Delayed childbearing

Ensuring life choices are informed

Vivienne O'Connor, MBChB, FRANZCOG, FRCOG, MEd, is Senior Lecturer, Discipline of Obstetrics and Gynaecology, University of Queensland.

Kate Johnson, MBBS, FRACGP, is a general practitioner, Gold Coast, and Associate Professor, Bond University, Queensland.

Most Australian women experience about 400 periods between menarche and menopause. This is less in societies where women become pregnant at a young age and breastfeed until their next pregnancy. In the developed world, choice means that women are having their first baby later: the average age for a first pregnancy in Australia is now 27 years. In Britain, the number of births for every thousand women in their early 30s now exceeds that for women in their 20s, and in the USA there has been an increasing rate and number of women with impaired fecundity over the past 30 years.[1–3]

Media coverage of high profile 'older' mothers and their successful pregnancies may give the impression that pregnancy is easily achieved and not subject to any constraints. So impaired fertility may come as a shock for couples having difficulty conceiving.

Postponing a first pregnancy until after the age of 30 years is often related to the pursuit of a career, the need for financial security, or lack of a suitable partner.[4] Many women fail to appreciate that fertility falls with age, or that assisted reproductive technology may not be able to provide the backup for any natural reproductive misfortune.[5]

What is the outlook for women postponing their first pregnancy? The aging ovary is the main problem: oocyte loss increases after the age of 37 years, with an additional increased susceptibility to aneuploidy and possible mutations in those oocytes remaining.[1] There may also be risks associated with increasing paternal age.[6]

Even when a pregnancy is achieved in an older woman, there is an increased risk of complications such as miscarriage, ectopic pregnancy, fetal death, low birth weight, preterm delivery and dizygotic twins; less physiological resistance for the mother; and an increased risk of pulmonary embolus, haemorrhage and cardiac disease.[7–9] Moreover, there has been more time to develop gynaecological problems such as endometriosis and fibroids, and medical conditions such as hypertension and diabetes – all of which threaten a successful pregnancy (and may in turn be affected by pregnancy).[10] For women who utilise artificial reproductive technology, the success rate decreases with age. Delayed fertility has costs – financial, social and psychological – for both the woman and society.

The real issue is whether the choice to delay childbearing is informed. The possible social advantages to having children later need to be weighed against the risks associated with, or failure to, achieve a pregnancy by the individual. Of course some women choose not to have a child, and for others there is no suitable partner. But for those women who want a child, perhaps timely information would provide them with options; perhaps even to consider a child without the presence of a long term partner.

The roles of the media and medical profession are to increase women's awareness of the 'fertility facts'; thereby allowing an informed choice. Clinicians also have a preventive role such as screening young women for chlamydia infection, and the identification and management of women with specific disorders that might affect fertility.

This month's issue of *Australian Family Physician* contains relevant articles on the approach to the infertile couple, the psychological and social impact of infertility, new advances in infertility treatment, and a patient's perspective of infertility. Impaired fertility is an increasing issue in our community, and the general practitioner is frequently the person who sets infertile patients on their long and often painful journey of assisted reproductive technology. The role of the GP in offering informed and appropriately person centred support as they travel this path cannot be underestimated.

References

1. Gosden R, Rutherford A. delayed childbearing. BMJ 1995;311:1585–6.
2. Heffner LJ. Advancing maternal age – how old is too old? N Engl J Med 2004;351:1927–9.
3. Chandra A, Stephen EH. Impaired fecundity in the United States: 1982–1995. Fam Plann Perspec 1999;31:34–42.
4. Francis HH. Delayed childbearing. IPPF Med Bull 1985;19:3–4.
5. Hammarberg K, Clarke VE. Reasons for delaying childbearing: a survey of women aged over 35 years seeking assisted reproductive technology. Aust Fam Physician 2005;34:187–8, 206.
6. Lian ZH, Zack MM, Erickson JD. Paternal age and the occurrence of birth defects. Am J Hum Genet 1986;39:648–60.
7. Salihu HM,Shumpert MN, Slay M, Kirby RS, Alexander GR. Childbearing beyond maternal age 50 and fetal outcomes in the United States. Obstet Gynecol 2003;102:1006–14.
8. Nybo Andersen A-M, Wohlfahrt J, Christens P, et al. Maternal age and fetal loss: population based register linkage study. BMJ 2000;320:1708–12.
9. Carolan M. The graying of the obstetric population: implications for the older mother. J Obstet Gynecol Neonata Nurs 2003;32:19–27.
10. Ankum WM. Higher maternal age was associated with increased risks for fetal death and ectopic pregnancy. Evid Based Med 2001;6:26–8.

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