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Supplementary Table 1. Studies examining maternal lipids in pre-existing and gestational diabetes mellitus. *

Reference	n	Type of diabetes	HbA1c % (mmol/mol)	BMI (kg/m ²)	Blood sampling	Main outcomes
Studies examining pre-existing diabetes						
Montelongo, 1992 (1) Spain No comment on ethnicity	12	Normal	FT 4.50 ± 0.36SE (26 ± 3.9 SE) ST 4.30 ± 0.43SE (23 ± 4.7) TT 4.40 ± 0.27SE (25 ± 3.0SE)	PP 22.4 ± 0.4SE	Following a 12h overnight fast, prior to morning insulin dose. Samples at gestational wks. 9-10, 21-23, 32-24, postpartum and post lactation	FFA levels ↑ in pre-existing and gestational diabetes compared to normal Triglycerides, VLDL-triglyceride, LDL-triglyceride, HDL-triglyceride and VLDL-C, LDL-C, HDL-C increased over gestation but no difference between diabetic and normal pregnancies
	12	Pre-existing DM (10 T1DM, T2DM)	FT 6.43 ± 0.26SE (47 ± 2.8SE) ST 5.54 ± 0.20SE (37 ± 2.2SE) TT 5.52 ± 0.17SE (37 ± 1.9)	PP 22.2 ± 0.3SE		
	9	GDM Diagnosed in the first trimester using a 50gGCT and 100g OGTT based on the 2 nd International workshop conference on GDM	FT 5.37 ± 0.37SE (35 ± 4.0SE) ST 4.83 ± 0.18SE (29 ± 2.0SE) TT 4.90 ± 0.18SE (30 ± 2.0SE)	PP 23.3 ± 0.6SE		
Biesenbach, 1994 (2) Austria No comment on ethnicity	10	T1DM	PP 6.9 ± 0.9 SD (52 ± 9.8 SD) FT 5.9 ± 0.6 SD (41 ± 6.6 SD) ST 5.3 ± 0.4 SD (34 ± 4.4 SD) TT 5.2 ± 0.5 SD (5.2	Weight FT 62 kg ± 9 SD	After an overnight fast Blood tests at 12 th , 20 th , 24 th weeks then every 4	Women with macroproteinuria had ↑ cholesterol, triglycerides, LDL-C and lower HDL-C in the third trimester compared to those without macroproteinuria The total and percent increase in

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			± 5.5 SD)		weeks until delivery	cholesterol and LDL-C across gestation was greater in women with macroproteinuria whereas the percent increase in triglycerides was similar between the groups and HDL fell in women with macroproteinuria.
	5	T1DM with macroproteinuria (>0.05g protein/24H in urine)	PP 7.6 ± 0.4 SD (60 ± 4.4 SD) FT 7.1 ± 0.7 SD (54 ± 7.7 SD) ST 6.6 ± 1.2 SD (49 ± 13.1 SD) TT 6.1 ± 1.2 SD (43 ± 13.1 SD)	Weight FT 63 kg ± SD 6 SD		
Kilby 1998 (3) United Kingdom Caucasian Values median (IQR)	22	Normal	TT 6.8 (IQR 6.3 – 7.8) (51, IQR 45 – 62) **	PP 24.3, (IQR 23.6 – 25.3)	Fasting, at time of planned caesarean section. Maternal glucose was maintained between 3-6 using an IV dextrose and insulin infusion (unclear if this was in both groups)	Women with T1DM had ↓ free fatty acids concentrations, and ↑ HDL-phospholipid concentration compared to normal women. The increase in HDL-phospholipid concentration was due to an increase in HDL ₂ -phospholipid concentration. Total cholesterol and triglyceride levels were not different. The cord blood of infants born to women with T1DM was higher in cholesterol, triglycerides, Apo-AI and Apo-B. Additionally, the cord blood HDL had a composition more similar to maternal HDL in infants born to women with T1DM.
	10	T1DM	TT 9.6, (IQR 8.2 – 10.7) (81, IQR 66 – 93)	PP 25.2, (IQR 24.2 – 26.7)		
Merzouk, 2000 (4) Algeria No comment on ethnicity	30	Normal	TT 5.8 ± 0.2 SEM (40 ± 2.2 SEM)	21.8 ± 2.3 SEM	Fasting blood samples at < 8 weeks gestation and within 48 hours of delivery	Women with good glucose control had similar lipoprotein levels to control women. No difference in cholesterol concentration between groups in the first or third trimester. ↑ total triglycerides, VLDL triglycerides, HDL ₂ -triglyceride content, HDL ₃ -triglyceride content, Apo B-100 in the
	20	T1DM, well controlled	TT 6.1 ± 0.3 SEM (43 ± 3.3 SEM)	22.14 ± 2.01 SEM		
	20	T1DM, poorly controlled	TT 8.9 ± 0.3 SEM (74 ± 3.3 SEM)	22.4 ± 1.9 SEM		

