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Continuous Glucose Monitoring and Neonatal Outcomes in Gestational Diabetes Mellitus: A Systematic Review and Meta-analysis of Randomized Trials

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Abstract

Aims

To evaluate the effect of continuous glucose monitoring on neonatal outcomes in women with gestational diabetes mellitus.

Materials and Methods

We conducted a systematic review and meta-analysis of randomized controlled trials comparing continuous glucose monitoring with self-monitoring of blood glucose in women with gestational diabetes. Random-effects models were used to estimate pooled risk ratios with 95% confidence intervals. A complementary Bayesian random-effects analysis was performed to estimate posterior probabilities of treatment benefit. The protocol was registered in PROSPERO (CRD420261323954).

Results

In frequentist random-effects meta-analysis, continuous glucose monitoring was associated with a lower risk of large-for-gestational-age birth, although the estimate was imprecise (RR 0.66, 95% CI 0.32–1.36; I^2 = 42%). Bayesian analysis suggested a high probability of benefit, with a posterior median RR of 0.68 (95% credible interval 0.40–1.15) and a 93.5% probability of reduction. Continuous glucose monitoring did not reduce the risk of small-for-gestational-age birth (RR 1.40, 95% CI 0.85–2.30; I^2 = 0%), with Bayesian analysis indicating a low probability of benefit (14.7%). Continuous glucose monitoring was associated with a lower risk of neonatal intensive care unit admission (RR 0.64, 95% CI 0.44–0.95; I^2 = 0%), with a 96.4% probability of reduction. Other secondary outcomes did not show consistent differences.

Conclusions

Continuous glucose monitoring in gestational diabetes was associated with fewer neonatal intensive care unit admissions and a possible reduction in large-for-gestational-age births, without clear evidence of an effect on small-for-gestational-age infants. These findings suggest that improved detection of maternal glycaemic fluctuations may contribute to improved neonatal outcomes.

Introduction

Gestational diabetes mellitus (GDM) is one of the most common metabolic complications of pregnancy, and its prevalence has increased worldwide in recent decades.(1, 2) This rise is largely related to increasing maternal age, higher rates of obesity, and wider screening strategies.(1, 3) Women with GDM are at increased risk of pregnancy complications such as hypertensive disorders and operative delivery.

Infants born to mothers with GDM are also more likely to develop complications including large-for-gestational-age (LGA) birth, neonatal hypoglycaemia, respiratory problems, and admission to neonatal intensive care units (NICU).(2, 4, 5)

The importance of maternal glycaemic control during pregnancy has been clearly demonstrated in clinical studies. The Hyperglycaemia and Adverse Pregnancy Outcome (HAPO) study showed a continuous association between maternal glucose levels and adverse pregnancy outcomes. Even modest elevations in maternal glucose levels were associated with higher risks of fetal overgrowth and perinatal complications.(4)

The biological mechanism linking maternal hyperglycaemia to fetal overgrowth is well established. Glucose crosses the placenta and stimulates fetal insulin secretion. Fetal insulin acts as a growth-promoting hormone and increases fat deposition and fetal growth. As a result, poor maternal glycaemic control can lead to excessive fetal growth and large-for-gestational-age birth. This condition is associated with complications such as birth trauma, neonatal hypoglycaemia, and respiratory distress.(6) For this reason, careful monitoring and management of maternal glucose levels are essential components of GDM care.

Self-monitoring of blood glucose (SMBG) is currently the standard method used to monitor glycaemia in women with gestational diabetes. SMBG usually requires several capillary glucose measurements each day, including fasting and post-prandial values. Although this approach is widely used, it provides only intermittent measurements of glucose levels. Short periods of hyperglycaemia between tests may therefore go undetected. Episodes of post-meal glucose excursions or nocturnal hyperglycaemia may not be captured with routine SMBG measurements.(1, 7)

Continuous glucose monitoring (CGM) provides an alternative approach to glucose monitoring during pregnancy. CGM systems measure interstitial glucose continuously using a small subcutaneous sensor and provide detailed information on glucose patterns, variability, and trends. Continuous glucose data may help clinicians and patients identify hyperglycaemia earlier and adjust treatment strategies more effectively. For this reason, CGM has gained increasing interest as a tool to improve glucose control during pregnancy.(7)

Several randomized controlled trials have examined the role of CGM in women with gestational diabetes. Some studies have reported potential benefits. The FLAMINGO trial suggested improved glycaemic control and reduced fetal overgrowth with flash glucose monitoring compared with standard monitoring.(8) The Steady Sugar trial reported lower rates of large-for-gestational-age births and neonatal intensive care admissions among women managed with CGM.(9) Similarly, the GRACE trial demonstrated a reduction in large-for-gestational-age birth with real-time CGM compared with conventional monitoring.(10) However, the findings across trials have not been entirely consistent, and some studies have not demonstrated clear improvements in neonatal outcomes with CGM use.(9, 11)Differences in study design, patient populations, and monitoring strategies may partly explain these variations.

