

TEENAGE PREGNANCY: AGE IS NOT JUST A NUMBER**¹Dr. Aditi Ranaut, ^{2*}Dr. Narinder Singh, ³Dr. Shikha Sharma, ⁴Dr. Anupam Sharma and ⁵Dr. Nitesh Mittal**¹MD Anesthesia, Zonal Hospital Dharamshala, Himachal Pradesh.²MS Orthopaedics, Zonal Hospital Dharamshala, Himachal Pradesh.^{3,4}MS Obstetrics and Gynaecology, Regional Hospital Bilaspur, Himachal Pradesh.⁵MD Anesthesia, Regional Hospital Bilaspur, Himachal Pradesh.***Corresponding Author: Dr. Narinder Singh**

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ABSTRACT

Teenage pregnancies are considered to be a very high risk event, because teenage girls are physically and psychologically immature for reproduction. In addition, there are some extrinsic factors such as inadequate prenatal care, illiteracy, and poor socio-economic conditions that affect the outcome of pregnancy in teenage girls. We report herein a case of 14 year old primigravida for emergency lower segment caesarean section (LSCS) at period of gestation (POG) 37 weeks with severe intrauterine growth restriction. This case report highlights the problems of early childbearing, discussing about the health and social issues as well as the reasons why this problem is of major concern.

KEYWORDS: Adolescent pregnancy, Primigravida, Socioeconomic status.**INTRODUCTION**

Health, in addition to its medical determinants, is influenced by many social and cultural factors. One such social hazard of serious consequences on the nation as a whole is pregnancy in an adolescent girl, who herself is yet to attain her full growth potential.^[1]

Adolescent pregnancy can be defined as a teenage or underage girl, who usually between age 13 to 19 years old, becoming pregnant. Teenage pregnancy is formally defined as a pregnancy in a young woman who has not reached her 20th birthday when the pregnancy ends, regardless of whether the woman is married or is legally an adult.^[2] Teenage pregnancies are considered to be a very high risk event because teenage girls are physically and psychologically immature for reproduction. In addition, there are some extrinsic factors such as inadequate prenatal care, illiteracy, and poor socio-economic conditions that affect the outcome of pregnancy in teenage girls.^[3-4] Several medical complications like preterm birth, poor maternal weight gain, pregnancy-induced hypertension, anemia, and sexually transmitted diseases are strongly associated with teenage pregnancy.^[5]

Case presentation

A 14 year old primigravida at POG 37 weeks with severe intrauterine growth restriction (IUGR) in labour taken for emergency LSCS with normal routine blood biochemistry. Patient didn't undergo any antenatal checkups (ANCs) and investigations. On per abdomen

examination the height of uterus (HOU) is 28-30 weeks, cephalic presentation, adequate liquor and FHS 135b/min with expected fetal weight <2Kg. In the operation theater (OT), routine monitoring included heart rate 121 beats/min, electrocardiogram, noninvasive blood pressure (NIBP) 126/82 mmHg, and pulse oximetry with SpO₂ at 99% on room air done and these baseline parameters were recorded. An intravenous (IV) access was already there, patient was preloaded with 500 mL of normal saline solution. Under all aseptic precautions, a subarachnoid block was performed at L3/L4 space in the left lateral position with a 26-gauge Quincke needle and 1.8 mL of hyperbaric bupivacaine was injected into the subarachnoid space after confirming a clear and free flow of cerebrospinal fluid (CSF). The patient was placed in supine position with left uterine displacement. The sensory block was assessed using pinprick testing. The surgical incision was started when the sensory level reached T4 level and a Bromage scale of 3.

Blood pressure was maintained with Inj. Phenylephrine and inj. Ephedrine intraoperatively. Baby was delivered with birth weight 1450 g. Inj oxytocin 40 Units given in 1L of ringer lactate solution after delivery of baby. Total blood loss and urine output during surgery was 1700ml and 150ml respectively. 1600 ml crystalloid solution was infused intraoperatively. After surgery, patient was monitored closely for 24 hours in postoperative ward. Postoperative period was uneventful.

DISCUSSION

Pregnancy during teenage years is associated with socioeconomic and health inequalities as regard both mother and child, including higher risks of deprivation, behavioural and emotional difficulties, maltreatment, morbidity and premature mortality.^[6-7] Therefore, it is a global concern. Sociocultural, economic, individual and health service factors were identified as the main determinants of adolescent pregnancy.

Various social and biological factors influence the odds of teenage pregnancy, these include exposure to adversity during childhood and adolescence, a family history of teenage pregnancy, conduct and attention problems, family instability, and low educational achievement.^[3-4] Teenage pregnancies have an adverse impact on maternal mortality and perinatal morbidity. Children are more likely to be born pre-term, have lower birth weight, and higher neonatal mortality, while mothers experience greater rates of post-partum depression and are less likely to initiate breastfeeding,^[5] likewise the patient discussed in present case study has severe IUGR and delivered the baby with very low birth weight. Our patient hadn't undergone any antenatal checkup or investigation which showed unawareness of poor socioeconomic strata people about health care services and poor implementation of the programs proposed by government. To address the health (including sexual and reproductive) risks of its young population, India launched the Adolescent Reproductive and Sexual Health Strategy (ARSH) (2005–2013) and subsequently Rashtriya Kishor Swasthya Karyakram (RKSK) or national adolescent health programme (2014-present). While RKSK is an evolution from ARSH, India still has a long way to go. At the policy level, convergence has emerged to be a key issue. Inter-departmental linkages continued to challenge implementation due to lack of ownership over programme components of non-health departments, and monitoring was not adequately done. Understanding the risk factors for teenage pregnancy and implementation of national programmes at ground level are prerequisites for reducing rates of teenage motherhood.

CONCLUSION

The sexual health education needs to be clubbed with social-emotional learning. Young mothers today face difficulties known to have long-lasting effects for women and their children. Preventions that target young mothers may reduce harm to the physical health, mental health, and social status of future generations.

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