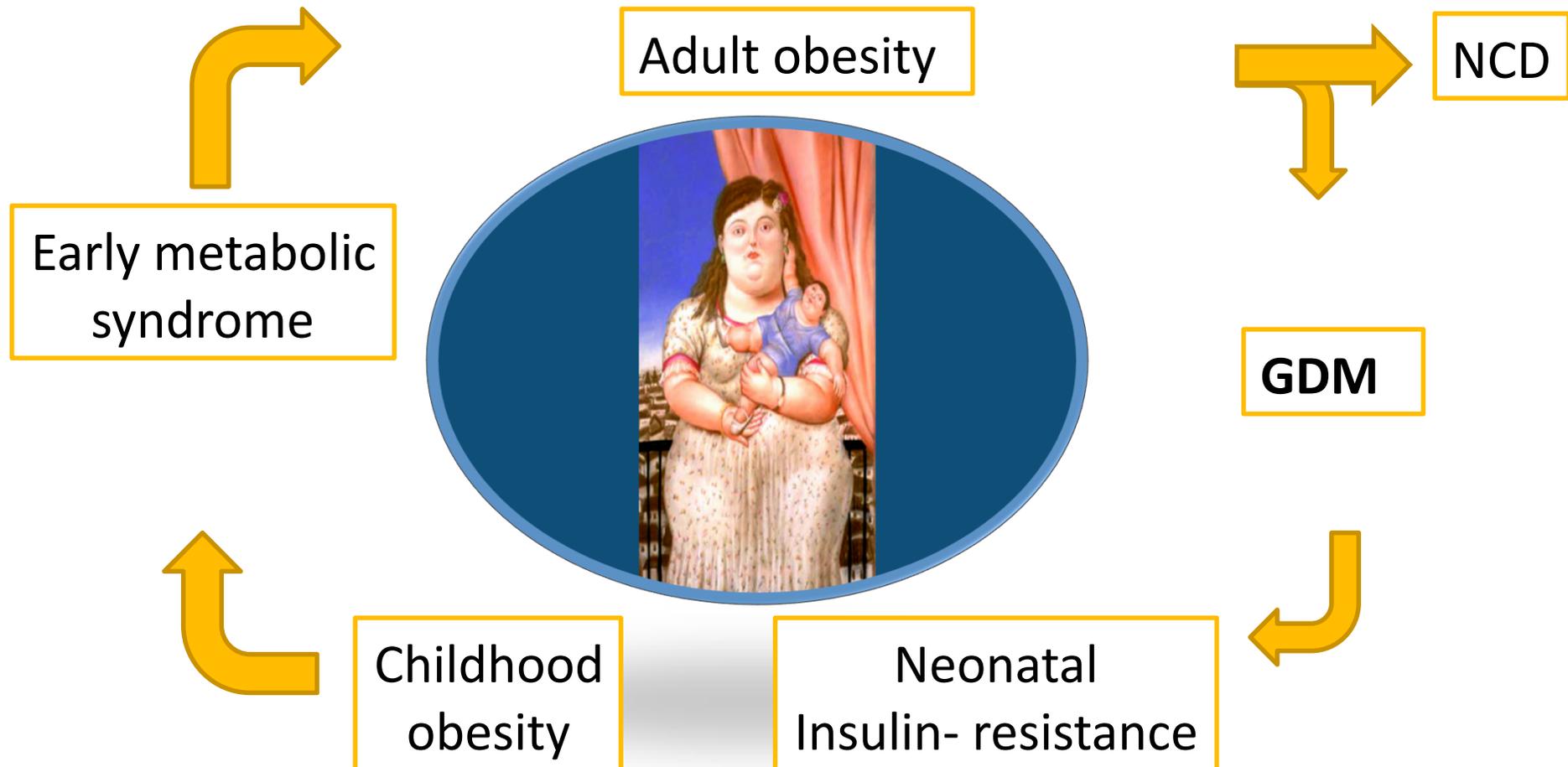


NCD epidemic

Obesity, Diabetes, Hypertension, Metabolic Syndrome & Pregnancy

The vicious cycle

Predictable and Preventable?



When Does The Malady Kick Start?

SGA or
•Gestational
Diabetes
•LGA



In adult life
elevated risk for:

- Obesity
- Cardiovascular disease
- Diabetes



Intergenerational
transfer of risk



It starts with a healthy pregnancy

Femal gender: the key for Diabetes prevention?

Lise Kingo, 6th International Symposium on Diabetes in Pregnancy, 2011

FIGO recognize that:



Obstetrician have a huge role to play!