Several systematic reviews and meta-analyses have evaluated the use of continuous glucose monitoring during pregnancy. Some analyses have suggested improvements in glycaemic control and possible reductions in adverse perinatal outcomes.(12, 13) However, many of these analyses included heterogeneous populations of diabetes in pregnancy, combining women with type 1 diabetes, type 2 diabetes, and gestational diabetes. In addition, previous meta-analyses often focused primarily on maternal glycaemic outcomes rather than clinically important neonatal outcomes. Differences in monitoring strategies and duration of CGM exposure across studies may also influence the observed results.

Clarifying the effect of CGM on fetal and neonatal outcomes in women with gestational diabetes therefore remains clinically important. A clearer understanding of these outcomes is relevant because complications such as large-for-gestational-age birth and neonatal intensive care admission continue to be major causes of morbidity in pregnancies affected by GDM.(4)

Therefore, we conducted a systematic review and meta-analysis of randomized controlled trials to evaluate the effect of continuous glucose monitoring compared with self-monitoring of blood glucose on neonatal outcomes in women with gestational diabetes mellitus. In addition to conventional frequentist meta-analysis, we performed complementary Bayesian analyses to estimate the probability that continuous glucose monitoring reduces clinically important neonatal outcomes.

Methods

Study design

This systematic review and meta-analysis was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (**PRISMA 2020**) guidelines (14) and prospectively registered in PROSPERO (CRD420261323954). The protocol defined CGM as the intervention of interest in women with GDM. The primary analytical approach used a conventional frequentist meta-analysis. In addition, a pre-specified Bayesian random-effects meta-analysis was conducted to provide a probabilistic interpretation of treatment effects.

Literature search and eligibility criteria

A systematic search of PubMed, Embase, and the Cochrane Central Register of Controlled Trials was performed from database inception to 1 March 2026. The search strategy combined keywords and subject headings related to gestational diabetes, continuous glucose monitoring, real-time CGM, flash glucose monitoring, and randomized controlled trials. Reference lists of included studies and relevant reviews were also screened to identify additional eligible trials. The full search strategy for each database is provided in **Supplementary Appendix 1**.

Randomized controlled trials were eligible if they enrolled pregnant women with gestational diabetes mellitus and compared continuous glucose monitoring (CGM) with self-monitoring of blood glucose (SMBG). Studies using different CGM strategies were eligible, including real-time CGM, intermittently scanned CGM (flash monitoring), and intermittent or short-term CGM use.

Given the limited number of sustained real-time CGM trials available, the primary analysis included all randomized trials evaluating CGM compared with SMBG, with subgroup analyses performed according to CGM exposure intensity.

Outcomes

The primary outcome was LGA birth, defined as birthweight above the 90th percentile according to study-specific standards. Secondary outcomes included SGA birth, neonatal hypoglycaemia, NICU admission, preterm birth before 37 weeks, caesarean delivery, birthweight, initiation of insulin therapy, and total insulin dose.

Study selection and data extraction

Two reviewers independently screened titles and abstracts and assessed full-text articles for eligibility. Data were extracted using a standardized form. Extracted variables included study characteristics, CGM modality and duration, gestational age at CGM initiation, sample size, event counts for binary outcomes, and means with standard deviations for continuous outcomes. Disagreements were resolved through discussion.

Risk of bias assessment

Risk of bias in randomized trials was assessed using the Cochrane Risk of Bias 2 (**RoB 2**) tool (15), which evaluates bias arising from the randomization process, deviations from intended interventions, missing outcome data, outcome measurement, and selective reporting. Detailed domain-level assessments are provided in **Supplementary Table S1**.

Statistical analysis

The primary meta-analysis was conducted using a random-effects model. For binary outcomes, pooled risk ratios (RR) with 95% confidence intervals (CI) were calculated using the restricted maximum likelihood estimator. The Hartung–Knapp adjustment was applied to account for uncertainty in between-study variance.(16) Continuous outcomes were analysed using pooled mean differences under random-effects models. Statistical heterogeneity was assessed using the I^2 statistic and between-study variance (τ^2). Prediction intervals were calculated for the primary outcome.(17)

Because CGM exposure strategies differed across trials, exploratory subgroup analyses were conducted according to CGM exposure intensity, including sustained CGM use throughout pregnancy, intermittent CGM monitoring, and short-term CGM exposure. Sensitivity analyses included leave-one-out influence analysis and comparison with fixed-effect models.

