

LETTER TO THE EDITOR: PREGNANCY IN T1DM ADOLESCENTS

Thank-you for your comprehensive article that highlighted the potential complications of pregnancy in teenagers with type 1 diabetes (T1DM). We were surprised at your findings that “chronically ill adolescents are less likely to receive contraceptive counseling and sexual education than their healthy counterparts”.¹ The clinical practice guidelines in Canada and the United States clearly require that adolescents with T1DM receive counseling on contraception and sexual health to avoid unplanned pregnancy.^{2,3} Given that adolescents with T1DM see a physician 3 to 4 times per year, there is much more opportunity to discuss sexual health and birth control issues compared to adolescents without chronic disease.

We are a multi-disciplinary team in a pediatric diabetes education and care program for children with diabetes. Pediatric endocrinologists, a masters-prepared social worker, nurses, and dietitians make up our team. As a quality assurance activity, we surveyed adolescents age 12 to 18 years with diabetes in our program from January to August 2001 to determine rates of smoking and sexual activity and their recall of teaching on these subjects.⁴ We found 11.8% of adolescents with T1DM were sexually active compared to the Canadian national average of 44% for females age 15 to 19 years.⁵ Only 5.9% of our adolescent males with T1DM reported sexual activity compared to 43% of Canadian boys age 15-19 years.⁵ Sixty percent of adolescent girls and 40% of adolescent boys in our clinic reported having been involved in a discussion about sexuality in the previous year. We understand that our rates may be low due to reluctance of the patients to divulge this information and because we included younger adolescents in the survey.

Our team begins education about adolescent issues including sexuality, birth control, and preconception counseling at approximately age 12 years. Oral contraceptives are encouraged as well as barrier methods to prevent sexually transmitted diseases. We know of only one pregnancy in more than 500 females with T1DM in our program since 1985. Our concern lies in the difficulties that adolescents face when they are transferred to adult care at age 18.⁶ The rate of dropout of diabetes care in young adult years has been found to be 25%,⁷ and this is alarming considering the risk of pregnancy without early care, as you clearly state in your paper. Our focus needs to be on supporting young adults through the stress of transition while remaining ever vigilant in the care of our adolescents in preventing pregnancy.

Sincerely,

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Author's Response

We appreciate your letter and kind words concerning our review on pregnancy in adolescents with T1DM, and we are grateful to learn of your comprehensive care program for adolescents with diabetes.⁴ Such programs are ideal and hopefully will translate into a decrease in the rate of pregnancies in diabetic adolescents. You are correct in quoting the guidelines in Canada and the United States that mandate education on contraceptive counseling and sexual education.^{2,3} Unfortunately, these guidelines are not a guarantee for appropriate contraception. The quality assurance activity that you reported⁴ may not reflect the true prevalence of sexual activity among T1DM adolescents. Your comparison group of non-diabetic adolescents (1994–95 National Population Health Survey) reported an estimated 43% of girls aged 15 to 19 years had at least one sex partner in the previous year. In addition, among sexually active 15- to 19-year-old adolescents, 51% reported having sex without a condom in the past year and less than 50% of the adolescent females who admitted to sexual activity reported using oral contraceptives.⁵ These surveys are not available for comparison in T1DM.

You reported that 69% of adolescent females in your clinic have been involved in a discussion about sexuality in the last year. The impact of these discussions to lower the pregnancy rate in T1DM patients is yet to be shown. Intensification of methods that prevent pregnancy in this high-risk population need to be implemented. Offering effective contraception, even without consent of the parents, may be the only means to decrease the pregnancy rate in adolescents. Hopefully, your program will provide the evidence and strategies that are applicable to diabetic adolescents and thus spur increased efforts to focus on pregnancy prevention.

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