- **Primary prevention**

Obesity/PCO's – lifestyle interventions

- **Secondary prevention**

GDM diagnosis and care

- **Tertiary prevention**

Prevent long term complications



www.figo.org

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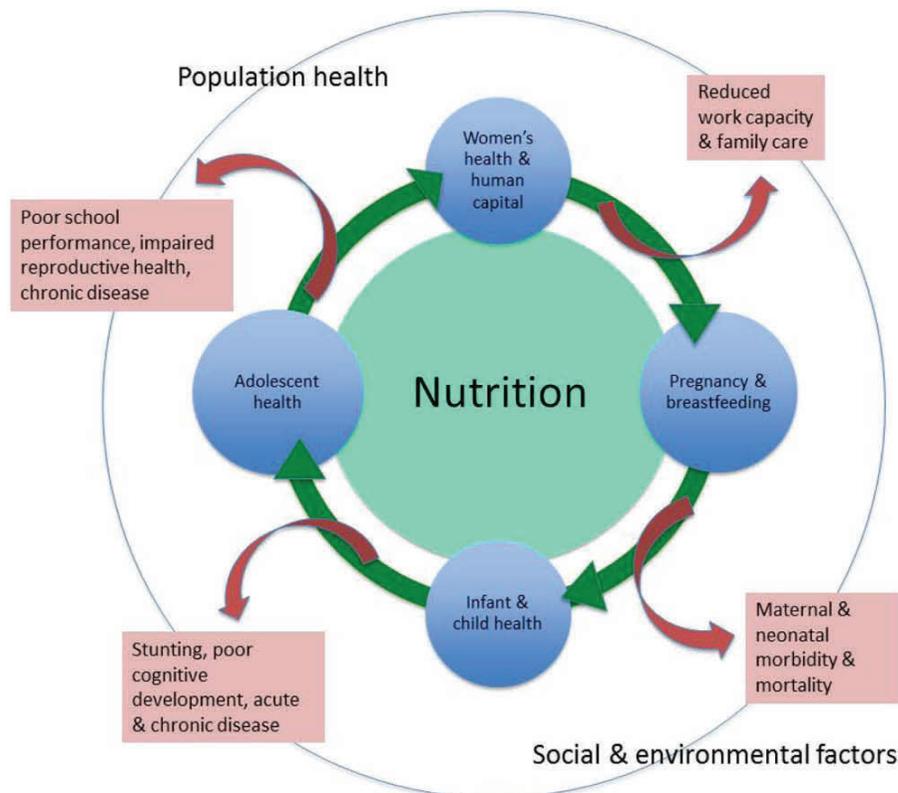
The International Federation of Gynecology and Obstetrics (FIGO) recommendations on adolescent, preconception, and maternal nutrition: “Think Nutrition First”#

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“Nutrition is a public health issue that affects females across their lifetime and that can even affect the health of future generations of children they bear”

The issue of nutrition

Nutrition has been traditionally neglected as an **essential component** of the healthcare system, especially for women and children



But...

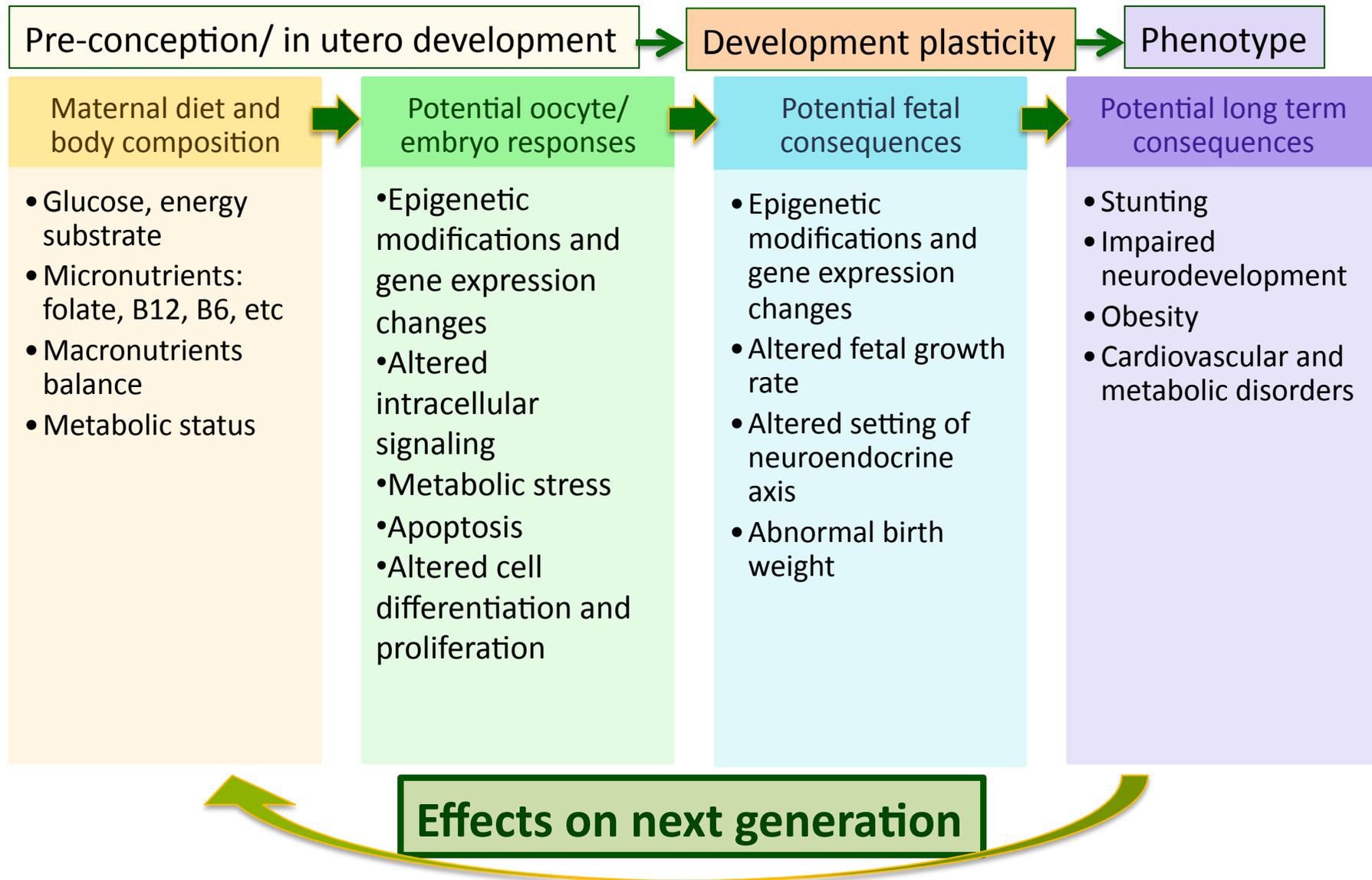
it has a **central role** in determining health across the lifetime course and in the economy of all countries



