

Prevalence and Outcome of Adolescence Pregnancy Over 17 years at King Abdul-Aziz University Hospital Jeddah Saudi Arabia.

Dr. Ettedal Al Jahdali

Department of Obstetrics and Gynecology, Faculty of Medicine, King Abdulaziz University Hospital, Jeddah
dr.aljahdali@hotmail.com

Abstract: Background: The growing number of teenage pregnancy cases apparently emerged as a global health problem in present generation. Pregnancy in early age is associated with poor maternal weight gain, premature birth, gestational hypertension, anemia, and STDs. It is one of the major cause of increased maternal and child mortality. **Objectives:** To determine the prevalence of adolescence pregnancy and associated percentage of mortality and morbidity among pregnant females at King Abdulaziz University Hospital (KAUH) Jeddah, Saudi Arabia. **Materials and Methods:** A chart review study that included (N=3,234) was conducted through data collection for all pregnant adolescents' chart review who delivered in King Abdulaziz University Hospital (KAUH) Jeddah, Saudi Arabia from January 2000 until December 2016. **Results:** the number of adolescent deliveries and percentage over the years was decreasing in the rate from (5.01%) in 2000 to (2.7%) in 2016. The majority (96%) were late adolescence (16-19y), 73.3% were booked for pregnancy care, 51.2% were Saudi, Two thirds (66.3%) were primigravida, the majority (90%) reported full term without abortion history and (99.5%) had normal infants. **Conclusion:** The prevalence of adolescence pregnancy decreased over the years of the study. Despite the rampant worldwide issue brought about by the risks of adolescence pregnancy, this study revealed that the mortality and morbidity rates of mothers and their child under this age group is not very high. [Ettedal Al Jahdali. **Prevalence and Outcome of Adolescence Pregnancy Over 17 years at King Abdul-Aziz University Hospital Jeddah Saudi Arabia.** *Life Sci J* 2017;14(8):62-66]. ISSN: 1097-8135 (Print) /ISSN: 2372-613X (Online). <http://www.lifesciencesite.com>. 9. doi:[10.7537/marslsj140817.09](https://doi.org/10.7537/marslsj140817.09).

Keywords: Adolescent, pregnancy, maternal, mortality, morbidity.

1. Introduction

Adolescents undergo vast physical changes that tremendously affect ones health and behavior (WHO, 2017). The person's characteristics and their environment also corresponds to these transformations (Eccles et al., 1993). These developments take place gradually and differs from one individual to another.

Lack of social support is associated with teenage pregnancy (Smith, 2001). Culture and tradition also served as contributing factors to early pregnancy, as an evidenced in a study conducted by Sedgh et al., found that adolescent pregnancy birth rates were significantly high in countries like Mexico and Sub-Saharan Africa, where it is a common practice for people to be married and bear a child at a very young age. (Sedgh et al., 2015).

Young pregnancy is associated with several health risks such as poor maternal weight gain, premature birth, gestational hypertension, anemia, and STDs (Klein JD, 2006). According to the World Health Organization (WHO, 2017), adolescent pregnancy is the leading factor causing maternal and child death. Teenagers have higher susceptibility to obstructed labor, fistula, and premature delivery and to deliver children with low birth weights (UNFPA, 2013).

Due to the negative outcome of adolescence adolescent pregnancies in the society, there since have been worldwide campaigns to prevent and resolve its impending consequences. Proper education, awareness and information dissemination are vital towards the success of this plan.

In addition, the parents plays an important role in actively monitoring their children as they encounter and undergo the puberty stage. Based on a study made by Sieverding et al., it confers that strict parental monitoring paved its way to reduce motivation of having intercourse, despite the heightened sexual inclination and development of these young individuals. The mothers implies great influence to their children and their relationship are foreseen to render cosmic effect for their young ones to take time before engaging with sexual activities (Sieving et al., 2000).

This study aimed to determine the mortality and morbidity among adolescent pregnant patients at King Abdul-aziz University Hospital (KAUH) Jeddah, Saudi Arabia from January 2000 until December 2016.

2. Materials and Methods

A cross sectional and cohort study that included (N=3,234) was conducted through data collection for all pregnant adolescents' chart review.

Included data were divided to 5 parts:

First part: included all deliveries conducted in KAUH from 2000-2016, and the percentage of adolescent deliveries.

Second part: (sociodemographic data) included age and nationality.

