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PREGNANCY OUTCOME IN FEMALES ABOVE 35 YEARS

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INTRODUCTION

In the last three decades, there has been a trend towards deferred childbearing, especially among healthy, well educated women with career opportunities. The proportion of pregnant women above 30 years vary from country to country. Formerly, pregnant women aged 35 years and older tended to have several unplanned pregnancies, whereas today, the proportion of first births to "elderly" pregnant woman is growing. Advanced maternal age is generally held to signify age after 35 years at the time of delivery. This implies decreased fertility and increased risk1.

A pregnancy is termed as high risk, when the probability of an adverse outcome for the mother or child is increased over and above the baseline risk2 of that outcome among the general population, by the presence of one or more ascertainable risk factors. There are different opinions regarding the age above which a pregnancy is termed elderly, the age above which there is a significant increase in the rate of complications. Most of the western physicians consider 35 years and older as elderly. In our country, where more than half of marriages are performed in the second decade of a woman's life, 30 years and above can be considered as "elderly"(Dawn et al, Dutta). Advanced maternal age has been associated with an increased risk of various complications like Hypertension, Diabetes mellitus, Intrauterine growth restriction and congenital malformations. Anticipation, timely and accurate diagnosis of complications and their treatment leads to favourable outcome thus stressing the importance of good prenatal care.

AIM

1. To estimate the incidence of pregnancy above 35 years.

MATERIALS AND METHODS

This prospective study included 100 randomly selected patients admitted in the labour room. The study group comprises of 50 patients with pregnancy above 35 years and compared with equal number of pregnant patients in 20 to 35 year age group (control group). After general examination, vitals were noted down. Obstetric examination carried out to asses gestational age, lie, presentation, liquor volume.
Bimanual pelvic examination done for patients nearing term.
Following investigations were done

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Urine protein, sugar, deposits Haemoglobin and Packed cell volume Blood sugar-fasting and postprandial (2 hours) HIV, VDRL, USG.
Special investigations for complications like:
PIH - Blood urea, Serum creatine, uric acid ,fibrinogen, LFT, 24 hour urine protein, Fundus examination.

RESULTS

The incidence of pregnancy above 35 years was 5.03% in our study.

Table 1: Baseline characteristics of study participants

Parameter	**Patients n=50**	**Controls n=50**	**P value**
Age	32.56±15.39 (mean±SD)	26.18±2.78 (mean±SD)	
Gravida			
1	9	23	0.001
2	16	18	
3	15	7	
4	5	1	
≥5	5	1	
H/O Abortion			
0	37	46	<0.0001
1	8	3	
2	4	1	
≥3	1	0	
H/O LSCS			
Present	13	9	<0.05
Absent	37	41	
Period of Gestation			
Preterm	17	13	<0.05
Term	31	30	
Post term	2	7	

DISCUSSION

In our observation, the majority of pregnant females above 30 years were second gravidae (G 2) in group 1. In group 2, the majority were primi gravidae . While comparing the two groups, there is a significant increase in the gravida score in the study group (GP 1). This could probably because our hospital caters to low socio economic class of people with majority of them uneducated or their educational status less than secondary school. They have poor knowledge about contraceptive usage or family planning accounting for the grand multiparity. There also appear to be less spacing between pregnancies in group 1 with only few patients having a history

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of sub fertility. There is a significant increase in the risk of miscarriage with advancing age. This correlates well with FASTER trial and other western studies. The incidence of spontaneous abortion ranges from 15% to 93% (according to Nyobo Anderson et al.,) in pregnancy above 30 years, while it is around 11% in pregnancy below 20 years. In our study, the incidence of sontaneous abortion is about 15.2% in group I and 5.2% in group II which is statistically significant. Most of the miscarriages were missed abortion (Blighted ovum) followed by incomplete abortion. There were few patients in group I who also opted for medical termination of pregnancy with concurrent sterilisation. In our study, the incidence of previous lscs in group 1 is 26.4% and 17.6% in group 2, which is statistically significant. Reasons are multifactorial. Patients who had their first pregnancy in late twenties with delivery by caesarean section came back for their second pregnancy, after good spacing. Many patients were not willing for puerperal sterilization following labour naturale. These patients land up in unplanned pregnancy thereby increasing the gravida score. Patients who were elderly gravidae with co-existing medical complications and history of infertility or sub fertility were also toppers for lscs.

The obstetricians and patients have a low threshold to perform a caesarean delivery in older women and hence we see a growing acceptance of primary elective caesarean deliveries.

CONCLUSION

The scientific era we are living in offer new opportunities to women equivalent to men there by compromising their family life to a certain extent. Although educated and professional women prefer late marriage and delayed child bearing (according to western studies), our hospital does not see any acute increase in the incidence of pregnancy above 35 years after 2003.

The occurrence of labor dysfunction and operative deliveries are also more. Though one third of women above 35 years give a history of infertility, many others are multiparae with unbooked and unplanned pregnancy with complications unattended. Hence, advancing maternal age definitely has more disadvantages than advantages. If on social or medical grounds, pregnancy above 30 years is unavoidable, then the adverse outcome is lessened by proper AN care, nutitional supplements, diagnostic imaging, appropriate investigations and delivery in a tertiary institution with proper NICU facilities.

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