Bayesian meta-analysis

A Bayesian random-effects meta-analysis was conducted using the bayesmeta package in R to provide a probabilistic interpretation of treatment effects.(18) Treatment effects were modelled on the log risk ratio scale. A weakly informative prior centred at no effect was used for the overall treatment effect ($\mu \sim \text{Normal}(0, 2.7^2)$). Between-study heterogeneity was assigned a half-normal prior ($\tau \sim \text{Half-Normal}(0.5)$), with sensitivity analysis using a wider heterogeneity prior ($\tau \sim \text{Half-Normal}(1.5)$). Posterior medians with 95% credible intervals were reported. Posterior probabilities were calculated for clinically relevant thresholds, including the probability that the risk ratio was below 1.0, 0.95, and 0.90.(19)

Publication bias and software

Formal assessment of publication bias using funnel plots or Egger's test was planned if at least ten studies were available for an outcome.(20) Because the number of trials was small, statistical testing for publication bias was not performed. All analyses were conducted using **R** (R Foundation for Statistical Computing, Vienna, Austria).

Results

Study selection and characteristics

The search identified 2,238 records, of which 1,461 duplicates were removed. After screening 777 titles and abstracts, 24 full-text articles were assessed for eligibility. Eighteen studies were excluded for predefined reasons, leaving six randomized controlled trials comprising 1,091 participants for inclusion in the final analysis (Fig. 1).

The included trials enrolled a total of 1,091 pregnant women with gestational diabetes mellitus. All studies compared continuous glucose monitoring (CGM) with self-monitoring of blood glucose (SMBG). The pattern of CGM use varied across trials, including sustained monitoring throughout pregnancy, intermittent monitoring, and short monitoring periods. Key study characteristics are summarised in Table 1.

Table 1
Characteristics of included randomized controlled trials evaluating continuous glucose monitoring versus self-monitoring of blood glucose in gestational diabetes mellitus. **Abbreviations: CGM**, continuous glucose monitoring; **SMBG**, self-monitoring of blood glucose; **LGA**, large-for-gestational-age; **SGA**, small-for-gestational-age; **NICU**, neonatal intensive care unit.

Study	Country	Sample size (CGM / SMBG)	CGM modality	Exposure pattern	Gestational age at enrolment	Key neonatal outcomes reported
GRACE (2026)	Austria, Germany, Switzerland	190 / 185	Real-time CGM (Dexcom G6)	Continuous until delivery	~ 28 weeks	LGA, SGA, NICU
Steady Sugar (2026)	USA	80 / 40	Real-time CGM (Dexcom G6)	Continuous until delivery	8–26 weeks	LGA, NICU
DipGluMo (2025)	Switzerland	156 / 143	Real-time CGM (Dexcom G6)	Continuous throughout pregnancy	24–28 weeks	LGA, NICU
FLAMINGO (2023)	Poland	50 / 50	Flash CGM (FreeStyle Libre)	Short-term (4 weeks after diagnosis)	24–28 weeks	LGA, SGA
Lai et al. (2023)	China	77 / 77	Intermittent CGM	Periodic (3 days every 4 weeks)	24–28 weeks	LGA, SGA, NICU
Valent et al. (2025)	USA	74 / 37	Real-time CGM (Dexcom G6)	Continuous until delivery	≥ 20 weeks	LGA, SGA, NICU

Risk of bias assessment

Risk of bias was evaluated using the Cochrane Risk of Bias 2 tool. Most studies were judged to have low risk of bias or some concerns, with no trial showing high risk across multiple domains.

The main source of potential bias related to deviations from intended interventions, largely because several studies used open-label designs. However, the primary neonatal outcomes were objectively measured and were therefore considered unlikely to be substantially affected by measurement bias. The overall risk-of-bias judgments are summarised in Supplementary Figure S1, and the domain-level traffic-light plot is presented in Supplementary Figure S2.

Large-for-gestational-age

Six randomized trials including 1,091 participants reported the incidence of large-for-gestational-age (LGA) infants. A summary of the main pooled neonatal outcomes and Bayesian probability estimates is

presented in Table 2. In the frequentist random-effects meta-analysis, CGM was associated with a lower risk of LGA compared with SMBG RR 0.66 **(95% CI 0.32–1.36; I² = 42%)** (Fig. 2).