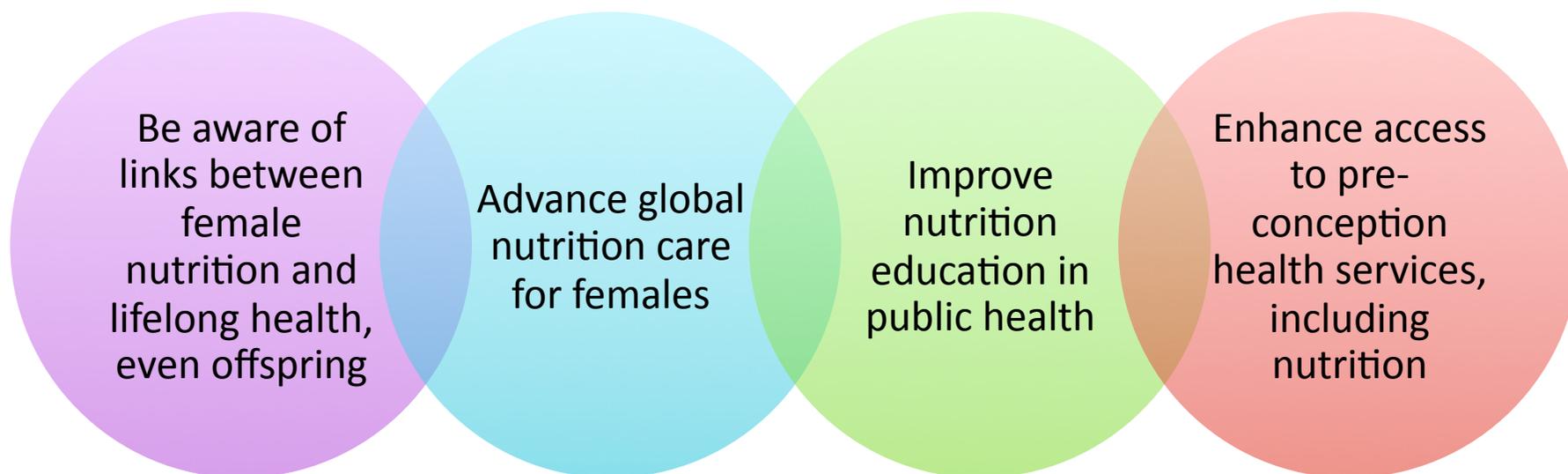
FIGO

INTERNATIONAL FEDERATION
OF
GYNECOLOGY & OBSTETRICS

The importance of preconception and maternal nutrition



FIGO issues a call to action for improving nutritional health in girls and women



Think Nutrition first!

FIGO's objective

- 1) To raise awareness of the links between poor maternal and fetal outcomes as well as to the future health risks to mother and offspring, and demand a clearly defined global health agenda to tackle this issue;
- 2) To create a consensus document that provides guidance for testing, management and care of women with GDM regardless of resources setting and to disseminate and encourage its use

Suggestions are provided for a variety of different regional and resource settings based on their financial, human, and infrastructure resources, as well as for research priorities to bridge the current knowledge and evidence gap.



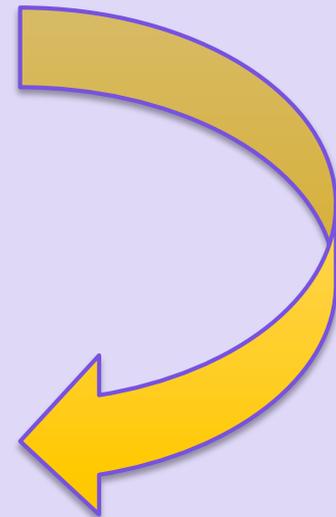
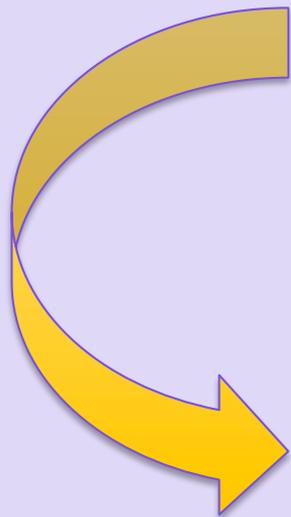
The challenge:

Limited high-quality evidence

High level of acceptability, feasibility, ease of implementation

- Current global standards
- Pragmatic recommendations

Significant impact



Quality assessment of evidence

1= strong recommendation (“we recommend”); 2= weak recommendations (“we suggest”)

Table 2

Interpretation of quality of evidence levels according to GRADE. ^a

Level of evidence	Definition
High ⊕⊕⊕⊕	We are very confident that the true effect corresponds to that of the estimated effect.
Moderate ⊕⊕⊕○	We are moderately confident in the estimated effect. The true effect is generally close to the estimated effect, but it may be slightly different.
Low ⊕⊕○○	Our confidence in the estimated effect is limited. The true effect could be substantially different from the estimated effect.
Very low ⊕○○○	We have very little confidence in the estimated effect. The true effect is likely to be substantially different from the estimated effect.

^aAdapted with permission from Balshem et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011;64(4):401-6. Copyright Elsevier (2011).

The FIGO Initiative on Gestational Diabetes Mellitus

Target audience

Healthcare providers

(obstetricians, diabetologists, endocrinologists, internists, pediatricians, neonatologists and general practitioners, midwives, nurses, advance practice clinicians, nutritionists, pharmacists, community health workers, laboratory technicians, etc)

Healthcare delivery organizations and providers

(governments, federal and state legislators, healthcare management organizations, health insurance organizations, international development agencies, and nongovernmental organizations)

Professional organizations

(international, regional, and national professional organizations of obstetricians and gynecologists, endocrinologists, diabetologists, internists, family practitioners, pediatricians, neonatologists, and worldwide national organizations dedicated to the care of pregnant women with diabetes.

Diagnosing Gestational Diabetes Mellitus

“In most parts of low-, lower middle-, and upper middle income countries (which contribute to over 85% of the annual global deliveries), the majority of women are either not screened or improperly screened for diabetes during pregnancy—even though these countries account for 80% of the global diabetes burden as well as 90% of all cases of maternal and perinatal deaths and poor pregnancy outcomes.”

Diagnosing Gestational Diabetes Mellitus

Selective versus universal screening

Variations in risk factors have resulted in different approaches, generally with poor sensitivity and specificity. The major problem of risk factorbased screening is its high demand on the healthcare providers with more complex protocols for testing, which result in lower compliance by both patients and healthcare providers.

In practice, slightly over half of the women with GDM have one or more of these risk factors, supporting the contention that identification of women who have GDM requires testing of **all pregnant women**

Diagnosing Gestational Diabetes Mellitus

FIGO adopts and supports the IADPSG/WHO/IDF position that **all pregnant women** should be tested for hyperglycemia during pregnancy using a one-step procedure.

FIGO encourages all countries and its member associations to adapt and **promote strategies to ensure universal testing** of all pregnant women for hyperglycemia during pregnancy

Diagnosing Gestational Diabetes Mellitus

FIGO adopts the WHO (2013) and IADPSG (2010) criteria for diagnosis of gestational diabetes mellitus.

Given the resource constraints in many low-resource countries, other strategies described here in are considered equally acceptable.

Diagnosing Gestational Diabetes Mellitus

Table 4

Options for diagnosis of gestational diabetes mellitus based on resource settings.

Setting	Strategy			Grade
	Who to test and when	Diagnostic test	Interpretation ^a	
Fully resourced settings	All women at booking/first trimester	Measure FPG, RBG, or HbA1c to detect diabetes in pregnancy		1 ⊕⊕⊕○
	24–28 weeks	If negative: perform 75-g 2-hour OGTT		
Fully resourced settings serving ethnic populations at high risk ^b	All women at booking/first trimester	Perform 75-g 2-hour OGTT to detect diabetes in pregnancy		2 ⊕○○○
	24–28 weeks	If negative: perform 75-g 2-hour OGTT		
Any setting (basic); particularly medium- to low-resource settings serving ethnic	All women between 24 and 28 weeks	Perform 75-g 2-hour OGTT		1 ⊕⊕⊕○

Nutritional therapy

Box 9

Recommendations for nutrition therapy in women with gestational diabetes mellitus.

Recommendations	Resource setting	Strength of recommendation and quality of evidence
<p>We recommend that the following principles should be adhered for all pregnant women with diabetes:</p> <ul style="list-style-type: none"> • Design an appropriate diet with respect to prepregnancy BMI, desired body weight, physical activity, habits, and personal and cultural preferences. • Provide routine follow-up and diet adjustments throughout pregnancy to achieve and maintain treatment goals. • Offer training, education, support, and follow-up by a qualified dietician experienced in care of women with diabetes. Issues for discussion include: weight control, food records, carbohydrate counting, prevention of hypoglycemia, healthy foods, and physical activity. 	All	1 ⊕⊕○○
<p>We suggest that caloric intake be calculated based on prepregnancy BMI and desirable weight gain as follows:</p> <ul style="list-style-type: none"> • 35–40 kcal/kg desirable body weight for underweight women • 30–35 kcal/kg desirable body weight for normal weight women • 25–30 kcal/kg desirable body weight for overweight women 	All	2 ⊕⊕○○
<p>We recommend limiting carbohydrate intake to 35%–45% of total calories, with a minimum of 175 g carbohydrate per day, distributed in three small-to-moderate sized meals and 2–4 snacks.</p>	All	1 ⊕⊕⊕○
<p>For obese women, caloric intake may be reduced by 30%, but not below 1600–1800 kcal/d</p>	All	2 ⊕⊕○○
<p>For women with diabetic nephropathy, protein may be lowered to 0.6–0.8 g/kg ideal body weight</p>	All	2 ⊕○○○

Box 10

Recommendations for physical activity in women with gestational diabetes mellitus.

