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Efficacy of Continuous Glucose Monitoring in Diabetic Pregnancy: A Systematic Review

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ABSTRACT

High levels of blood glucose during pregnancy cause complications such as macrosomia and neonatal health problems. Intermittent finger-prick tests and HbA1c levels are usually ineffective at detecting sudden changes and glycemia spikes. We prepared a systematic review of the literature from Jan-2016 to Nov-2025, which evaluates whether Continuous Glucose Monitoring (CGM) yields better results than the common standard of care in Type 1 Diabetes (T1D) and Gestational Diabetes Mellitus (GDM). The goal was to determine if using this technology reduced the incidence of large-for-gestational-age (LGA) infants and whether Time-in-Range (TIR) is a better predictor of fetal health than the traditional HbA1c marker. For the T1D, the data are clear. CGM has emerged as the standard, consistently fostering glycemic stability needed to curb excessive birth weight. In GDM, the therapeutic value of the CGM and the systems used depends on the timing of the intervention. It has the greatest impact when deployed during the early gestational window or utilized as the primary driver for insulin titration. An important finding across all groups is that TIR is a far more accurate predictor of fetal growth than HbA1c, which can often appear normal even when dangerous glucose spikes are occurring. The shift from intermittent to continuous monitoring is a major improvement in obstetric care. CGM allows for the detection of hidden high and low blood sugar trends that standard testing misses. This review supports the expanded adoption of CGM in diabetic pregnancies.

Keywords: Continuous Glucose Monitoring, Type 1 Diabetes, Gestational Diabetes Mellitus, Time in Range (TIR).

1. INTRODUCTION

Hyperglycemia during pregnancy, including both T1D and GDM, is still one of the most important risk factors for adverse perinatal outcomes, which is modifiable. The main pathophysiological concern is maternal hyperglycemia, which facilitates excessive transplacental glucose transfer and stimulates fetal pancreatic beta-cell function. Maternal hyperglycemia can lead to fetal hyperinsulinemia, which

stimulates fetal overgrowth, leading to LGA infants or macrosomia, and increases the risk of neonatal hypoglycemia, shoulder dystocia, and subsequent admission to the Neonatal Intensive Care Unit (Feig et al., 2017; Voormolen et al., 2018). That is why preserving strict maternal euglycemia is the basis of obstetric management.

The basis of standard obstetric practice is capillary-based monitoring and glycated hemoglobin (HbA1c). These tests might not be enough to monitor the metabolic changes that occur during pregnancy. The main disadvantage of Self-Monitoring of Blood Glucose (SMBG) is that it provides only a brief insight into glycemia. The silent nocturnal drops or rapid post-meal spikes that could influence fetal outcomes are therefore often missed (Kytö et al., 2024).

Physical changes occur during pregnancy to quickly adapt to the high demands of a growing fetus. They include increased erythropoiesis and hemodilution. Such changes may result in an artificial drop in HbA1c values. These changes make HbA1c an insufficient indicator of real-time stability as well as a less reliable marker (Scott et al., 2020). HbA1c values within the range can create a sense of clinical security. However, the mother may present with optimal HbA1c levels and remain subject to high-velocity glucose oscillations that quietly fuel fetal macrosomia and disproportionate growth (Rademaker et al., 2023).

The beginning of the usage of CGM and FGM marks a change in prenatal care. Unlike SMBG, these devices measure interstitial fluid glucose every 5 to 15 minutes, generating data that allows for the calculation of TIR. The definition of TIR is the percentage of time that is spent within the target glucose range of 63–140 mg/dL (3.5–7.8 mmol/L) (Feig et al., 2016). Evidence suggests that TIR is a better prognostic marker than HbA1c and shows a stronger linear correlation with neonatal birth weight and LGA risk (Scott et al., 2020).