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						women with poor glucose control compared to control and those with good control in both the first and third trimesters ↓ HDL ₃ -cholesterol and lower Apo A-I in the women with poor glucose control compared to control and those with good control in both the first and third trimesters
Merzouk 2000 (5) Algeria No comment on ethnicity	20	T1DM, poorly controlled and macrosomic infant	TT 8.9 ± 0.3 SEM (74 ± 3.3 SEM)	22.4 ± 1.9 SEM	Fasting sample, collected within 48 hours of delivery	Women with well controlled diabetes had lipoprotein and apolipoproteins levels similar to non-diabetic women Women with poorly controlled diabetes had higher triglyceride, VLDL, Apo B-100 and HDL triglyceride concentrations, and lower Apo A-I and HDL ₃ concentrations than non-diabetic women. Macrosomic infants born with women with poorly controlled diabetes had ↑ concentrations of all lipoproteins, Apo A-I and Apo B-100 than appropriately grown infants Macrosomic infants born to non-diabetic mothers had similar lipoprotein profiles to appropriately grown infants.
	20	T1DM, well controlled and appropriately grown infant	TT 6.3 ± 0.4 SEM (45 ± 4.4 SEM)	22.1 ± 1.6 SEM		
	18	Non-diabetic women with macrosomic infant	TT 6.0 ± 0.3 SEM (42 ± 3.3 SEM)	22.8 ± 1.7 SEM		
	30	Non-diabetic women with appropriately grown infant	TT 5.8 ± 0.2 SEM (40 ± 2.2 SEM)	21.8 ± 2.3 SEM		
Toescu, 2004 (6) United Kingdom No comment on ethnicity	17	Normal	-	24.9 ± 1.1 SEM	Non fasting, morning sample 2 hours after breakfast. Samples taken week 12, 24, 36.	Total cholesterol and triglycerides ↑ in all groups through pregnancy but no difference between groups except that women with GDM had higher triglycerides in the second trimester than normal Small dense LDL ↑ in all diabetic groups compared to normal but no difference between diabetic groups. Total antioxidant capacity was lower in
	19	T1DM		27.6 ± 1.2 SEM		
	12	T2DM		30.7 ± 2.2 SEM		
	12	GDM		30.9 ± 1.7 SEM		

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						women with diabetes throughout pregnancy, lipid hydroperoxides higher in all diabetic women compared to normal
Wender-Ozegowska, 2011 (7) Poland No comment on ethnicity Median (min-max values)	24	T1DM with metabolic syndrome pre-pregnancy	FT 6.9, (range 5.5-9.3) (52, range 37 – 78) ** TT 6.6, (range 5.1-7.9) (49, range 32 – 63) **	PP 30.8, (range 21.7-42.4) **	Fasting maternal bloods collected between 8-13 weeks and again in the week before delivery. Retrospective observational study	Triglycerides were ↑ and HDL-C ↓ in the first trimester in women with metabolic syndrome There were no differences in lipoprotein concentrations in the third trimester. In women with metabolic syndrome the only lipoprotein to change significantly from first to third trimester was HDL, which increased. In women without metabolic syndrome, triglyceride, cholesterol, HDL-C, LDL-C increased from first to third trimester Oxidised LDL-C was not different between women with and without metabolic syndrome and did not change from first to third trimester Oxidised LDL-C was higher in those women with hypertension There were no differences in infant outcome between women with and without metabolic syndrome
	74	T1DM without metabolic syndrome pre-pregnancy	FT 7.6, (range 5.0-13.2) (60, range 31-121) ** TT 6.4, (range 4.9-9.4) (46, range 30-79) **	PP 20.8, (range 16.0 – 35.8) **		
Gobl 2010 (8) Austria No comment on ethnicity	137	Normal	-	-	unclear	Women with T2DM had ↑ triglycerides and ↓ HDL-C than women with T1DM in the first trimester In the third trimester, the lipid levels of women with T1DM were similar to those in women with normal glucose tolerance. In the third trimester, women with T1DM had higher cholesterol, LDL-C and HDL-C than women with T2DM Elevated triglycerides and low HDL cholesterol in the third trimester were
	109	T1DM	7.2 ± 1.4 SD (55 ± 15.3 SD)	24.8 ± 3.8 SD		
	64	T2DM	6.8 ± 1.3 SD (51 ± 14.2 SD)	32.0 ± 7.4 SD		