Recommendations	Resource setting	Strength of recommendation and quality of evidence
<p>We suggest that appropriate, personally adapted, physical activity be recommended for all women with diabetes:</p> <ul style="list-style-type: none">• Planned physical activity of 30 min/day• Brisk walking or arm exercises while seated in a chair for 10 min after each meal.• Women physically active prior to pregnancy should be encouraged to continue their previous exercise routine.	All	2 ⊕⊕○○

✓ FIGO recognizes that nutrition counseling and physical activity are the primary tools in the management of GDM.

✓ FIGO recommends that women with GDM receive practical nutrition education and counseling that empowers them to choose the right quantity and quality of food.

✓ Women with GDM must be repeatedly advised to continue the same healthy eating habits after delivery to reduce the risk of future T2DM.

Management of hyperglycemia during pregnancy

“There is insufficient evidence concerning the optimal frequency of blood glucose testing of GDM. Based on the data available the general recommendation is four-times daily glucose monitoring performed at fasting and either at 1-hour or 2-hour intervals after each meal. Once the patient’s glucose levels are well-controlled by her diet, the frequency of glucose monitoring can be modified.

In its 2015 clinical practice recommendations, the ADA encourages pre- and postprandial monitoring of blood glucose but does not recommend a specific frequency of testing.”

Box 5

Recommendations for glucose monitoring in women with gestational diabetes mellitus.

Recommendations	Resource setting	Strength of recommendation and quality of evidence
<p>Self-monitoring of blood glucose is recommended for all pregnant women with diabetes, 3–4 times a day:</p> <ul style="list-style-type: none"> • Fasting: once daily, following at least 8 hours of overnight fasting • Postprandial: 2-3 times daily, 1 or 2 hours after the onset of meals, rotating meals on different days of the week 	All	2 ⊕⊕○○
<p>Self-monitoring of blood glucose is recommended for all pregnant women with diabetes at least once daily, with documented relation to timing of meal</p>	Low	2 ⊕○○○

Management of hyperglycemia during pregnancy

Box 6

Recommendations for glycemic targets for gestational diabetes mellitus.^a

Recommendations	Resource setting	Strength of recommendation and quality of evidence
Targets for glucose control during pregnancy: <ul style="list-style-type: none"> • Fasting glucose <5.3 mmol/L (95 mg/dL) • 1-hour postprandial <7.8 mmol/L (140 mg/dL) • 2-hour postprandial <6.7 mmol/L (120 mg/dL) 	All	1 ⊕⊕○○
Educate to recognize and treat signs of hypoglycemia: <ul style="list-style-type: none"> • Ingest 15 g of simple carbohydrate (sugar, rapidly absorbed tablets, sweetened liquids) 	All	1 ⊕⊕⊕⊕
Teach family members how to use the glucometer	All	2 ⊕⊕○○
Target for glucose control during labor and delivery: <ul style="list-style-type: none"> • 4–7 mmol/L (72–126 mg/dL) 	All	1 ⊕⊕⊕⊕

^a Source: American Diabetes Association [30].

Pharmacological treatment

Box 11

Recommendations for pharmacological treatment in women with gestational diabetes mellitus.

Recommendations	Resource setting	Strength of recommendation and quality of evidence
<p>Insulin, glyburide, and metformin are safe and effective therapies for GDM during the second and third trimesters, and may be initiated as first-line treatment after failing to achieve glucose control with lifestyle modification. Among OADs, metformin may be a better choice than glyburide [109].</p>	All	2 ⊕⊕○○
<p>Insulin should be considered as the first-line treatment in women with GDM who are at high risk of failing on OAD therapy, including some of the following factors [129]:</p> <ul style="list-style-type: none"> • Diagnosis of diabetes <20 weeks of gestation • Need for pharmacologic therapy >30 weeks • Fasting plasma glucose levels >110 mg/dL • 1-hour postprandial glucose >140 mg/dL • Pregnancy weight gain >12 kg 	High	2 ⊕⊕○○

Box 12

Recommendations for insulin treatment in women with gestational diabetes mellitus.

Recommendations	Resource setting	Strength of recommendation and quality of evidence
<p>The following insulins may be considered safe and effective treatment during pregnancy: regular insulin, NPH, lispro, aspart and detemir.</p>	All	1 ⊕⊕⊕○

Management of hyperglycemia during pregnancy

Box 1

Recommendations for prenatal supervision in women with gestational diabetes mellitus.