It is important to acknowledge that the clinical application of CGM is not the same across different types of diabetes. In T1D pregnancy, the CONCEPTT trial established CGM as the standard of care and demonstrated clear reductions in LGA rates and neonatal morbidity (Feig et al., 2017). On the other hand, the role of CGM in GDM remains a matter of debate and trials. Over the years, they have produced conflicting results. Possible reasons for that included differences in study populations or the lack of standardized therapy (Voormolen et al., 2018; Lane et al., 2019). However, recent randomized controlled trials published between 2023 and 2025 have begun to question this view. Analyses involving newer-generation sensors showed benefits when CGM is used in insulin-treated GDM (Valent et al., 2025). These benefits occur especially when it is initiated early during the gestation period (Elkind-Hirsch et al., 2025) or used to actively direct therapeutic escalation (Majewska et al., 2023; Lai et al., 2023; Wei et al., 2016). It is also important to consider the economic burden and feasibility of these interventions across different medical systems (Ahmed et al., 2021; Amylidi-Mohr et al., 2025).

Given the rapid evolution of this technology and the publication of multiple trials over the last five years, there is a need to synthesize the current evidence. This systematic review intends to evaluate the efficacy of CGM compared to standard SMBG in improving perinatal outcomes in both T1D and GDM pregnancies. Furthermore, it aims to assess the prognostic value of TIR metrics relative to traditional HbA1c in predicting fetal macrosomia.

2. REVIEW METHODS

Protocol and Registration

We conducted this systematic review according to the 2020 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) standards. We designed the review protocol a priori to evaluate the efficacy of CGM versus SMBG in pregnancies complicated by pre-existing or gestational diabetes. We conducted a literature search of the PubMed database, which involved articles published between January 2016, and November 2025. The search strategy used Medical Subject Headings (MeSH) as well as free-text keywords related to three domains:

1. "Diabetes, Gestational", "Diabetes Mellitus, Type 1", "Pregnancy in Diabetics".
2. "Continuous Glucose Monitoring", "Flash Glucose Monitoring", "Time in Range", "Glucometrics".
3. "Fetal Macrosomia", "Large for Gestational Age", "Birth Weight", "Pregnancy Outcome".

Additionally, we manually screened the reference lists of included studies and relevant review articles to identify eligible studies that the electronic search missed.

Inclusion Criteria

Studies were selected based on the following framework:

1. Studies investigating the use of Real-Time Continuous Glucose Monitoring (rt-CGM) or Flash Glucose Monitoring (FGM) for any duration during pregnancy in pregnant women diagnosed with T1D or GDM. The comparison was made towards standard care comprising intermittent capillary SMBG or HbA1c monitoring alone.

2. The primary outcome of concern was neonatal macrosomia or LGA infants (defined as birth weight >90th percentile).
3. Secondary outcomes considered were neonatal hypoglycemia, admission to the Neonatal Intensive Care Unit (NICU), preeclampsia, and maternal glycemic metrics (TIR 63–140 mg/dL).
4. Randomized Controlled Trials (RCTs), post-hoc analyses of RCTs, and prospective observational studies with a control group.
5. We included only peer-reviewed studies in the review.

Exclusion Criteria

1. We excluded case reports, editorials, conference abstracts without full text, animal studies, and studies using retrospective data where we could not verify the specific type of glucose monitoring.
2. Language other than English.
3. Studies that do not meet academic standards.

Study Selection

We imported the retrieved records into reference management software and removed the duplicates. Full-text articles of potentially relevant studies were subsequently retrieved and assessed for eligibility. We resolved disagreements regarding inclusion through consensus. The initial search consisted of 253 records. 184 records remained after applying filters, and we screened them based on titles and abstracts, excluding 156 articles that did not meet the study criteria. We retrieved 28 full-text articles and assessed for eligibility. We later excluded 14 due to the absence of specific neonatal outcomes (e.g., LGA or macrosomia) or of specific glucometric data. Finally, 14 studies met all inclusion criteria. The PRISMA flow diagram illustrates the selection process (Figure 1).

