**FIG 8-22** Large-for-gestational age infant. This infant of a diabetic mother (IDM) weighed 5 kg at birth and exhibits the typical round facies. (From Zitelli BJ, McIntire SC, Nowalk AJ: *Zitelli and Davis' atlas of pediatric physical diagnosis,* ed 6, St Louis, 2012, Saunders/Elsevier.)

**Congenital hyperinsulinism**, a condition which causes neonatal macrosomia and profound hypoglycemia, is often present in the neonatal period. However, this condition is usually not associated with maternal diabetes mellitus but appears to have a genetic etiology; the condition is also associated with syndromes, such as Beckwith-Wiedemann syndrome (Sperling, 2011).

## Therapeutic Management

The most important management of IDMs is careful monitoring of serum glucose levels and observation for accompanying complications such as RDS. The infants are examined for the presence of any anomalies or birth injuries, and blood studies for determination of glucose, calcium, hematocrit, and bilirubin are obtained on a regular basis.

Because the hypertrophied pancreas is so sensitive to blood glucose concentrations, the administration of oral glucose may trigger a massive insulin release, resulting in rebound hypoglycemia. Therefore, feedings of breast milk or formula begin within the first hour after birth, provided that the infant's cardiorespiratory condition is stable. Approximately half of these infants do well and adjust without complications. Infants born to mothers with poorly controlled diabetes may require IV dextrose infusions. Treatment with 10% dextrose and water (IV) is initiated