

Pattern and outcome of gynaecological emergencies at a Nigerian secondary Health Care Centre

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Citation

D Buowari. *Pattern and outcome of gynaecological emergencies at a Nigerian secondary Health Care Centre*. The Internet Journal of Tropical Medicine. 2009 Volume 6 Number 2.

Abstract

BACKGROUND: Gynaecological emergencies form a large proportion of workload for the doctor. **METHOD:** This is a prospective study of all emergencies presenting with gynaecological problems from February to November 2006 was included in this study. **RESULT:** 153 patients presented with gynaecological emergencies in this study. 143(93.5%) had spontaneous abortion and 10(6.5%) women had ectopic pregnancy. **CONCLUSION:** Emergency gynaecological practice is more stressful in Nigeria than in developed countries because of poor infrastructure and difficulty in sourcing the materials required to treat patients.

INTRODUCTION

Any primary care doctor should be prepared to encounter and to handle gynaecological emergencies in patients, even those in critical ill states¹. Whilst there are many conditions that may lead to an emergency presentation, there are four emergencies, which account for the great majority. These are spontaneous abortion, pelvic sepsis including bartholin's abscess, ectopic pregnancy, and accidents to ovarian cyst². These common conditions should be at the forefront of the doctor's mind when asked to see a patient presenting as a gynaecological emergency whether she is referred by her general practitioner or presents herself to the casualty department. Only when those diagnoses have been excluded should one consider alternative less common gynaecological emergencies.

Worldwide, abortions and its complications constitute the single most frequent cause of admissions of women to gynaecological wards and to female wards in smaller general hospitals³. Abortions constitute a major cause of maternal morbidity and mortality particularly so in the many tropical and less developed countries of the world.

Many human conceptions are genetically abnormal and end in miscarriage, which is the commonest complication of pregnancy⁴. Ectopic pregnancy is a common life threatening gynaecological emergency in our environment⁵. The frequency of ectopic pregnancy is still high in this environment⁶. Its frequency of its occurrence varies not only

from one country to the other; incidence rates also can be significantly different between communities within the same country. Some of these pregnancies may be terminated spontaneously before they give rise to notable clinical symptoms.

It is not possible to be precise about the frequency of spontaneous miscarriage because many of the early cases are not diagnosed, but are regarded as a delayed or abnormal menstrual period⁷. Abortion is the termination of a pregnancy before the foetus attains the age of viability. A spontaneous abortion is the termination of a pregnancy through natural causes. The incidence of abortions reported varies depending on the degree of abortion in the area studied.

Very early miscarriage due to failure of the fertilized egg to divide or implant may occur without causing the woman to miss a period⁷.

An Ectopic pregnancy is a pregnancy that occurs outside the uterine cavity. Ectopic pregnancy refers to the implantation of pregnancy outside the endometrial cavity². It is life a threatening complication of pregnancy. When it ruptures, it may cause massive haemoperitoneum with haemorrhagic shock. It is a condition that occurs in all races, all countries and in any socio-economic class of women during the reproductive years. Ectopic pregnancy is an important cause of morbidity and mortality worldwide⁸. If not treated vigorously and early enough it may be fatal². Abortion and

ectopic pregnancy especially may produce hypovolaemic shock². The purpose of this study is to determine the pattern and outcome of gynaecological emergencies.

METHOD

This a ten-month prospective study of patients admitted with gynaecological problems from February to November 2006 at General Hospital Aliero. General Hospital Aliero is located in a rural area in Kebbi State, northern Nigeria. Being a small general hospital patients with gynaecological problems are admitted into the female medical ward and those who had surgeries are admitted into the female surgical ward since there is no gynaecological ward. The hospital is a general hospital, which does not have an active gynaecological unit as the patients are being managed by the general practitioners posted to the hospital. The patients were admitted through the casualty as emergencies or the out patient clinic. At presentation, a brief history was taken and physical examination for pallor, jaundice, cyanosis, any form of bleeding and pain. The patients were monitored and followed up until discharge. Investigations done were urinalysis, packed cell volume and grouping and cross matching of blood. Where necessary, abdominopelvic ultrasound was done. Surgery was done for those presenting with ectopic pregnancy. Analgesics were administered for pain. Anaemia was corrected with either blood transfusion or haematinics. Manual vacuum aspiration was done for those with incomplete and septic abortion. Antibiotics were administered also. The patients were monitored and followed up until discharge

RESULTS

All patients admitted for gynaecological problems between February to November 2006 were included in the study. During the period of study, 153 patients presented with gynaecological emergencies. 148(78.3%) patients were admitted for spontaneous abortion of which 113 were incomplete abortion, 19 threatened abortions, 7 complete abortions, 5 missed abortion, and 4 septic abortion. Other gynaecological admissions were ovarian cyst 15(7.9%), hydatidiform mole 12(6.3%), ectopic pregnancy 10(5.3%) and uterine fibroid 4 (2.1%). This is as shown in Table I.