Table 2

Summary of main outcomes from randomized trials comparing continuous glucose monitoring with self-monitoring of blood glucose in gestational diabetes mellitus

Outcome	No. of studies	Participants	Risk ratio (95% CI)	I²	Posterior probability (RR < 1)
Large-for-gestational-age (LGA)	6	1091	0.66 (0.32–1.36)	42%	93.5%
Neonatal intensive care unit admission (NICU)	5	989	0.64 (0.44–0.95)	0%	96.4%
Small-for-gestational-age (SGA)	4	676	1.40 (0.85–2.30)	0%	14.7%

Abbreviations: *RR, risk ratio; CI, confidence interval.*

A complementary Bayesian analysis produced similar estimates. The posterior median risk ratio was 0.68 (95% credible interval 0.40–1.15), corresponding to a 93.5% probability that continuous glucose monitoring reduces the risk of large-for-gestational-age birth. The distribution of treatment effects across clinically relevant thresholds, including clinically meaningful reductions, is illustrated in Fig. 5 (detailed posterior distributions shown in Supplementary Figure S10).

Small-for-gestational-age

Four trials including 676 participants reported small-for-gestational-age (SGA) births.

The frequentist analysis did not show a significant difference between CGM and SMBG (RR 1.40 (95% CI 0.85–2.30); I² = 0%) (Fig. 3).

The Bayesian model also suggested substantial uncertainty, with a 14.7% probability that CGM reduces SGA.

Neonatal intensive care unit admission

Five randomized trials including 989 participants reported neonatal intensive care unit (NICU) admission.

CGM was associated with a lower risk of NICU admission compared with SMBG (RR 0.64 (95% CI 0.44–0.95); I² = 0%) (Fig. 4).

The Bayesian analysis showed a 96.4% probability that CGM reduces NICU admission.

Other neonatal outcomes

Other neonatal outcomes, including preterm birth, neonatal hypoglycaemia, and caesarean delivery, showed no consistent differences between CGM and SMBG across studies (Supplementary Figures S3–S5).

Bayesian Results

In the Bayesian random-effects analysis, CGM was associated with a high probability of reducing large-for-gestational-age (LGA) births (posterior median RR 0.68, 95% CrI 0.40–1.15), with a 93.5% probability that CGM reduces LGA.

For small-for-gestational-age (SGA), the posterior median RR was 1.37 (95% CrI 0.48–3.66), with a low probability of reduction (14.7%), and the posterior distribution was centered above unity.

For neonatal intensive care unit (NICU) admission, the posterior median RR was 0.64 (95% CrI 0.29–1.50), with a high probability of reduction (96.4%). Bayesian analyses are shown in Supplementary Figures S10–S12, and sensitivity analyses using alternative heterogeneity priors yielded similar results.

Subgroup analysis

Subgroup analyses were conducted according to CGM exposure intensity, including sustained monitoring, intermittent monitoring, and short monitoring periods. The direction of effect remained broadly similar across subgroups, although the limited number of studies restricted detailed comparisons (Supplementary Figures S6–S9).

Sensitivity analyses

Leave-one-out analyses showed that no single study materially influenced the pooled estimates. The overall direction of effect remained unchanged after sequential removal of individual trials (Supplementary Figures S1–S3).

Publication bias

Visual inspection of funnel plots for the primary outcome did not suggest substantial publication bias. However, interpretation is limited by the small number of available trials (Supplementary Figure S4).

Discussion

Continuous glucose monitoring has increasingly been explored as a strategy to improve glycaemic control during pregnancy, yet its effect on clinically important neonatal outcomes in gestational diabetes remains uncertain. In this systematic review and meta-analysis of randomized trials including 1,091 women with gestational diabetes, CGM was associated with fewer neonatal intensive care unit admissions and showed a probable reduction in large-for-gestational-age births. However, no clear effect was observed on small-for-gestational-age infants. These findings suggest that improved detection of maternal glycaemic fluctuations may translate into clinically meaningful neonatal benefits. These findings contribute to the growing body of evidence evaluating the role of continuous glucose monitoring

in gestational diabetes and provide a quantitative synthesis of randomized trial data focusing on clinically important neonatal outcomes.

