INTRODUCTION

In the pre-insulin era,diabetes in females was associated with reduced fertility. The untreated disease frequently led to atrophic changes in the genital organs, with ammenorrhoea and anovulation. In recent years, the incidence of diabetes with pregnancy has been increasing. This is probably due to two factors; first : with increased experience in diabetic control, more diabetic women retain normal fertility and, second : diabetes is diagnosed more frequently and at an earlier stage than before (Brown and Dixon, 1980).

Pregnancy provides an excellent opportunity for abnormal carbohydrate metabolism (Drury et al., 1977). Subclinical, or so - called chemical diabetes is known to increase the perinatal mortality (O'Sullivan et al., 1973). Therefore, screening of pregnant females for diabetes mellitus in antenatal clinics is important.

Risk factors for gestational diabetes were used in screening pregnant women for gestational diabetes by 23 groups of workers, starting with Wilkerson and Remein in 1957.

Leading the factors are history of a perinatal loss or large baby in a previous pregnancy or a family history of diabetes and glycosuria in the current pregnancy (Border and Knowles, 1981). This approach to screening for diabetes has however, two disadvantages, first: a large number of unnecessary glucose tolerance tests are performed, as approximately one in three antenatal patients has potential features of diabetes in her history and, second: chemical diabetes may arise in women without potential diabetic features (Gillmer et al., 1980).

The frequency of detection of abnormal carbohydrate metabolism in a pregnant population screened on the basis of clinical or historical risk factors for gestational diabetes has been shown to be no higher than that determined among the general pregnant population screened routinely (O'Sullivan et al., 1973 - Lavine et al., 1981).