Recommendations	Resource setting	Strength of recommendation and quality of evidence
Routine prenatal care should include visits to: <ul style="list-style-type: none"> Healthcare professionals skilled in care of women with diabetes in pregnancy (obstetrician, perinatologist, diabetologist, diabetes educator, nutritionist etc): 1-3 weeks as needed Nurse: Weight, blood pressure, dipstick urine protein: 1-2 weeks as needed 	High	1 ⊕○○○
Prenatal follow-up determined locally according to available resource: <ul style="list-style-type: none"> A minimum of monthly check-ups with a healthcare provider knowledgeable in diabetes in pregnancy 	Mid and Low	2 ⊕○○○

Management of hyperglycemia during pregnancy

Box 2

Recommendations for fetal growth assessment in women with gestational diabetes mellitus.

Recommendations	Resource setting	Strength of recommendation and quality of evidence
Clinical and sonographic growth assessments every 2–4 weeks from diagnosis until term	High	1 ⊕○○○
Periodic clinical and sonographic growth assessments from diagnosis until term	Mid and Low	2 ⊕○○○

Box 3

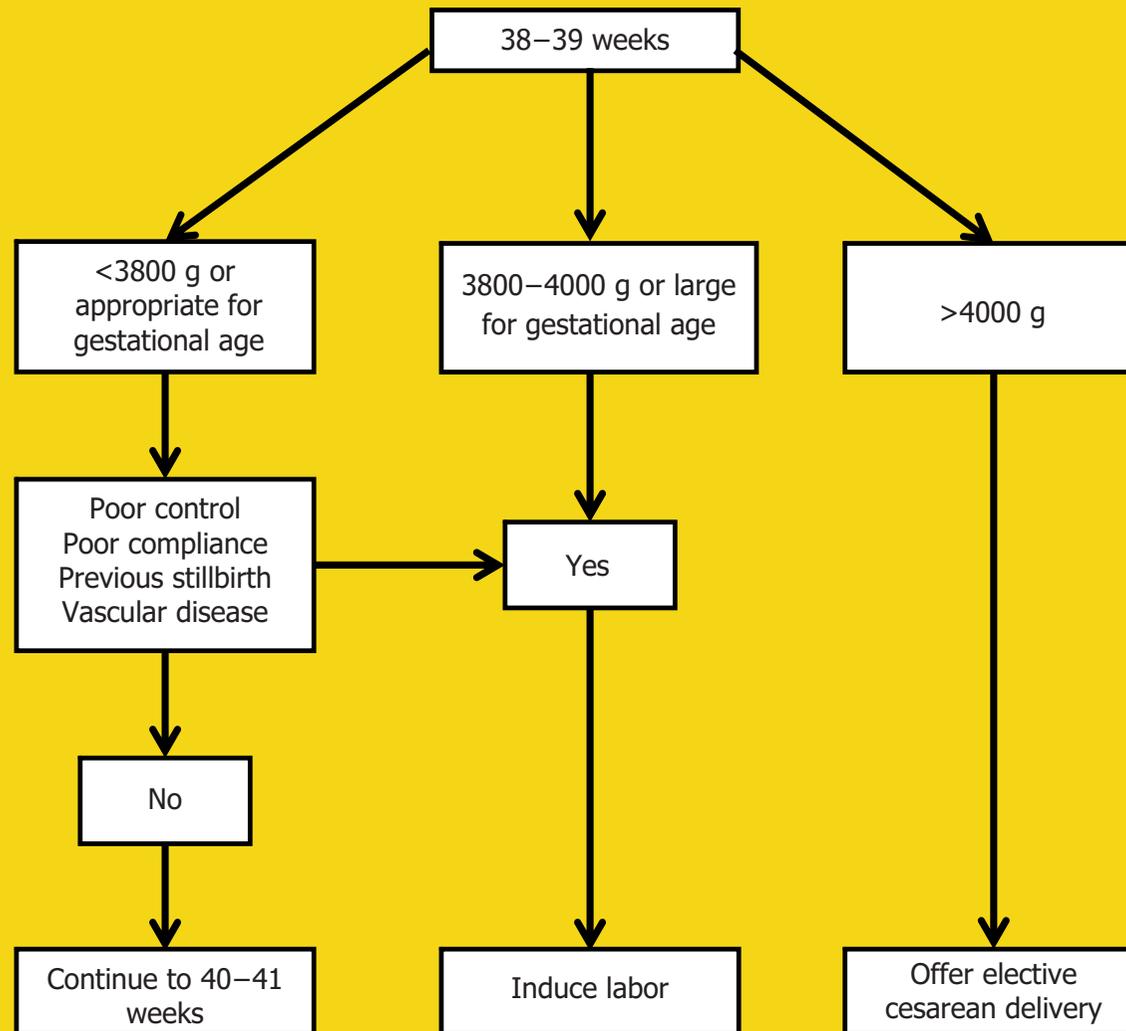
Recommendations for fetal well-being surveillance in women with gestational diabetes mellitus.

Recommendations	Resource setting	Strength of recommendation and quality of evidence
Use cardiotocography and/or biophysical profile or kick-count as indicated according to local protocol	All	1 ⊕○○○

Box 4

Recommendations for timing and mode of delivery in women with gestational diabetes mellitus.