Although the frequentist estimate suggested a lower risk of large-for-gestational-age births with continuous monitoring (RR 0.66, 95% CI 0.32–1.36), the confidence interval was wide. The Bayesian analysis, however, indicated a high probability of benefit, with a 93.5% probability that continuous monitoring reduces large-for-gestational-age births. Similarly, continuous monitoring was associated with a lower risk of neonatal intensive care unit admission (RR 0.64, 95% CI 0.44–0.95), corresponding to a posterior probability of benefit of 96.4%. Importantly, Bayesian analysis provides a probabilistic interpretation of treatment effects, which may be particularly informative when the number of available randomized trials is limited, and conventional confidence intervals are wide. Posterior predictive analyses suggested that the direction of effect is likely to be maintained in future similar studies for LGA and NICU admission, although uncertainty remains for LGA, while no consistent benefit was predicted for SGA.

In contrast, there was no clear evidence that continuous monitoring reduced the risk of small-for-gestational-age infants (RR 1.40, 95% CI 0.85–2.30), and the probability of reduction was low. Taken together, these findings suggest that continuous monitoring may primarily influence complications related to fetal overgrowth rather than uniformly altering the entire birthweight distribution.

Our findings are broadly consistent with several recent randomized trials evaluating continuous glucose monitoring in gestational diabetes. Previous systematic reviews have reported mixed findings regarding neonatal outcomes with CGM use during pregnancy, partly because many analyses included heterogeneous populations of diabetes in pregnancy, combining women with type 1 diabetes, type 2 diabetes, and gestational diabetes, rather than focusing specifically on gestational diabetes.(12, 13)

The GRACE randomized trial reported fewer large-for-gestational-age births among women using real-time continuous glucose monitoring compared with standard monitoring, although the proportion of small-for-gestational-age infants was numerically higher in the monitoring group.(10) Similarly, the Steady Sugar trial observed improvements in neonatal outcomes, including lower rates of large-for-gestational-age births and neonatal intensive care unit admission among women managed with continuous monitoring.(21) However, other studies have reported neutral findings.(8, 11) The DipGluMo randomized trial, for example, did not demonstrate improvement in a composite perinatal outcome despite high patient satisfaction with continuous monitoring devices.(22) Differences across studies likely reflect variation in baseline glycaemic control, timing of monitoring initiation, duration of device use, and differences in clinical management protocols. In addition, the included trials used different CGM technologies, including real-time CGM systems and intermittently scanned flash monitoring devices, which may influence patient engagement, clinical decision-making, and treatment adjustments.

The potential mechanisms underlying these findings are biologically plausible. Maternal hyperglycaemia leads to increased placental glucose transfer to the fetus, stimulating fetal insulin secretion and promoting adipose deposition and accelerated fetal growth.(4, 6) Continuous glucose monitoring

provides a more comprehensive picture of glycaemic patterns than intermittent capillary testing and allows clinicians to detect postprandial excursions and glycaemic variability that may otherwise remain unnoticed. Earlier recognition of these fluctuations may enable more timely adjustments in diet, lifestyle measures, or pharmacologic therapy, thereby reducing fetal exposure to hyperglycaemia. Nevertheless, the available evidence remains limited, and the true magnitude of benefit may vary across clinical settings depending on patient characteristics, baseline glycaemic control, and treatment protocols.

The pattern observed in this analysis suggests that continuous monitoring may preferentially reduce complications associated with excessive fetal growth. Large-for-gestational-age infants are at increased risk of shoulder dystocia, birth trauma, neonatal hypoglycaemia, and prolonged hospital stay.(3, 4) The reduction in neonatal intensive care unit admission observed in this study therefore represents a clinically meaningful outcome. The improvement in neonatal intensive care unit admission despite an imprecise estimate for large-for-gestational-age births may reflect improved neonatal metabolic stability rather than large shifts in birthweight distribution.

From a clinical perspective, these findings suggest that continuous glucose monitoring may be particularly useful for identifying glycaemic excursions that contribute to excessive fetal growth. Targeted use of CGM in women with suboptimal glycaemic control or those requiring pharmacologic therapy may help optimise glucose management during pregnancy.

This study has several strengths. Only randomized controlled trials were included, which reduces the likelihood of confounding. The analysis focused on clinically meaningful neonatal outcomes rather than glycaemic metrics alone. In addition, the use of both frequentist and Bayesian meta-analytic approaches allowed complementary interpretations of the available evidence. Bayesian analysis provides an estimate of the probability that an intervention is beneficial, which may be particularly informative when the number of trials is limited.