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						significant predictors for LGA infants, and remained significant after correction for maternal age and HbA1c
Basu, 2012 (9) Austria, Norway, United States No comment on ethnicity	21	Normal	FT 5.0 ± 0.3 SD (31 ± 3.3 SD)	FT 24 ± 4 SD	Overnight fast, samples taken before insulin administration at 12, 22, 32 weeks gestation. (Blood also taken at term but not shown here) Note, none of the preeclampsia term bloods were fasting.	Women with T1DM who later developed preeclampsia had higher LDL-C in early pregnancy and higher total cholesterol and LDL-C in the second trimester than women with T1DM who did not develop preeclampsia Women with T1DM who did not develop preeclampsia had lower triglycerides and VLDL-C in the first trimester than women without diabetes HDL-C did not differ between groups Women with T1DM who later developed preeclampsia had increased large LDL particles, increase ApoB and ApoB:ApoAI ratio.
	26	T1DM + preeclampsia	FT 7.3 ± 1.1 SD (56 ± 12.0 SD)	FT 28 ± 6 SD		
	92	T1DM	FT 6.8 ± 1.1 SD (51 ± 12.0 SD)	FT 26 ± 5 SD		
Studies examining gestational diabetes mellitus						
Knopp 1992 (10) United States No comment on ethnicity	521	Normal	ST 4.7 ± 0.6 SD (28 ± 6.6 SD)	22.5 ± 3.6 SD	Taken 1 hour after 50g oral glucose after an overnight fast between 24-32 weeks gestation	Women with GDM had higher triglycerides than the other two groups which were similar to each other
	264	Abnormal 50gGCT, normal 75g OGTT	ST 4.9 ± 0.7 SD (30 ± 7.7 SD)	22.8 ± 4.1 SD		
	96	GDM 100g OGTT by Carpenter and Coustan criteria (5.3/10.1/8.7/4.8 mmol/L)	ST 5.2 ± 0.7 SD (33 ± 7.7 SD)	23.8 ± 4.6 SD		
Koukkou, 1996 (11)	22	Normal	ST 6.0 ± 0.7 SD (42 \pm	29.7 ± 5.1	Fasting	Women with GDM had elevated

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United Kingdom	20	GDM	7.7 SD) ST 6.6 ± 0.7 SD (49 ± 7.7 SD)	SD 32.2 ± 5.2 SD	bloods at the time of OGTT	triglycerides and lower LDL-C compared to normal
Mixed ethnicity, mostly Caucasian, Asian, African/Afrocaribbeans		Diagnosis per the EASD criteria: glucose > 9 mmol/L at 120 mins post glucose load				
Clark 1997 (12)	126	Normal	-	27.5, (IQR 22.8 – 32.8) **	Blood samples taken at fasting and 2H during the OGTT Median gestation of screening 27.6 weeks	Women with GDM had higher fasting triglycerides and free fatty acids and higher 2H triglycerides. Women with GDM had lower HDL-C fasting
United States	52	GDM	-	30.4, (IQR 24.9 – 42.2) **		
Median, IQR		GDM diagnosed by 50g GCT – positive if > 7.2 at 1H Followed by a 100g 3H test: any two of 5.3/9.5/8.3/7.4 mmol/L				
Couch 1998 (13)	25	Normal	ST 4.56 ± 0.34 SD (26 ± 3.7 SD) TT 4.77 ± 0.37 SD (29 ± 4.0 SD)	PP 23.6 ± 3.6 SD	Fasting samples after GDM diagnosis and before treatment, at 33-34 weeks and at 37-38 weeks.	Women with GDM had higher plasma triglycerides and higher HDL and VLDL triglyceride content. In women with GDM, there were increased VLDL core lipids (triglycerides and cholesterol) and the triglyceride/cholesterol ratio was higher in HDL.
United States	25	GDM	ST 4.98 ± 0.48 SD (31 ± 5.2 SD) TT 5.05 ± 0.49 SD (32 ± 5.4 SD)	PP 25.6 ± 6.3 SD		
Mixed ethnicity, Mainly Caucasian		GDM diagnosed by the O’Sullivan and National				