Recommendations	Resource setting	Strength of recommendation and quality of evidence
As per local protocol or as suggested in Figure 4	All	2 ⊕○○○



Postpartum management

The glycemic status should be re-evaluated with a 75-g oral OGTT at 6–12 weeks after delivery

FIGO supports the concept that the postpartum period in women with GDM provides an important platform to initiate **early preventive health for both the mother and the child** who are both at a heightened risk for future obesity, metabolic syndrome, diabetes, hypertension, and cardiovascular disorders.

Women should be advised to maintain a healthy lifestyle with an appropriate diet, regular exercise, and normal body weight.

1 of 4

FIGO INITIATIVE ON GESTATIONAL DIABETES

FIGO recommends that hyperglycemia/ Gestational Diabetes Mellitus (GDM) be considered a global health priority



Hyperglycemia is one of the **most common medical conditions** women encounter during pregnancy



1 in 6 live births occur to women with some form of hyperglycemia

84% of which are due to GDM



HYPERGLYCEMIA/GDM IS ASSOCIATED WITH:

- Leading causes of **maternal mortality**
- Higher incidence of **maternal morbidity**
- Higher incidence of **perinatal and neonatal morbidity**
- **Later long term consequences** for both mother and child



GDM IS ON THE RISE GLOBALLY

Low and middle income countries account for:

- 85%** of the annual **global deliveries**
- 80%** of the **global diabetes burden**
- 90%** of all cases of **maternal and perinatal deaths and poor pregnancy outcomes**

PREGNANCY OFFERS A WINDOW OF OPPORTUNITY TO:

- **Establish services**
- **Improve health**
- **Prevent intergenerational transmission** of non-communicable diseases

TO WORK TOWARDS ACHIEVING SUSTAINABLE DEVELOPMENT GOAL (SDG) 3

Given the link between hyperglycemia in pregnancy, poor pregnancy outcome, and future risk of diabetes in both mother and offspring, a focus on **prevention, screening, early diagnosis and managing hyperglycemia** in pregnancy is needed globally



Taken from The International Federation of Gynecology and Obstetrics (FIGO) Initiative on Gestational Diabetes Mellitus: A Pragmatic Guide to Diagnosis, Management and Care. Int J Gynecol Obstet 2015;131(Suppl 3):273-272. The FIGO GDM Initiative (Phase 1) was funded with an unrestricted educational grant from Novartis.

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FIGO INITIATIVE ON GESTATIONAL DIABETES

FIGO recommends universal testing—all pregnant women should be tested for hyperglycemia during pregnancy using a one-step procedure

WHY TEST DURING PREGNANCY?

- **Maternal and newborn outcomes** depend on maternal glycemic control
- Testing is the **only route to diagnosis** and management
- Testing only women with 'risk factors' will **miss half of the women** with GDM
- Accounting for long term benefits and outcomes show that universal testing is **cost effective**

SUCCESSFUL DIAGNOSIS

Diagnosis is best using lab results of **VENOUS PLASMA SAMPLES** but using a plasma calibrated **HAND HELD GLUCOMETER** is also acceptable

Use **WHO** diagnosis criteria

Pragmatic guides for testing, diagnosis and management must be based on each country's available:

- Finances**
- Human Resources**
- Infrastructure Resources**

All countries have an obligation to implement the best testing and management practices they can!



These 8 countries account for 55% of global live births and 55% of the global burden of diabetes

PRIORITY COUNTRIES: India, China, Nigeria, Pakistan, Indonesia, Bangladesh, Brazil and Mexico



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FIGO INITIATIVE ON GESTATIONAL DIABETES

FIGO recommends that all countries provide the best GDM management possible given available resources

Aims:

- FREQUENT FOLLOW UP**
- ANTENATAL CARE** with a GDM trained healthcare provider
- SELF-MONITORING BLOOD GLUCOSE** for all pregnant women with diabetes

LIFESTYLE MANAGEMENT

Nutrition counselling and physical activity are **KEY** to reduce risk of future obesity, type 2 diabetes, and cardiovascular diseases

PHARMACOLOGICAL MANAGEMENT

If lifestyle modification alone fails to achieve glucose control, **metformin, glyburide, or insulin** are safe and effective treatment options

Fetal sonographic assessment can help determine size of the baby and diagnose fetal macrosomia (the most frequent complication of GDM)

Baby well-being should be assessed through a simple **fetal kick count** technique or when resources are available through **biophysical profile** including cardiotocography

Pregnancy with good glycemic control and appropriate size fetus can continue until **40-41 weeks**

Elective cesarean delivery may be recommended if fetal weight exceeds **4000 grams**

Post-delivery the newborn must be **carefully observed** for respiratory distress and hypoglycemia



Taken from The International Federation of Gynecology and Obstetrics (FIGO) Initiative on Gestational Diabetes Mellitus: A Pragmatic Guide to Diagnosis, Management, and Care. Int J Gynecol Obstet 2015;131(Suppl 3):273-272. The FIGO GDM Initiative (Phase 1) was funded with an unrestricted educational grant from Novartis.