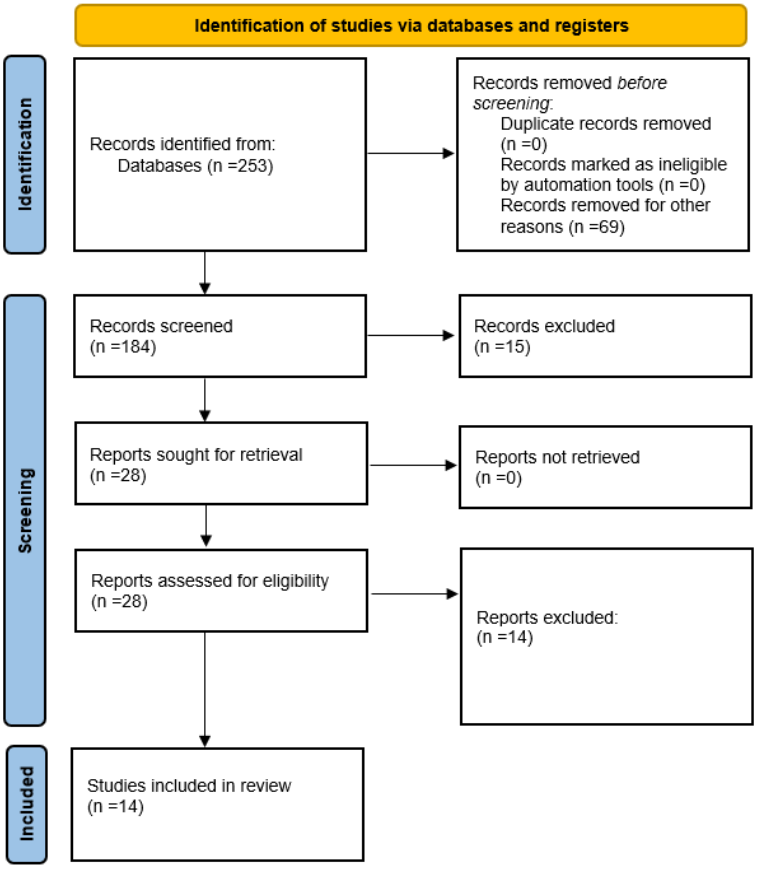

Figure 1. PRISMA chart

We collected the following data:

1. First author, year of publication, country, study design, and sample size.

2. Type of diabetes (T1D vs. GDM), mean baseline HbA1c, and gestational age at enrollment.
3. Type of sensor used
4. Incidence of LGA/macrosomia, definition of TIR used (e.g., 63–140 mg/dL vs. 70–180 mg/dL), and statistical associations between glucometrics and neonatal anthropometry.

Domains assessed included the randomization process, departures from described interventions, lack of outcome data and the reason for it, measurement of the outcome, and selection of the reported result. The researchers did not blind the participants in the studies. Due to differences in study designs, populations evaluated, interventions, and devices, a meta-analysis was considered inadequate. That is why we decided to conduct a narrative synthesis. Results were stratified by diabetes type (T1D vs. GDM) and by the specific comparison (Clinical Efficacy of Device vs. Prognostic Value of Biomarkers). This stratification approach enabled careful evaluation of how different technological techniques influence perinatal outcomes.

3. RESULTS & DISCUSSION

Efficacy in Type 1 Diabetes (T1D)

The multicenter CONCEPTT trial dominates the evidence for T1D. Feig et al., (2017) demonstrated that the use of rt-CGM during pregnancy was associated with a modest but clinically significant improvement in HbA1c (Mean Difference - 0.19%) and an increase in TIR by 7%. We calculated it to be approximately 1.7 hours per day. This change not only increased the TIR, a mere value, but most importantly improved neonatal outcomes and demonstrated that it can make a real difference for expecting mothers with diabetes. The CGM participants of the studies had a significantly lower incidence of LGA infants (Odds Ratio 0.64) and lower rates of neonatal hypoglycemia than the SMBG group. More analyses reinforced these findings:

Temporal Precision

Scott et al., (2020) analyzed temporal glucose profiles from the CONCEPTT cohort and found that nocturnal glucose control was a key driver of fetal overgrowth—a metric often missed by standard capillary monitoring. Figure 2 presents the comparison between SMBG and CGM.