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		Diabetes Data Group criteria				
Barden, 2004 (14)	22	GDM + preeclampsia	5.27 ± 0.16 SEM (34 ± 1.7 SEM)	PP 33.7 ± 1.4 SEM	Fasting sample at 28 weeks gestation	12% of women with GDM developed preeclampsia At diagnosis of GDM, there was no difference in lipoproteins between women who later did or did not develop preeclampsia In logistic regression, the significant independent predictors for developing preeclampsia were fasting glucose, c-reactive protein, family history of hypertension, and the proband's mother having gestational diabetes
Australia No comment on ethnicity	162	GDM GDM diagnosed using ADIPS criteria after 75gOGTT	5.03 ± 0.04 SEM (31 ± 0.4 SEM)	PP 29.8 ± 0.4 SEM		
Di Cianni, 2005 (15)	121	Normal	-	PP 23.6 ± 4 SD Data given for the group as a whole	Fasting sample at the time of the oral glucose tolerance test at 27 weeks gestation	Triglycerides significantly ↑ in women with GDM compared to IGT or normal at 28 weeks Macrosomia and LGA were more common in IGT than in GDM or normal In women with IGT, the incidence of LGA infants was increased in those with triglyceride levels > 75 th centile (2.30 mmol/L) Pre-pregnancy BMI, weight gain in pregnancy, fasting serum triglycerides, and 2H post OGTT glucose levels were all positively and significantly associated with neonatal body weight With multiple regression, only pre-pregnancy BMI and serum triglycerides remained significantly associated with birth weight
Italy	23	Impaired glucose tolerance				
No comment on ethnicity	36	GDM Impaired glucose tolerance and GDM diagnosed using a 50g CGT then a 100g OGTT, using Carpenter and Coustan criteria				
Sanchez-Vera, 2007 (16)	34	Non-diabetic and BMI<25	-	21.6 ± 1.70 SD	Sample after overnight fasting at	Women with GDM had higher triglycerides and cholesterol compared to
	11	Non-diabetic and	-	28.5 ± 2.4		

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Spain Caucasian	20	BMI>25 GDM and BMI <25	ST 4.73 (28)	SD 22.2 ± 2.1 SD	week 15, 24, 32.	non-diabetic women from the first trimester onward LDL from women with GDM had increased susceptibility to oxidation
	42	GDM and BMI > 25 GDM diagnosis by American Diabetes Association criteria at 24 weeks using a 50g GCT		30.5 ± 4.22 SD		
Qiu, 2007 (17) United States Mixed ethnicity, primarily non-Hispanic White, African American and Other.	96	Normal	-	PP 22.8 ± 0.4 SE	Non-fasting blood samples collected intrapartum	Mean LDL particle size is reduced in women with GDM The OR 1.8 (95%CI 0.9-3.3) of developing GDM for every 10-A reduction in LDL particle size
	105	GDM GDM diagnosed by the National Diabetes Data Group expert committee 1997 criteria using 100g OGTT	-	PP 29.5 ± 0.7 SE		
Schaefer-Graf, 2008 (18) Germany	150	GDM GDM diagnosed with a 75g OGTT using the Carpenter and Coustan criteria	-	PP 27.8 ± 6.2 SD	Taken at 28 weeks, 32, 36 and 39 weeks gestation. Reported on bloods close to delivery. Fasting status unclear	Maternal triglycerides and free fatty acids correlated positively with fetal abdominal circumference, and with birth weight and infant fat mass After adjustment maternal free fatty acids and triglycerides at delivery remained positively and significantly related to LGA
Szymanska 2008 (20)	41	Normal	-	PP 23.15	Unclear if	Women with GDM had higher

