

Risk factors for preterm birth and outcomes of pregnancy among Northeastern Thai teenage pregnancies in Khon Kaen, Thailand.

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Description

Preterm birth may permanently affect some surviving babies. Teenage pregnancy is known to be a risk factor for preterm birth. Studies on risk factors for preterm birth in teenage pregnancy in Thailand is scant. This retrospective cohort study aimed to evaluate risk factors for preterm birth and outcomes of pregnancy among teenage mothers who gave birth in a tertiary hospital in Northeastern Thailand.

All teenage pregnancies who gave birth at Khon Kaen hospital, Thailand, from January 2014 to December 2015 were retrospectively reviewed to identify risk factors for preterm birth and outcomes of pregnancy. Data and information on the characteristics of teenage mothers and outcomes of pregnancy were extracted from electronic files of medical records and charts.

Multivariable logistic regression analysis was used to evaluate independent risk factors for preterm birth among teenage mothers. Results: During the study period, 1,042 teenage mothers were identified. The preterm birth rate among those teenage mothers was 16.8%. Teenage mothers were divided into 2 groups; term and preterm. Fetal complication and fetal anomaly were higher in the preterm group compared with the term group.

There was no incident of stillbirth in the term group, while in preterm group there was a rate of 2.2%. BMI before pregnancy of less than 18.5 (OR, 1.89; 95% CI, 1.28-2.81), weight gain of <5 kg (OR, 5.11; 95% CI, 2.96-8.81), prenatal visit of <4 times (OR, 5.16; 95% CI, 3.50-7.61), Premature Rupture Of Membrane [PROM] (OR, 4.22; 95% CI, 2.20-8.11) and previous preterm birth (OR, 46.56; 95% CI, 13.15-164.88) were found to be independent risk factors for preterm birth in teenage mothers. Conclusions: Previous preterm birth, BMI before pregnancy of less than 18.5, weight gain of <5 kg, prenatal visit of <4 times, and PROM should be taken into consideration for prevention of preterm birth in teenage pregnancy.

Thorough investigations are warranted to rule out other causes of miscarriage. Once ruled out, a diagnosis of idiopathic recurrent miscarriage is confirmed. For women presenting with a clinical diagnosis of idiopathic recurrent miscarriage (having experienced two or more), there is a reduction in the rate of miscarriage with the use of dydrogesterone. Dydrogesterone should be administered as early as possible, at the diagnosis of pregnancy or during the luteal phase, in stimulated cycles. Oral dydrogesterone should be offered. Manufacturer dosage: 10–20 mg daily, until the 20th week of pregnancy. Treatment should preferably start before conception. If symptoms of threatened miscarriage occur during treatment, continue treatment as stated for that indication.

The size of the newborn determines the health and development in the first months of life, for this reason it is considered as a variable of importance and permanent study as a marker of the health status in countries. The purpose of this study is to identify the trend and maternal factors associated with adverse birth weight. Cross-sectional design. The analysis uses the 2009-2015 Uruguay's data on 303,625 newborns.

LBW decreases while macrosomia increases. The health and nutritional status of women at the beginning of pregnancy, pathologies of the last trimester, smoking, shorter duration of pregnancy and inadequate controls are associated with LBW. Overweight, obesity and metabolic diseases determine macrosomia.

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