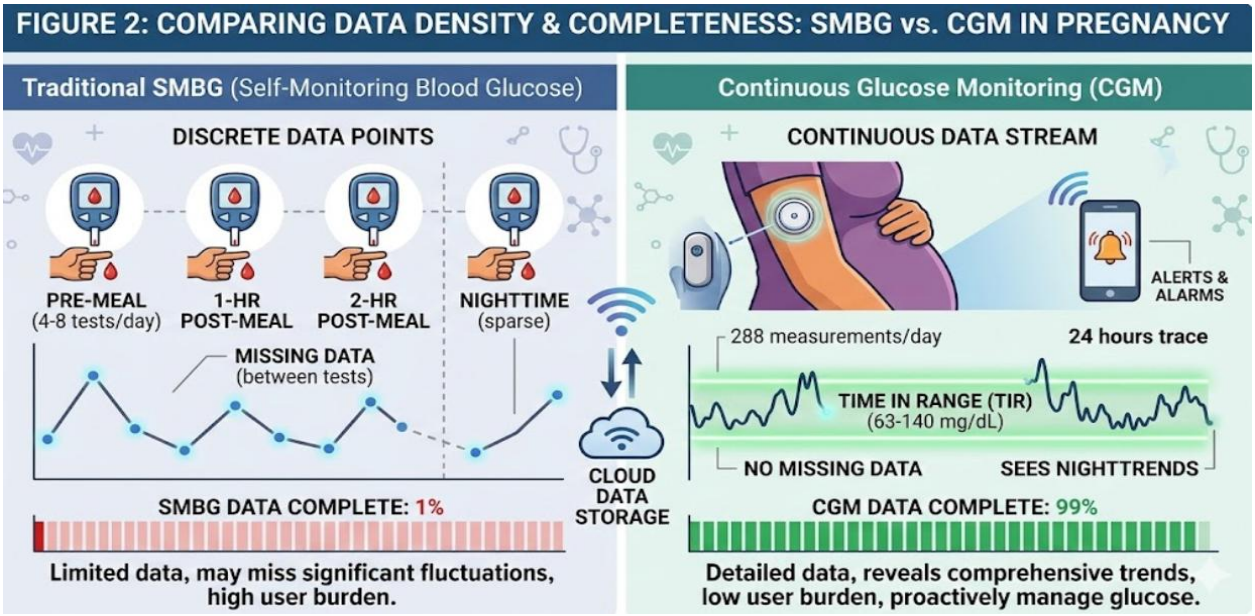

Figure 2. Comparison of SMBG and CGM

Economic Viability

Ahmed et al., (2021) conducted a cost analysis. The finding led to the conclusion that while CGM sensors entail an upfront cost, the reduction in NICU admissions (an approximately 1-day reduction in length of stay) can help offset costs in high-risk populations.

Efficacy in Gestational Diabetes Mellitus (GDM)

The impact of CGM on GDM outcomes showed diversity in the timing of initiation across populations studied (diet-controlled vs. insulin-treated). The GlucoMOMS trial (Voormolen et al., 2018) initially reported no significant difference in macrosomia rates between CGM and SMBG groups in a mixed cohort. Also, Lane et al. (2019) highlighted that device adherence is a critical confounder; without consistent sensor wear (>70% of the time), clinical benefits are not sufficient.