Several limitations should also be considered. The number of randomized trials remains relatively small, and sample sizes for some outcomes were limited. In addition, the small number of trials limited the ability to explore potential sources of heterogeneity or to conduct detailed subgroup analyses. The included studies differed in the timing and intensity of continuous glucose monitoring, ranging from continuous monitoring throughout pregnancy to shorter or intermittent monitoring strategies. Differences in treatment protocols and thresholds for initiating pharmacologic therapy may also influence outcomes. In addition, some neonatal outcomes were reported by only a subset of trials, which may limit statistical precision. Although Bayesian analyses rely on model assumptions and prior distributions, the results remained consistent across sensitivity analyses using alternative modelling assumptions, supporting the robustness of the findings.

These findings suggest that continuous glucose monitoring may provide clinically meaningful benefits in the management of gestational diabetes by improving detection of glycaemic excursions and facilitating earlier therapeutic adjustments. Wider use of continuous glucose monitoring in selected patients with

gestational diabetes could therefore contribute to reducing neonatal complications associated with maternal hyperglycaemia.

In conclusion, continuous glucose monitoring in gestational diabetes may improve neonatal outcomes, particularly through reductions in neonatal intensive care unit admission and a probable reduction in excessive fetal growth. However, current evidence does not demonstrate a clear effect on small-for-gestational-age births. Larger randomized trials are needed to confirm these findings and to clarify the optimal role of continuous glucose monitoring in the management of gestational diabetes.

Declarations

Author Contributions:

The first author conceptualized and designed the study, performed data analysis, and drafted the manuscript. The second author contributed substantially to study selection, data extraction, data interpretation, and critical revision of the manuscript. Other authors contributed to study selection, data extraction, data interpretation, methodological review, clinical input, and manuscript editing. All authors reviewed and approved the final manuscript.

Data Availability Statement:
All data used in this study are derived from previously published studies and are included in the article and its supplementary material.

Ethics Statement:
Ethical approval was not required for this study, as it is a systematic review and meta-analysis of previously published data.

Conflict of Interest:
The authors declare no conflict of interest.