Third part: (medical characteristics data) included chronic illnesses and surgical history.

Fourth part: (obstetric history data) included Gestational age, abortion, parity, mode of delivery, indication of C/S.

Fifthpart: included APGAR score) American Pediatric Gross Assessment Record,) blood loss, Congenital Anomalies, placenta, birth weight at admission.

All pregnant adolescents with ages 12 to 19, from all nationalities, who delivered in King Abdulaziz University Hospital (KAUH) Jeddah, Saudi Arabia from January 2000 to December 2016 were included in the study, while all non-adolescent pregnant patients who delivered in KAUH were excluded.

Table (1) Total no. of delivery in adolescence and Prevalence of pregnancy in adolescence.

year	Total no. of delivery	Total no. of delivery in adolescence	Prevalence of pregnancy in adolescence per 100
2000	3127	158	5.05
2001	3770	180	4.77
2002	4150	208	5.01
2003	4928	287	5.82
2004	4717	252	5.34
2005	3871	208	5.86
2006	3814	204	5.84
2007	3913	218	5.57
2008	4399	216	4.91
2009	4243	182	4.29
2010	4211	157	3.72
2011	4760	229	4.81
2012	4599	201	4.37
2013	4373	180	4.12
2014	3283	118	3.59
2015	3554	128	3.60
2016	3997	108	2.70
Total	69709	3234	4.63

The majority of pregnant adolescent (96%) were from late adolescent group age 16-19, 73.3% were booked for pregnancy care, 51.2% were Saudi. Two thirds (66.3%) were primigravida. The majority (90%) reported full term and without abortion history. (Table 2)

Data Analysis

The statistical analysis was done using the Statistical package for social science (SPSS) 16.0 software package.

3. Results:

Table (1) showed the number of total deliveries in each year, and the number of adolescent deliveries and percentage for each year, there was decreasing in the rate from (5.01%) in 2000 to (2.7%) in 2016. (Table 1)

The majority of the participants (93.2%) didn't have any chronic illness, and 97.2% didn't have any surgical history. More than half (56.9%) reported SVD and episiotomy as the mode of delivery. In fourth of the C/S cases (29.1%) the indication was

Table (2) Demographic, clinical characters of the adolescence pregnancy during the period from 2000 to 2016.

Variables	N	%
Age group		
12 year	7	(0.2)
13-15	122	(3.8)
16-19	3105	(96)
Bookingfor pregnancy care		
Booked	2372	(73.3)
Unbooked	862	(26.7)
Nationality		
Saudi	1657	(51.2)
Others	1577	(48.8)
Parity		
1	2145	(66.3)
2-4	1062	(32.8)
5	27	(0.8)
Abortion		
0	2913	(90)
1	275	(8.5)
More than 1	46	(1.4)
Gestational age		
Full term	2932	(90.7)
Preterm	257	(7.9)
premature	45	(1.4)

Fetal distress and in the other fourth (27.1%) the indication was abnormal presentation. (Table 3) Almost all the cases reported complete placenta (99.5%) and had normal infants (98.3%) with normal APGAR score, 78.5% of the cases had blood loss <300cc. More than two thirds (71%) had baby with normal birth weight. Only 45 (1.4%) cases dead and 120 (3.8%) admitted to NICU. (Table 4)

Table (3): Medical characters and obstetric history of the adolescent pregnancy during the period from 2000 to 2016.

Variables	(N %)
Medical characters	
None	3012 (93.2)
DM	25 (.8)
HTN, PET, Eclampsia	100 (3.1)
Cardiac Disease	11 (0.3)
Renal	1 (0.003)
CNS (Epilepsy, MS)	9 (0.3)
Others	75(2.3)
Surgical history	
Yes	89 (2.8)
No	4145(97.2)
Mode of delivery	
SVD	416(12.9)
SVD + Episiotomy	1841(56.9)
SVD+ Tear	405(12.5)
SVD+ Episiotomy+ Tear	60 (1.9)
Elective C/S	106 (3.2)
Emergency C/S	252(7.8)
Instrumental Delivery	91 (2.8)
Vaginal Breech +Episiotomy	38 (1.2)
Twins SVD	25 (.8)
N= 358 Indication of CS	
Fetal Distress	104(29.1)
Preterm	2(.6)
Multiple Pregnancy	9(2.5)
Failure to Progress	57 (15.9)
Abnormal Presentation	97 (27.1)
Others	47(13.1)
APH (Placenta Previa, Abruption)	11 (3.1)
Previous C/S	27 (7.5)
Anomalies	3 (.8)
Infections (Hepa, HPV)	1 (.3)

Table (4) outcomes of the adolescence pregnancy during the period from 2000 to 2016.