Taking into consideration trials conducted after 2023 that used advanced sensors demonstrated clear benefits. Over time, scientists develop better technology, and the growing volume of gathered information enables them to improve the sensors they use and create more advanced ones. The Steady Sugar trial (Elkind-Hirsch et al., 2025) and the study by Valent et al., (2025) found that earlier CGM implementation during pregnancy is beneficial for GDM patients. Early implementation of CGM may lead to a reduction of neonatal complications, morbidity, and LGA rates. The FLAMINGO trial (Majewska et al., 2023), however, showed that FGM might not reduce macrosomia in low-risk populations. It is valuable, though, as it detects significantly more hyperglycemic spikes than SMBG, prompting earlier therapeutic escalation. The data correspond with findings by Wei et al., (2016) and Lai et al. (2023), who observed lower rates of preeclampsia and macrosomia when pregnant women used CGM data to modify treatment actively.

Prognostic Value of Time-in-Range (TIR) vs HbA1c

In both T1D and GDM, TIR was a better predictive marker. Rademaker et al., (2023) analyzed the GlucoMOMS trial. Higher TIR (63–140 mg/dL) was significantly associated with appropriate birth weight. However, HbA1c did not manage to distinguish between risk categories and was often within the normal range. Scott et al., (2020) further quantified this, showing that a 5-7% increase in TIR is linearly associated with improved neonatal health.

The Shift from "Monitoring" to "Management"

The findings of this systematic review reinforce a critical evolution in obstetric diabetology: the device is not simply a monitor but a management tool. The studies established the efficacy of CGM in T1D. Feig et al., (2017) provided evidence strong enough to change the guidelines. On the other hand, in the literature on GDM, the most dynamic findings occur. The contrast between the neutral results of Voormolen et al., (2018) and the positive outcomes of recent trials, such as Elkind-Hirsch et al., (2025), highlights that the benefit of CGM in GDM depends on the actual usage of the data. Wearing the device itself is not enough. It has to lead to action. The main clinical benefits occur when women use the data to titrate insulin or introduce lifestyle changes. It is especially important as it can reduce postprandial spikes of blood glucose and nocturnal variability (Majewska et al., 2023; Valent et al., 2025). Figure 3 summarizes the key benefits of CGM.