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FIGO INITIATIVE ON GESTATIONAL DIABETES

FIGO recommends using the postpartum period for increased engagement to improve health for mother and child



EARLY DETECTION of infections



SUPPORT of breastfeeding



ADVICE on pregnancy spacing



RETEST all women with GDM at 6-12 weeks postpartum



Future blood glucose TESTS

The postpartum period is an important platform to **initiate early preventive health** for both the mother and the child who are both at higher risk of:

- **Future Obesity**
- **Metabolic Syndrome**
- **Diabetes**
- **Hypertension**
- **Cardiovascular Disorders**

Both lifestyle intervention and metformin can be effective in **delaying or preventing diabetes** in women with impaired glucose tolerance and a history of GDM

Obstetricians to link with other healthcare providers to support postpartum follow-up through **child vaccination/regular health visits**

AIMS FOR PRECONCEPTION & INTER-PREGNANCY INTERVALS

- Increase acceptance and access to preconception services**
- Universal pre-conception screening** for malnutrition, anemia, overweight and obesity, hypertension, diabetes and thyroid dysfunction



Taken from The International Federation of Gynecology and Obstetrics (FIGO) Initiative on Gestational Diabetes Mellitus: A Pragmatic Guide to Diagnosis, Management, and Care. Int J Gynecol Obstet 2015;131(Suppl 3):273-272. The FIGO GDM Initiative (Phase 1) was funded with an unrestricted educational grant from Novartis.



DIP2017

*The 9th International Symposium on
Diabetes, Hypertension, Metabolic Syndrome and Pregnancy*

Maternal Medicine meets Fetal Medicine



FETAL MEDICINE BARCELONA

MARCH 8-12, 2017 • BARCELONA, SPAIN

*The Barcelona Declaration On Hyperglycemia in
Pregnancy For Europe*



EUROPEAN ASSOCIATION OF
PERINATAL MEDICINE



FIGO
INTERNATIONAL FEDERATION
OF
GYNECOLOGY & OBSTETRICS

*The Barcelona Declaration On Hyperglycemia
in Pregnancy For Europe*



Herby declare

That maternal obesity and HIP is a significant public health challenge impacting maternal, newborn and child health and the future burden of type 2 diabetes and cardio metabolic disorders globally and in Europe.

That until and unless urgent action is taken to systematically address the issue, it has the potential to undo the gains in maternal and newborn health and worsen the ongoing diabetes and obesity epidemic.

That focusing on maternal obesity and HIP provides a unique opportunity to integrate services, to lower traditional maternal and peri natal morbidity and mortality indicators and address inter-generational prevention of NCDs such as obesity, diabetes, hypertension, CVD and stroke

That we resolve to address the challenges posed by the rising rates of hyperglycemia in pregnancy and maternal obesity and to convert them into opportunities for improved health outcome for mothers and the future generation of Europeans.

And to this effect,

We, Herby Agree

To undertake actions in our various capacities to support efforts to address the link between maternal health obesity and diabetes as a public health priority

To accelerate the implementation of the FIGO GDM initiative ([http://www.ijgo.org/issue/S0020-7292\(15\)X0015-4](http://www.ijgo.org/issue/S0020-7292(15)X0015-4)) in Europe, including by pursuing supportive policy actions and mobilizing resources for its implementation.

To support efforts to increase public awareness about hyperglycemia in pregnancy and its impact on maternal and child health, encourage preconception counseling, antenatal care and post-natal follow up.

To promote and celebrate a National GDM Awareness Day as an instrument to bring public attention and raise awareness of the problem

To support and encourage task shifting, role based training to build capacity for prevention, early diagnosis, and treatment of HIP and continued engagement with the high risk mother child pair over a prolonged time period.

To advocate for access to uninterrupted diagnostic supplies, medications and trained manpower for diagnosis and appropriate management for HIP at all levels of care at affordable costs keeping the pregnant women's convenience in mind.

To ensure that as a minimum, all pregnant women in Europe attending health facilities are tested for hyperglycemia using a single-step procedure, as advocated by FIGO.

To make all efforts to support post-partum follow up and engagement of the high risk mother child pair post-GDM pregnancy linked to the child's vaccination program by engaging and collaborating with other health care professionals.

To help develop, support and carry out a robust research agenda that fuels both the discovery of new tools and procedures to improve point of care diagnostics, monitoring and management of HIP and the ability to engage, counsel and track the mother-child pair over the long term; as well as carry out operational research to improve collaboration and efficacy in existing programs, keeping in mind the health care delivery realities in different parts of Europe.

Barcelona, March 2017

Trasformare una situazione difficile in opportunità: la chiave per spezzare il circolo vizioso

"All'inizio è stata dura, avevo troppa fame la notte. Col passare di mesi invece ho avuto una bellissima sorpresa: niente più fame ma piacere per i nuovi cibi (pasta e pane integrale, tanta verdura e legumi). Non ho più toccato cibi fritti e merendine confezionate di cui prima andavo ghiotta, ma soprattutto le mie glicemie si sono stabilizzate e ho raggiunto un peso forma ottimale: solo 6 Kg a 38 settimane! Non posso che essere felice. Continuerò questa dieta in allattamento e oltre perché come disse Winston Churchill "il successo non è definitivo e l'insuccesso non è fatale. L'unica cosa che conta davvero è il coraggio di continuare". Grazie!" R.F.



Grazie per l'attenzione