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Poland No comment on ethnicity				± 0.56 fault	fasting.	triglyceride levels
	81	GDM GDM diagnosed with fasting glucose and a 50gCGT or a 75gOGTT Fasting above 6.9 mmol/L twice = GDM, If on the 50 GGCT 1H glucose > 11.1 mmol/L, GDM was diagnosed. If 1H between 7.8 mmol/L and 11.1 mmol/L then a 75g OGTT was performed: fasting 7.5 mmol/L, 1H 10 mmol/L, 2H 7.8 mmol/L then GDM	-	PP 25.94 ± 0.73 fault	Average GDM diagnosis testing at 28 weeks Samples were taken after diagnosis or exclusion of GDM	
Rizzo, 2008 (21)	23	Normal	ST 4.4 ± 0.6 SD (25 ± 6.6 SD)	PP 28 ± 4 SD	Between 24-28 weeks	No difference in the concentration of any of the lipoproteins. They also measured Apo AI, Apo B and Lp(a) and there was no difference.
Turkey No comment on ethnicity	27	GDM GDM diagnosed by American Diabetes Association	ST 5.1 ± 0.5 SD (32 ± 5.5 SD)	PP 29 ± 4 SD	gestation, following a 12-14 hour overnight fast	

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		criteria using a 100g OGTT				
Marseille-Tremblay, 2008 (22) Canada No comment on ethnicity	29	Low cholesterol, no diabetes (cholesterol < the median 6.42 mmol/L)	-	PP 23.2 ± 4.9 SEM	Bloods at delivery. Unclear fasting status, unclear if pre or post-delivery.	High maternal cholesterol at delivery is associated with higher LDL-C, ApoB100 and triglyceride concentrations in maternal blood GDM was not associated with a difference in maternal lipid profile Cord blood cholesterol was not different between groups
	30	High cholesterol, no diabetes (cholesterol > the median 6.42 mmol/L)	-	PP 21.0 ± 3.3 SEM		
	7	Normal cholesterol, no diabetes	-	PP 22.5 ± 1.6 SEM		
	7	GDM GDM diagnostic criteria unclear	-	PP 28.0 ± 4.1 SEM		
Son, 2010 (23) Korea No comment on ethnicity	104	GDM GDM by 50g GCT then 100g OGTT by Carpenter and Coustan criteria	-	PP 23.2 ± 4.1 SD	Fasting, within two weeks of diagnosis of GDM (24-32 weeks gestation)	Maternal triglyceride levels were higher in mothers of LGA infants No correlation was found between maternal glucose, total cholesterol, HDL cholesterol and infant weight
Savvidou 2010 (24) London Mixed ethnicity, mainly Caucasian, Black, Asian	248	Normal	-	FT 32.6 ± 5.2 SD	Bloods taken at 11-13 weeks gestation, Fasting status unclear.	Women who later developed GDM had higher triglycerides, LDL-C, and cholesterol and lower HDL-C in early pregnancy. This difference was significant even when adjusted for clinical factors including maternal age, GMI, ethnicity, parity, smoking, gestational age at sampling.
	124	GDM Diagnosis based on 75g OGTT performed on patients selected	FT 5.8 ± 0.8 SD (40 ± 8.7 SD)	FT 34.3 ± 5.0 SD		

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		because of risk factors. Criteria per WHO. < 7 mmol/L fasting, < 7.8 mmol/L at 2H				
Retnakaran 2010 (25) Canada Mixed ethnicity, mainly Caucasian and Asian	87	Normal	-	PP 22.9 (IQR 21.3 – 26.1) **	Fasting bloods at time of the OGTT in late second, early third trimester. They also measured at 3 months postpartum	There were no significant differences in cholesterol, triglycerides, LDL-C, Apo B or apoA1. HDL-C was lower in women with GDM Postpartum, cholesterol, triglycerides, apoB, LDL, cholesterol to HDL ratio all worsened across the groups from normal to GDM.
	170	Abnormal GCT, normal OGTT	-	PP 23.5 (IQR 21.2 – 27.5) **		
	89	Impaired glucose tolerance on OGTT	-	PP 23.5 (21.9 – 27.9) IQR		
	136	GDM GDM diagnosed by 100g OGTT per the National Diabetes Data Group 1979 (any two of 5.8/10.6/9.2/8.1 mmol/L)	-	PP 25.0 (22.0 – 30.1) IQR		
Schaefer-Graf 2011 (19) Germany	190	Normal	-	PP 25.7 ± SEM 0.4	Fasting, either morning of caesarean section or within the week prior to delivery	No difference in maternal glucose, triglycerides, free fatty acids or cholesterol levels between normal and GDM women Cord blood glucose and free fatty acids were lower in infants born to uncomplicated pregnancy In women without diabetes, maternal glucose and fatty acids and glycerol correlated with cord blood levels but not with neonatal weight or fat mass
	150	GDM Diagnosed using a 75g OGTT with Carpenter and Coustan criteria (5.0/10.0/8.6 mmol/L)	-	PP 27.7 ± SEM 0.4		

