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The adolescent girl

Adolescent health care, particularly of girls, needs much improvement

Adolescence is the period of transition from carefree childhood to responsible adulthood and a time of vulnerability and risk. The World Health Organization (WHO) defines it as the age group from 10 to 19 years (1).

Adolescents have high-risk behaviour associated with a change in their life style from a family centred parent controlled one to an independent peer influenced one. More than the boy, the adolescent girl is particularly vulnerable and exposed to reproductive health risks. These are related to early unsafe sexual activity, sexual abuse, early unwanted pregnancy, adverse pregnancy outcomes, reproductive tract infections (RTI) including sexually transmissible diseases (STD), emotional lability and substance abuse. Choices and behaviour adopted during this period usually have far reaching effects later.

Most health care systems have traditionally focussed attention on antenatal, intrapartum and postnatal care, paediatric care, adult care and care of the elderly. Adolescent health is often neglected. Health care needs of adolescents are often different from those of an adult. Adolescents are not a homogeneous group. Their life styles vary with gender, age, social class, culture and country. This diversity should be taken into account when managing an adolescent. Problems of sexuality and reproductive health in the adolescent girl should ideally be managed by a gynaecologist who is fully aware of their special needs.

Interviewing and obtaining a history

Although parents should be present initially and allowed to 'fill in the gaps' when necessary, questions should be directed to the girl herself to give her confidence. Thereafter the girl should be interviewed alone. There should be a confidential, frank and candid discussion for which the doctor should have good communication skills. Half-truths or white lies are unacceptable. The girl should be encouraged to talk by asking for clarifications and getting her to reflect on the problem. The doctor should be non-judgmental and should give explanations and suggestions regarding risks rather than lecturing and moralising. The doctor should also mediate and resolve any conflicts between the girl and her parents. Parental consent is not needed for adolescent consultation and treatment in most instances. If the girl is uncertain about confidentiality she may suppress important information or delay in seeking medical help. However, privileged communications and confidentiality are invalid in cases of abuse or if the girl's life is in danger (2,3).

It is important to look for signs of depression. Poor attendance and performance in school, decreased self-esteem, withdrawal from friends and

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extracurricular activities, and high risk health behaviour should be noted. The doctor must check on sexual activity, explain their health risks and counsel the girl regarding prevention. Whether the parents should be present during examination of the girl would depend on the girl's choice.

Ideally, the parents should also be interviewed separately giving them opportunity to express their concerns. The final counselling and discussion of treatment and further management should include the girl as well as her parents.

Adolescent clinics

In the USA preventive health services for adolescents are recommended from 13 years of age onwards (2). If facilities permit, there should be a special clinic for adolescents. This would be an ideal setting for providing educational leaflets on hygiene, contraception, and protection from rape and sexual abuse, and even fixed learning modules on topics such as contraception and STD. The environment in the clinic should be pleasant unlike typical hospital clinics. It should preferably be held on a Saturday morning to stress the importance of schooling. The adolescent girl should be allowed to obtain an appointment and attend the clinic by herself if she wishes.

Sexuality

Adolescent sexuality is rarely discussed as it is considered embarrassing. With the reduction in the age of puberty the gap between menarche and marriage has widened. During this period the girl has a rapid development of her sexuality. As a result of biological changes in the body, she develops sexual feelings and embarks on establishing sexual relationships. In the USA many adolescent girls progress from masturbation and non-coital behaviour to sexual intercourse by the time they reach high school. Although the majority of them are American about 20% of Asian students too have a similar pattern of behaviour (4).

The situation in Sri Lanka is probably not very different. In Galle about 30% of girls in university entrance classes were found to be sexually active. The majority were from upper social classes and the commerce and arts streams (5). Although an adolescent girl may have heterosexual and homosexual experiences these do not necessarily predict future sexual orientation. Interaction of biological factors with feelings, attractions, behaviour and life style contribute to the development of a sexual identify. About 90% of adolescent girls who attend STD clinics in Sri Lanka are heterosexual.

Sexual abuse

In a survey in the USA 1 in 10 adolescent girls reported being sexually abused during the previous year (6). In Galle, 11% of girls in University entrance classes, more than 65% of them from the lower socio-economic strata, had been sexually abused. The abuser was probably an immediate family member. Furthermore, 40% of commercial sex workers reported being sexually abused (7).

Pregnancy

The vast majority of adolescent pregnancies are unplanned, unwanted, and end in termination (8,9). In an obstetric unit in Galle 62% of teenage pregnancies were unplanned, mainly due to ignorance about contraception (10). Teenage pregnancies, particularly in those below 17 years of age have an

increased risk of adverse pregnancy outcomes and probably carry a higher risk of later cervical cancer. The adverse psychosocial effects are of greater concern than the obstetric and medical complications. These adverse effects afflict even older teenagers (11).