Funding:
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Figures

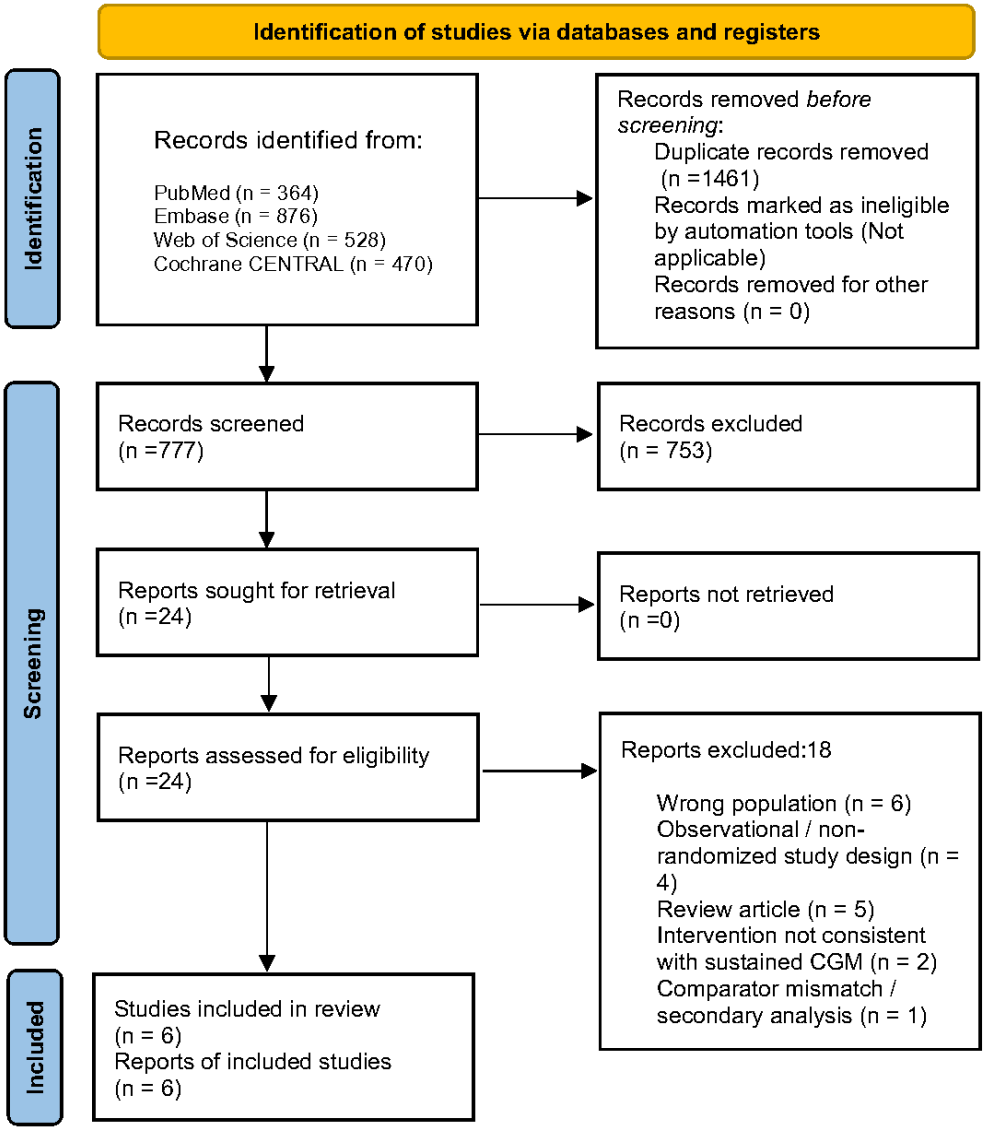


Figure 1. PRISMA 2020 flow diagram *illustrating the study selection process for the systematic review and meta-analysis of continuous glucose monitoring versus self-monitoring of blood glucose in gestational diabetes mellitus.*

Figure 1

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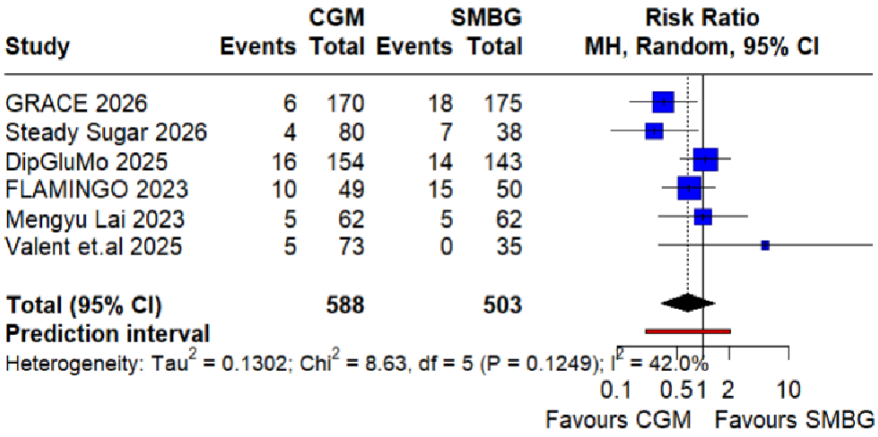


Figure 2. *Forest plot of randomized trials comparing continuous glucose monitoring (CGM) with self-monitoring of blood glucose (SMBG) for large-for-gestational-age (LGA) birth, using a random-effects model.*

Figure 2

See image above for figure legend

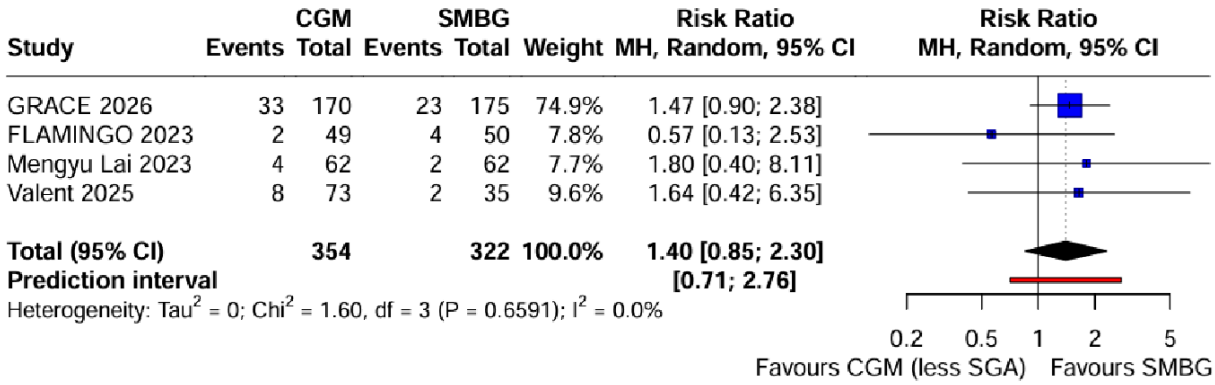


Figure 3. *Forest plot of randomized trials comparing continuous glucose monitoring (CGM) with self-monitoring of blood glucose (SMBG) for small-for-gestational-age (SGA) birth, using a random-effects model.*