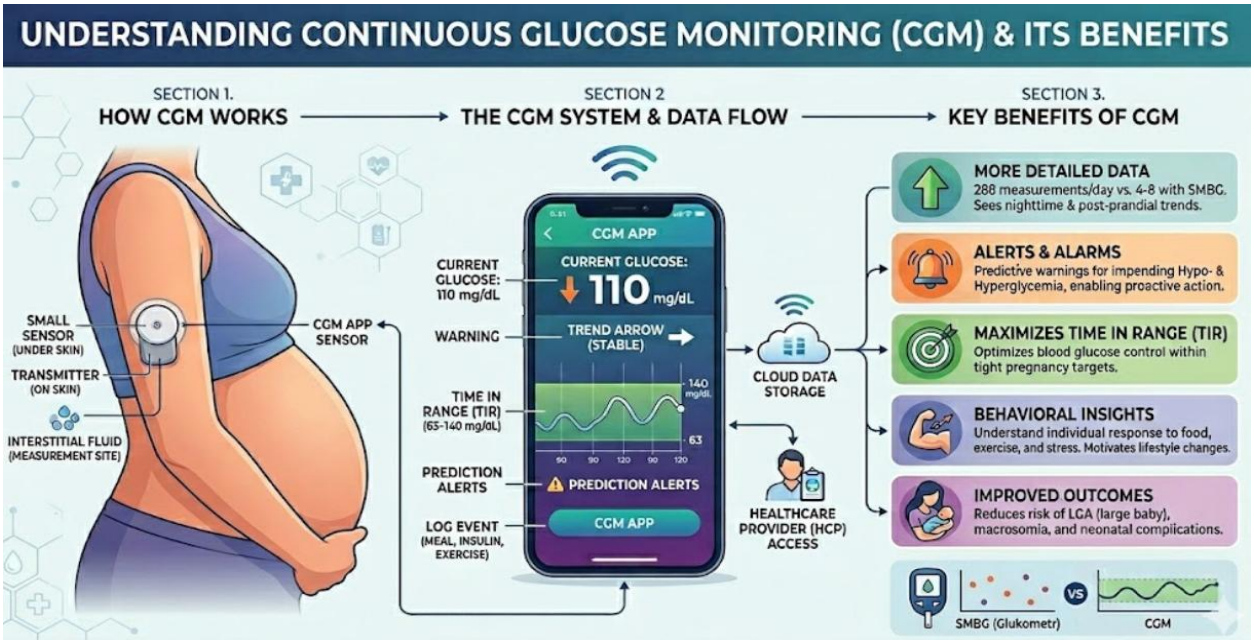

Figure 3. Key benefits of CGM

TIR vs HbA1c

Diabetes management during pregnancy should not fully and solely rely on HbA1c levels. It is very useful before conception, but with physiological changes, such as hemodilution and altered red blood cell kinetics, it can sometimes lead to false HbA1c results (Scott et al., 2020). The studies found that TIR (63–140 mg/dL) correlates more strongly with LGA than HbA1c (Rademaker et al., 2023). The clinical implication for obstetricians is that they should focus more on maximizing TIR rather than only HbA1c targets, as TIR captures the glycemic variability that drives fetal hyperinsulinemia.

Digital Adherence and Feasibility

Kytö et al., (2024) and Amylidi-Mohr et al., (2025) demonstrated that digital tools increase patient engagement, which is crucial to a holistic approach towards the treatment of diabetes. In GDM, dietary adherence is important, and immediate biofeedback from a CGM tracing can more effectively strengthen positive behavioral changes than a logbook of numbers.

Future Research

For the reasons mentioned in the review, healthcare providers should support the reimbursement and prescription of CGM devices not simply for T1D but also for high-risk GDM pregnancies. The conversation around CGM needs to stop asking if it works and start asking how we actually use it. We have moved past simple efficacy; the real challenge now is implementation science. Specifically, we need to pinpoint the exact week of pregnancy when starting CGM is most cost-effective. There are also insufficient guidelines for insulin titration. Research should focus on analyzing and calculating the exact number of insulin units to adjust for each percentage shift in Time in Range (TIR). Future studies need to fill the gap between clinical efficacy and real-world application. The start point is determining exactly when, in the pregnancy timeline, CGM becomes most cost-effective. Research should focus on defining specific dose adjustments based on percentage shifts in TIR. The logical evolution of this field is the move toward automated insulin delivery systems. Such technology represents a shift from monitoring data to actively managing it. It can potentially remove the burden of manual decision-making for patients.

Strengths and Limitations

This review's strength lies in its inclusion of the most recent RCTs from 2023 to 2025, which incorporate the performance of modern, accurate sensors previously unavailable to researchers. Limitations include the heterogeneity of GDM populations. Another limitation of the review is that it considers studies in which the definition of "standard care" differs. The "standard of care" can vary across medical systems and countries, making direct comparisons difficult.

4. CONCLUSION

This review provides evidence of the efficacy of CGM in GDM and T1D. CGM is more beneficial compared to SMBG for managing high blood sugar during pregnancy. In the T1D world, CGM became a standard of care, directly linked to healthier birth weights and fewer cases of neonatal hypoglycemia. It differs in the case of GDM. While older studies left us with more questions than answers, our synthesis of modern data shows that CGM is a proven solution. It catches the asymptomatic nocturnal hypoglycemia and the postprandial surges that intermittent testing inevitably ignores.

These outcomes require a paradigm shift in obstetric diabetology from "monitoring" to "active management." The most critical implication for clinicians is the demonstrated obsolescence of HbA1c as a standalone prognostic marker in pregnancy. Physiological hemodilution makes HbA1c a less reliable marker compared to TIR. This systematic review supports the idea that clinical guidelines should prioritize more TIR as the primary target. The evidence suggests that achieving target TIR is associated with improved fetal outcomes and is more accurate than HbA1c in preventing fetal macrosomia.

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Conflict of interest
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Data and materials availability
All data associated with this study will be available based on the reasonable request to corresponding author.

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