One hundred and eighty nine patients were admitted for gynaecological problems during the period of study. Other than the gynaecological emergencies, other reasons for admission were ovarian cyst, hydatidiform mole, and uterine fibroid. The ages of patients ranged from fifteen to forty-five years.

All patients recovered after management and were discharged home. No mortality was recorded.

DISCUSSION

Worldwide, there is evidence of high maternal mortality associated with abortion³. Any of the varieties of abortion may be complicated by infection.

Despite a long list of aetiological factors, the causes of most spontaneous abortions are uncertain⁷. Malaria is a common cause of spontaneous abortion in many developing countries.

Ectopic pregnancy presents a major health problem for women of childbearing age⁹. Ectopic pregnancy can lead to massive haemorrhage or death. It mimics virtually every condition that causes acute abdomen in women of the reproductive age group¹⁰. Multiple factors contribute to the relative risk of ectopic pregnancy. In theory, anything that hampers the migration of the embryo to the endometrial cavity could predispose women to ectopic gestation⁹. Women with ectopic pregnancy continue to present late precluding early diagnosis and use of conservative modalities of management. Morbidity remains high but mortality has declined. The delayed diagnosis of ruptured ectopic pregnancy is an important cause of death in women¹¹.

There is currently an increased incidence of ectopic pregnancy globally¹². This incidence may be related to a higher incidence of tubal disease notably salpingitis.

Technological advances have led to earlier diagnosis of ectopic pregnancies with a decline in morbidity and mortality in developed countries.

In the surgical management of ectopic pregnancy, the benefits of salpingectomy over salpingostomy are uncertain⁸. Early presentation, high index of suspicion and use of modern diagnostic techniques will improve overall clinical outcome of patients. Considerable progress has been accomplished in the diagnosis and treatment of ectopic pregnancy¹³. The combination of pain, vaginal bleeding, and shock is the classical presentation of ruptured ectopic pregnancy though the presentation can be variable.

In this study, surgery (salpingectomy) was done for patients with ectopic pregnancy. Patients received blood transfusion. All patients with ectopic pregnancy in this study had a history of collapse at home and were pale at presentation. Urgent packed cell volume was done with grouping and cross matching of blood. Patients were faced with the risk of

blood transfusion reaction and complications of blood transfusion. There was no blood transfusion reaction in patients in this study.

Promotion of family planning, early treatment of pelvic inflammatory disease and good quality obstetric care could be important preventive intervention measures ⁶.

In developed countries, diagnosis is made before rupture occurs, however most cases in our environment still present late with severe intraperitoneal haemorrhage ⁵. Apart from late presentation is a problem in this environment. All patients in this study had ruptured ectopic pregnancy at the time of surgery.

Blood bank services and availability of antibiotics are necessary in the management of most gynaecological emergencies. This is a problem in some developing countries and sometimes absent in hospitals in the rural areas. Transportation to an appropriate health facility can be a cause of late presentation. Most gynaecological emergencies that are managed by laparotomy can be treated by laparoscopy and benefit both patients and the health facility ¹⁴.

References

1. www.find-health-articles.com
2. Monaghan JM: Common Gynaecological Emergencies. Wright, London; 1988: 3
3. Akinkugbe A. A Textbook of Obstetrics and Gynaecology for Students, Medical Practitioners, and Senior Midwives in Southern Developing Countries. Ibadan, Evans Brothers(Nigeria Publishers) Ltd; 1996: 258-274
4. Raj R, Rigan I. Recurrent Miscarriage. The Lancet, 2006; 368: 601-611
5. Nwagha UI, Iyioke C, Nwagha TU. Current Trends in the Management of Ectopic Pregnancy: A Review. J College of Medicine, 2007; 12(2): 67-75
6. Adesiyun GA, Adze J. Ectopic Pregnancies at the Ahmadu Bello University Teaching Hospital, Kaduna, Northern Nigeria. Trop J Obstetrics and Gynaecology, 2001; 18(2): 82-86
7. Chamberlain G(Ed). Gynaecology by Ten Teachers. Sixteenth Edition. Britain, Arnold; 1997:194-204
8. Farquhar CM. Ectopic Pregnancy. The Lancet, 2005; 366: 583-591
9. Sepilian VP, Wood E. Ectopic Pregnancy, 2007; www.emedicine.com/med/topic3121.htm
10. Kigbu JH, Pam IC, Ekwempu CC, Swem PD. Splenic Rupture Masquerading Ruptured Ectopic Pregnancy. Highland Med Res J, 2006; 4(1): 119-122
11. Fowler PBS. Ectopic Pregnancy. The Lancet, 2006; 367: 27
12. Kwame-Arye RA, Seefah JD: Handbook of Gynaecology: a Practical Guide to Students and Practitioners. Belteam Publications Limited. Accra: 1991: 82
13. Ayoubi J, Fanchin R. Ectopic Pregnancy: Which Side to Operate? The Lancet, 2003; 367: 1183
14. Baumann R, Magos AL, Turnbull AC: Managing Gynaecological Emergencies with Laparoscopy. Maternal mortality J. 1989. 299: 371-4

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