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Adolescent Pregnancy Guidelines

This Clinical Practice Guideline has been prepared by the Canadian Paediatric and Adolescent Gynaecology and Obstetricians (CANPAGO) committee, reviewed by the Family Physician Advisory, Aboriginal Health Initiative, Maternal Fetal Medicine, and the Clinical Practice—Obstetrics Committees, and approved by the Executive and Board of the Society of Obstetricians and Gynaecologists of Canada.

PRINCIPAL AUTHORS

Nathalie Fleming, MD, Ottawa ON

Teresa O'Driscoll, MD, Sioux Lookout ON

Gisela Becker, RM, Calgary AB

Rachel F. Spitzer, MD, Toronto ON

CANPAGO COMMITTEE

Lisa Allen, MD (Co-chair), Toronto ON

Debra Millar, MD (Co-chair), Vancouver BC

Philippa Brain, MD, Calgary AB

Nancy Dalziel, RN, Ottawa ON

Elise Dubuc, MD, Montreal QC

Julie Hakim, MD, Ottawa ON

Deanna Murphy, MD, St. John's NL

Rachel Spitzer, MD, Toronto ON

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Key Words: Pregnancy, adolescent, teen, teenager, youth

Abstract

Objective: To describe the needs and evidence-based practice specific to care of the pregnant adolescent in Canada, including special populations.

Outcomes: Healthy pregnancies for adolescent women in Canada, with culturally sensitive and age-appropriate care to ensure the best possible outcomes for these young women and their infants and young families, and to reduce repeat pregnancy rates.

Evidence: Published literature was retrieved through searches of PubMed and The Cochrane Library on May 23, 2012 using appropriate controlled vocabulary (e.g., Pregnancy in Adolescence) and key words (e.g., pregnancy, teen, youth). Results were restricted to systematic reviews, randomized control trials/controlled clinical trials, and observational studies. Results were limited to English or French language materials published in or after 1990. Searches were updated on a regular basis and incorporated in the guideline to July 6, 2013. Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology-related agencies, national and international medical specialty societies, and clinical practice guideline collections.

Values: The quality of evidence in this document was rated using the criteria described in the Report of the Canadian Task Force on Preventive Health Care (Table 1).

Benefits/Harms/Costs: These guidelines are designed to help practitioners caring for adolescent women during pregnancy in Canada and allow them to take the best care of these young women in a manner appropriate for their age, cultural backgrounds, and risk profiles.

Recommendations

1. Health care providers should adapt their prenatal care for adolescents and offer multidisciplinary care that is easily accessible to the adolescent early in the pregnancy, recognizing that adolescents often present to care later than their adult counterparts. A model that provides an opportunity to address all of these needs at one site may be the preferred model of care for pregnant adolescents. (II-1A)
2. Health care providers should be sensitive to the unique developmental needs of adolescents through all stages of pregnancy and during intrapartum and postpartum care. (III-B)
3. Adolescents have high-risk pregnancies and should be managed accordingly within programs that have the capacity to manage their care. The unique physical risks of adolescent pregnancy should be recognized and the care provided must address these. (II-1A)

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Table 1. Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care

Quality of evidence assessment*	Classification of recommendations†
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II-1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II-2: Evidence from well-designed cohort (prospective or retrospective) or case–control studies, preferably from more than one centre or research group	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category	D. There is fair evidence to recommend against the clinical preventive action
	E. There is good evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.[119]

†Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.[119]

4. Fathers and partners should be included as much as possible in pregnancy care and prenatal/infant care education. (III-B)
5. A first-trimester ultrasound is recommended not only for the usual reasons for properly dating the pregnancy, but also for assessing the increased risks of preterm birth. (I-A)
6. Counselling about all available pregnancy outcome options (abortion, adoption, and parenting) should be provided to any adolescent with a confirmed intrauterine gestation. (III-A)
7. Testing for sexually transmitted infections (STI) (II-2A) and bacterial vaginosis (III-B) should be performed routinely upon presentation for pregnancy care and again in the third trimester; STI testing should also be performed postpartum and when needed symptomatically.
   a. Because pregnant adolescents are inherently at increased risk for preterm labour, preterm birth, and preterm pre-labour rupture of membranes, screening and management of bacterial vaginosis is recommended. (III-B)
   b. After treatment for a positive test, a test of cure is needed 3 to 4 weeks after completion of treatment. Refer partner for screening and treatment. Take the opportunity to discuss condom use. (III-A)
8. Routine and repeated screening for alcohol use, substance abuse, and violence in pregnancy is recommended because of their increased rates in this population. (II-2A)
9. Routine and repeated screening for and treatment of mood disorders in pregnancy is recommended because of their increased rates in this population. The Edinburgh Postnatal Depression Scale administered in each trimester and postpartum, and more frequently if deemed necessary, is one option for such screening. (II-2A)
10. Pregnant adolescents should have a nutritional assessment, vitamins and food supplementation if needed, and access to a strategy to reduce anemia and low birth weight and to optimize weight gain in pregnancy. (II-2A)
11. Conflicting evidence supports and refutes differences in gestational hypertension in the adolescent population; therefore, the care usual for adult populations is supported for pregnant adolescents at this time. (II-2A)
12. Practitioners should consult gestational diabetes mellitus (GDM) guidelines. In theory, testing all patients is appropriate, although rates of GDM are generally lower in adolescent populations. Practitioners should be aware, however, that certain ethnic groups including Aboriginal populations are at high risk of GDM. (II-2A)
13. An ultrasound anatomical assessment at 16 to 20 weeks is recommended because of increased rates of congenital anomalies in this population. (II-2A)
14. As in other populations at risk of intrauterine growth restriction (IUGR) and low birth weight, an ultrasound to assess fetal well-being and estimated fetal weight at 32 to 34 weeks gestational age is suggested to screen for IUGR. (III-A)
15. Visits in the second or third trimester should be more frequent to address the increased risk of preterm labour and preterm birth and to assess fetal well-being. All caregivers should be aware of the signs and symptoms of preterm labour and should educate their patients to recognize them. (III-A)
16. It should be recognized that adolescents have improved vaginal delivery rates and a concomitantly lower Caesarean section rate than their adult counterparts. (II-2A) As with antenatal care, peripartum care in hospital should be multidisciplinary, involving social care, support for breastfeeding and lactation, and the involvement of children's aid services when warranted. (III-B)
17. Postpartum care should include a focus on contraceptive methods, especially long-acting reversible contraception methods, as a means to decrease the high rates of repeat pregnancy in this population; discussion of contraception should begin before delivery. (III-A)
18. Breastfeeding should be recommended and sufficient support given to this population at high risk for discontinuation. (II-2A)
19. Postpartum care programs should be available to support adolescent parents and their children, to improve the mothers' knowledge of parenting, to increase breastfeeding rates, to screen for and manage postpartum depression, to increase birth intervals, and to decrease repeated unintended pregnancy rates. (III-B)