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Barrett, 2013 (26) New Zealand and Australia Mixed ethnicity, predominately Caucasian, Polynesian, Asian, Indian. From the Metformin in Gestational diabetes RCT (27).	242	GDM randomized to insulin	TT 5.60 ± 1.10 SD (38 ± 12.0 SD)	TT 34.6 (95% CI 33.7–35.5)	Fasting after diagnosis of GDM prior to pharmacotherapy commencement And at 36 weeks	Maternal triglycerides increased more from randomization to 36 weeks in women allocated metformin (21.93%) compared to those allocated insulin (9.69%) The strongest associations with birth weight > 90 th centile were maternal triglycerides and measures of maternal glucose
	236	GDM randomized to metformin. GDM diagnosed by ADIPS criteria	TT 5.60 ± 1.12 SD (38 ± 12.2 SD)	TT 35.2 (95% CI 34.2–36.2)		

* This includes only studies from 1990 onward and only includes the changes noted during gestation rather than postpartum or during lactation. Where possible gestational timing of measurements has been stated. HbA1c has been given as % (mmol/mol). HbA1c in mmol/mol has been calculated using the Diabetes Care online calculator. Data for HbA1c and BMI are expressed as mean, except where marked as ** which indicate the median has been used.

Abbreviations as follows: PP pre-pregnancy, FT first trimester, ST second trimester, TT third trimester, T1DM type 1 diabetes mellitus, T2DM type 2 diabetes mellitus, GDM gestational diabetes mellitus, FFA free fatty acids, LDL-C low density lipoprotein, HDL high density lipoprotein, VLDL very low density lipoprotein, Apo apolipoproteins, IV intravenous, GCT glucose challenge test, OGTT oral glucose tolerance test, SE standard error, SEM standard error of the mean, SD standard deviation, 95%CI 95 percent confidence interval.

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Supplementary Table 2. Pharmacological agents.

Pharmacological therapy	Placental passage	Effects on lipids *	Safety in pregnancy
Metformin	Yes (1)	↓serum triglycerides, ↓total cholesterol and ↓ LDL-C, these latter two independently of glycaemic control (2) ↓free fatty acid levels from adipose tissue (3) and ↓VLDL levels (4).	No increase in congenital malformations when used in early pregnancy (5). Similar pregnancy outcomes as insulin in randomized trials for GDM. (6-8)
Insulin	None to minimal (9; 10)	↓triglycerides by 10-40% , and normalization of lipoprotein composition (11)	Safe to use
Omega-3 fatty acids	Yes (12)	20-50% ↓in triglyceride levels, with a possible ↑/- LDL-C ↑/-HDL-C (13)	Supplementation with up to 1g/d DHA has not been reported to be harmful. (12; 14)
Statins	Variable depending on type of statin (15; 16)	Anti-inflammatory, antithrombotic and antioxidant effects. ↓triglycerides by 10-40%, ↓LDL-C and ↓non-HDL-C, and ↑HDL-C (13)	No recurrent pattern of malformations reported in animal studies (17) Statins have been shown to have effects on placental development in vitro, with decreased migration of cytotrophoblasts and syncytiotrophoblasts (18)
Niacin	Unclear	↓triglycerides by 20-50%, ↓LDL-C by 5-25%, while ↑HDL-C 15-35% (13) ↓ Hepatic synthesis of VLDL and triglycerides are also reduced (19)	Very small numbers of case reports, no reported adverse infant effects (20)
Fibrates	Unclear	↓triglyceride concentration by 20-50% , ↓ LDL-C 0-20% and ↑HDL-C levels 6-20% (13).	Very small numbers of case reports, no reported adverse infant effects (20)
Resveratrol	Likely: detected in fetal plasma in rodents (21)	↓LDL cholesterol, ApoB, triglycerides and ↓intrahepatic lipid content (22)	Reduction in neural tube defects in rodent models of diabetic pregnancy (21) Not tested in humans

* this refers to general effects, not pregnancy specific effects.

SUPPLEMENTARY DATA

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