Variables	N	%
Placenta		
Complete	3219	(99.5)
Incomplete	6	(0.2)
Manual Removal	9	(0.3)
Blood loss		
<300cc	2539	(78.5)
300-600cc	540	(16.7)
>600cc	155	(4.8)
Birth weight		
<2.5	557	(17.2)
2.5-3.5	2297	(71)
>3.5	380	(11.8)
Congenital Anomalies		
None	3195	(98.8)
Skeletal	5	(0.2)
CNS	5	(0.2)
Chromosomal	1	(0.003)
GI	4	(0.1)
Renal	4	(0.1)
Cardiac	4	(0.1)
Others	20	(6)
Apgar score		
Normal (≥ 5 out of 5)	3180	(98.3)
Abnormal (<5 out of 5)	9	(.3)
Dead	45	(1.4)
Admission		
Nursery	3069	(94.8)
NICU for distress	26	(0.8)
NICU for preterm	76	(2.4)
NICU for anomalies	18	(0.6)
Dead	45	(1.4)

4. Discussion

Adolescence pregnancy is a worldwide health problem and happens in all communities, which differ from country to country. Despite that adolescent mothers are married and receiving full social, financial and emotional support in Islamic countries, this support cannot protect them from the obstetric complications related to young age and incomplete physical and psychological developing. (Mesleh et al, 2001)

The current study findings showed that the prevalence of adolescence pregnancy decreased during the last seventeen years from 5.01% to 2.7%,

with rate of 4.6% during study period. This rate is lower than previous studies, India (10.4%), (Talawar et al, 2013) Riyadh (6%), (Mesleh et al, 2001), Egypt study (7.5%), (Rasheed S et al, 2011), USA (57%) and Switzerland (8%). (Sedgh G et al, 2015), indicating decreasing in the trend of adolescence pregnancy, and increasing in the awareness of the danger of adolescent pregnancy particularly at early adolescence.

Most of the cases were primigravida, with no abortion history. In contrast in USA the rate of abortion was 15%, in Switzerland (5%), (Sedgh G et al, 2015), while in India study there was no abortion

among the participants, where all were married. (Talawar et al, 2013) This could be explain by the fact that being married provide the women with a level of financial and emotional supports to keep their pregnancy, where previous studies provide the evidences of unmarried mothers trends to terminate pregnancy. (Rasheed S et al, 2011; Talawar et al, 2013)

Almost three fourth were booked and receiving antenatal care, which is more than Thailand (66.5%). Indicating family support and good level of health service.

Regarding the mode of delivery, more than half delivered SVD + Episiotomy, and only 11% delivered C/S due to fetal distress and abnormal presentation. Similar results were found in Thailand studies (10%) and (11.8%). (Thaithae S et al, 2011; Narukhutrpicchai P, 2016) In contrast, in Egypt study (45.9%) had C/s with main reasons cephalopelvic disproportion and dysfunctional labor. (Rasheed S et al, 2011), 26.7% in Portugal, Iran and Mexico, (Azevedo WF et al, 2015), While in India study only 1% had C/S with mean reasons cephalopelvic disproportion and fetal distress. (Talawar et al, 2013). This varies in C/S rate could be explain by the fact that there is wide difference in the opinions of surgical intervention among adolescent mothers. On the other hand, several studies explained the higher rate of using instrumental deliveries in adolescent pregnancies. By the fact that the pelvis of adolescent is underdeveloped. (Talawar et al, 2013; Tripathy M et al, 2014; Narukhutrpicchai P, 2016)

The findings of the current study showed good outcomes in general, where more than 90% had normal baby with normal APGAR score, good birth weight, no hemorrhage, with nursery admission and complete placenta. Indicating good antenatal and perinatal care, also it could be due to the fact that most of the participants were from late adolescence age group (16-19) were the rate of poor outcomes of delivery stabilized and become near to adult rate.

