

Adverse effects of metformin in non-pregnant individuals include nausea, diarrhea, and the rare complication of lactic acidosis (2). This complication is reduced by careful patient selection. Metformin crosses the human placenta (5). Cord levels may exceed maternal levels (6) and could affect fetal cellular function and embryonic development, as insulin is an important fetal growth hormone. Metformin could be detrimental in conditions associated with decreased placental perfusion and fetal growth restriction, when the fetus may rely on development of peripheral insulin resistance to enhance survival.

Preliminary data suggest that metformin may be safe, but there is minimal evidence suggesting efficacy. Results of randomized clinical trials are necessary before the questions of safety or efficacy are answered. In PCOS, there is a randomized trial underway, comparing metformin with placebo through pregnancy. In women with gestational diabetes, MiG: TOFU will address neonatal and childhood outcomes.

It is premature for the ADA to claim that metformin has been shown to be safe and effective in pregnancy (1). The article in the *Bayside Tribune* misrepresented the speakers' message of caution. This newsletter was distributed to many of the 18,000 meeting attendees. The article's prominent position (on the first page) in-

sured broad readership, misinforming many providers.

In our opinion, women with diabetes who present in the first trimester of pregnancy and are taking metformin should change to insulin therapy. There may be specific circumstances when metformin is continued or started during pregnancy, but this decision should be made with a woman giving informed consent after discussing the limitations of current data. Metformin's time has not yet come.

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