Figure 3

See image above for figure legend

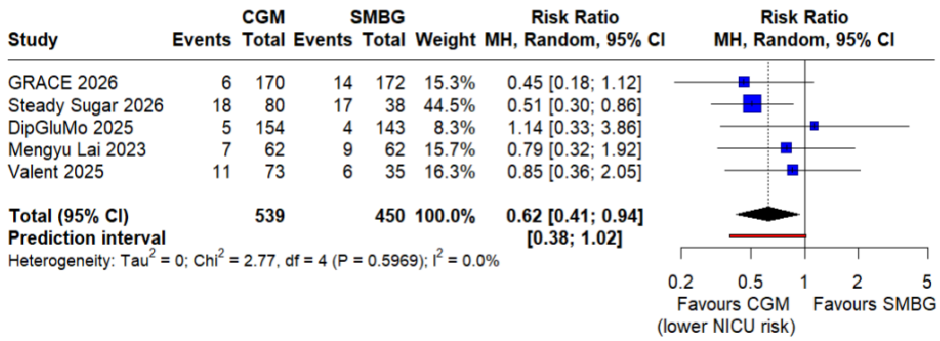


Figure 4 *Forest plot of randomized trials comparing continuous glucose monitoring (CGM) with self-monitoring of blood glucose (SMBG) for neonatal intensive care unit (NICU) admission, using a random-effects model.*

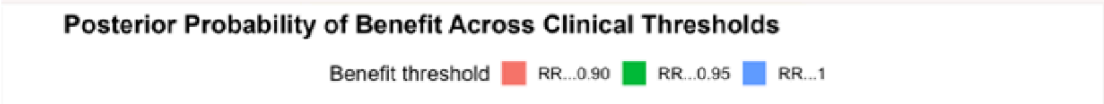


Figure 4

See image above for figure legend

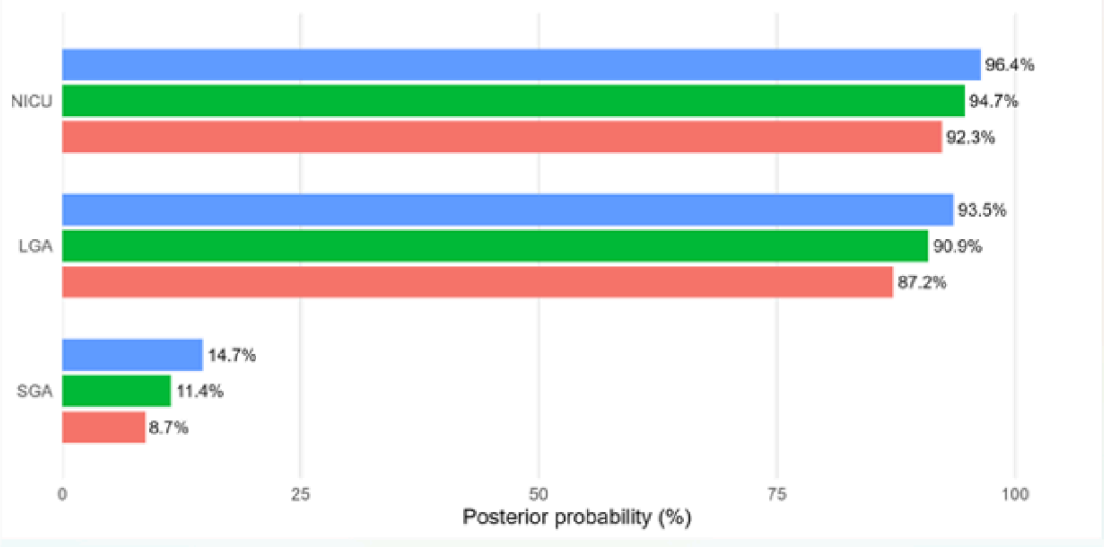


Figure 5. *Posterior probability that continuous glucose monitoring (CGM) reduces neonatal outcomes compared with self-monitoring of blood glucose (SMBG) across clinically relevant thresholds.*

Abbreviations: *LGA, large-for-gestational-age; SGA, small-for-gestational-age; NICU, neonatal intensive care unit; RR, risk ratio.*

Figure 5

See image above for figure legend

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- SupplementaryAppendix.docx