While in Egypt study the rate of pre-eclampsia, eclampsia, preterm labor and premature rupture of membranes was higher among younger mother. (Rasheed S et al, 2011) Similar results were found in India study (Talawar et al, 2013) and other previous studies, where the main poor outcomes were related to the infants not to the mothers. (Azevedo WF et al, 2015) Several studies attribute poor outcomes to several factors : low socioeconomic status, low educational level, inappropriate antenatal and prenatal care, and inappropriate weight gain during pregnancy. (Narukhutrpicchai P, 2016)

Limitation

This study had fewer limitations, first only one center was included in the study, and second all the eight years of adolescence stage considered as one period of time and ignoring the fact that biologic, physiologic, and even anatomic maturation of the human pelvis and reproductive organs may differ from one year to the other during this period.

Conclusion and Recommendation

Despite the rampant worldwide issue brought about by the risks of adolescent pregnancy, this study revealed that the mortality and morbidity rates of mothers and their child under this age group is not high, and decreased from 5.01% in 2000 to 2.7% in 2016. The results of the current study showed low rate of poor outcomes due to good antenatal and perinatal care and as the majority of them are at late adolescence close to adult anatomical, physiological and psychological characteristics. Further studies need to be conducted to clarify the adverse outcomes and to improve the awareness about adolescence pregnancy and the importance of seeking good perinatal and prenatal care.

References:

1. Azevedo WF, Diniz MB, Fonseca ES, Azevedo LM, Evangelista CB. Complications in adolescent pregnancy: systematic review of the literature. *Einstein (Sao Paulo)*. 2015 Oct-Dec;13(4):618-26.
2. Eccles JS, Midgley C, Wigfield A, Buchanan CM, Reuman D, Flanagan C and Mac Iver D. Development during adolescence: The impact of stage-environment fit on young adolescents' experiences in schools and in families. *American Psychologist* 1993;48(2):90-101.
3. Klein JD. Adolescent Pregnancy: Current Trends and Issues. 2006. Retrieved from http://qikan.9med.net/html/qikan/fckxyekx/xekyx_qk/200571167/20080831165912975_222038.htm.
4. Mesleh RA, Al-Aql AS, Kurdi AM. Teenage pregnancy. *Saudi Med J*. 2001 Oct;22(10):864-7.
5. Narukhutrpicchai P, Khrutmuang D, Chattrapiban T. The Obstetrics and Neonatal Outcomes of Teenage Pregnancy in Naresuan University Hospital. *J Med Assoc Thai*. 2016 Apr;99(4):361-7.
6. Rasheed S, Abdelmonem A, Amin M. Adolescent pregnancy in Upper Egypt. *Int J Gynaecol Obstet*. 2011 Jan; 112(1):21-4. doi: 10.1016/j.ijgo.2010.08.006.
7. Sedgh G, Finer L, Bankole A, Eilers M, and Singh S. Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Recent Trends. *Journal of Adolescent Health* 2015;56(2):223-230.

8. Sieverding JA, Adler N, and Witt S. The Influence of Parental Monitoring on Adolescent Sexual Initiation. *Arch Pediatr Adolesc Med.* 2005;159(8):724-729. doi:10.1001/archpedi.159.8.724.
9. Sieving RE, McNeely CS, and Blum RW. Maternal Expectations, Mother-Child Connectedness, and Adolescent Sexual Debut. *Arch Pediatr Adolesc Med.* 2000;154(8):809-816. doi:10.1001/archpedi.154.8.809.
10. Smith GCS. Teenage pregnancy and risk of adverse perinatal outcomes associated with first and second births: population based retrospective cohort study. *BMJ* 2001;323:476. doi: <https://doi.org/10.1136/bmj.323.7311.476>.
11. Talawar S and Venkatesh G. Outcome of Teenage Pregnancy. *Journal of Dental and Medical Sciences.* 2013; 6(6): 81-83
12. Thaitae S1, Thato R. Obstetric and perinatal outcomes of teenage pregnancies in Thailand. *J Pediatr Adolesc Gynecol.* 2011 Dec;24(6):342-6. doi: 10.1016/j.jpag.2011.02.009.
13. Tripathi M and Sherchand A. Outcome of Teenage Pregnancy. *Journal of Universal College of Medical Sciences.* 2014; 2(2):11-14
14. UNFPA. *Motherhood in childhood: Facing the challenge of adolescent pregnancy: The State of World Population 2013.* United Nations Population Fund, New York 2013:163-196.
15. World Health Organization (WHO). 2017. Retrieved from <http://www.who.int/mediacentre/factsheets/fs364/en/>; http://www.who.int/maternal_child_adolescent/topics/adolescence/development/en/.