Contraception

There is a dilemma between moral, legal and ethical aspects of contraception in adolescents especially as the legal age of marriage is 18 years whereas the age of consent is 16. In a judgement in the UK it was ruled that even a girl under 16 years of age should be provided with contraception. The rationale was that the girl in question was mature enough to understand the consequences of her actions and that she would engage in sexual intercourse even if contraception was not provided (12). It has been suggested that conventional as well as specially designed primary prevention strategies are unable to delay the initiation of intercourse, improve the use of contraceptives or prevent unwanted pregnancies (13, 14). But other studies have shown that school based health education programs and provision of contraceptive services to sexually active teenagers at the community level can prevent or reduce unwanted teenage pregnancies (15, 16).

Mental health

The adolescent girl has conflicting emotions, for she is neither a child nor an adult. She tries to imitate her seniors and adults while being reluctant to give up the things she enjoyed as a child. As mental health problems during adolescence can hamper the intellectual, emotional and social development of the individual, and also lead to mental health problems later, there is an urgent need to improve adolescent mental health care in Sri Lanka (17). Abnormal behaviour and emotional problems, which are commoner than medical illnesses, were found in 11% of adolescents in a rural population of Sri Lanka. Good family and social support can make the adolescent more resilient and enable her to face the multiple risks and challenges in life.

Eating disorders ranging from the classical anorexia nervosa with amenorrhoea to bulima nervosa and binge eating may be seen in the adolescent girl (18). Because of the associated hypo-oestrogenaemia, the risk of osteopenia and osteoporosis is highest in amenorrhoeic athletes and those who undertake strenuous exercises in association with compulsive disorders (19). Hormone replacement therapy using the combined oral contraceptive pill (OCP) has been recommended in such patients after the eating disorder is stabilised (20). A team approach involving a gynaecologist experienced in handling adolescent health problems, a nutritionist, a psychologist and a psychiatrist is needed to manage these patients.

Menstrual abnormalities

A thorough knowledge of the control of menstruation is needed to treat menstrual abnormalities which are common in the adolescent. The majority are due to anovulation and immaturity of the hypothalamo-pituitary-ovarian axis. A significant minority of young girls can have an underlying problem such as a bleeding disorder or thyroid malfunction that needs to be diagnosed and treated.

Primary dysmenorrhoea is common in the adolescent. This usually responds to treatment with an anti-prostaglandin or OCP. Sometimes the parents may dislike the recommendation of OCP for fear that the girl may start sexual activity or fear of future subfertility. Reassurance and appropriate counselling are required.

Hirsutism

Idiopathic hirsutism is common. The commonest pathological cause of hirsutism is polycystic ovarian disease. After excluding virilism due to androgen excess and correcting any underlying disorder such as adrenal enzyme deficiency, the commonly used treatment options are OCP, spironolactone, cyproterone accetate, electrolysis and depilatory creams. The hirsute girl is often embarrassed and worried about her appearance. However, she may not talk about it with the doctor. The doctor should be tactful here to avoid making her self-conscious and creating a negative self-image which she did not have earlier.

Congenital malformation of the genital tract

Other than benign hyperplasia of the labia minora and cryptomenorrhoea due to a vaginal septum, abnormalities of the external genitalia are similar to those of an adult, but rarely seen. The former needs reassurance and the latter surgical correction.

Major malformations of the genital tract are associated with a significant adverse psychological impact which often persists throughout life. Although surgical correction of the anatomical defect may be possible they may continue to be infertile and have a life-long feeling of imperfection and inadequacy. The gynaecologist should take this into consideration when attempting to correct the abnormality based on a sound knowledge of normal sexual differentiation and development.

Breast disorders

The doctor should have a basic knowledge of the development of the breasts and the changes associated with normal puberty. Abnormalities of size (especially when small) and asymmetry are worrying to the girl and generally need only reassurance. Referral to a plastic surgeon is rarely needed. Fibroadenomata are not uncommon and are usually excised. Although rare, a carcinoma must be considered in the differential diagnosis especially if she has a past history of childhood malignancy or chest radiotherapy. Routine self examination of breasts is usually not recommended except in subjects who have a positive family history of breast cancer and have been found to carry the $BRCA_1$ and $BRCA_2$ genes (21). Ultrasonography is appropriate in the presence of a mass to differentiate between solid and cystic lesions. It should be combined with fine needle aspiration biopsy (22).

Pelvic pain

Pelvic pain is common in adolescent girls. It can be due to endometriosis, pelvic inflammatory disease, intra- or extra-uterine pregnancy or complications of an adnexal mass. The management involves accurate diagnosis and appropriate treatment. Chronic pelvic pain can also be functional in origin and may require physical therapy, cognitive behavioural therapy, and rarely, even psychotropic medication (23). If the problem has led to absenteeism from school a gradual return to school is recommended.

Sexually transmissible diseases (STD)

In a study in the USA, one in four sexually active adolescents was found to have an STD, mainly due to *Neisseria gonorrhoeae* or *Chlamydia trachomatis* (24). Approximately 5 to 6% of patients attending STD clinics in Sri Lanka are adolescents and the ratio of girls to boys is about 3:2. Sexually active adolescents face barriers to health care access mainly due to fears of 'being found out by parents'. They should be provided with confidential and comprehensive counselling regarding prevention, screening and treatment of STD.

Conclusion

There is an urgent need to improve adolescent health care in Sri Lanka in general, and the reproductive and mental health care of the adolescent girl in particular.

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