Pattern Of Gynaecological Admission At A Rural Hospital In Nigeria

D Buowari

Citation

D Buowari. *Pattern Of Gynaecological Admission At A Rural Hospital In Nigeria*. The Internet Journal of Tropical Medicine. 2009 Volume 7 Number 1.

Abstract

BACKGROUND: To determine the disease pattern and outcome of management of gynaecological emergencies from a large proportion of work load for the DoctorMETHOD: A ten months prospective study of patients admitted with gynaecological problems from February to November 2006. Patients were followed up until discharge.RESULTS: Patients admitted during the period of study for gynaecological problems were 189. 148(78.3%) were admitted for spontaneous abortion, 15(7.9%) for ovarian cyst, 12(6.3%) for hydatidiform mole, 10(5.3%) for ectopic pregnancy and 4(2.1%) for uterine fibroid.CONCLUSION: Information, education and counselling on reproductive health and provision of affordable health services will increase the utilization of hospital facilities and reduce morbidity. The highest percentage of admissions due to gynaecological problems was spontaneous abortion

INTRODUCTION

Gynaecological problems cause morbidity in women from time to time. Any primary care doctor should be prepared to encounter and to handle gynaecological emergencies in patients even those in critical states [1]. In big hospitals, such patients are admitted into the gynaecological ward while in smaller hospitals they are admitted into the female medical or surgical ward. Some of the patients are admitted through the clinic while others come in as emergencies.

Worldwide abortions and its complications abortions and it's constitute the single most frequent cause of admission of women to gynaecological ward and to female wards in smaller general hospitals [1]. Abortion constitutes a major cause of maternal morbidity and mortality particularly so in the many tropical and less developed countries of the world.

Ectopic pregnancy presents a major health problem for women of childbearing age [3]. Ectopic pregnancy is an important cause of maternal morbidity and mortality in the first trimester of pregnancy [4,5]. It is a common life threatening gynaecological emergency in our environment and a major surgical emergency in gynaecology [6,7]. The frequency of ectopic is still high in this environment.

Hydatidiform mole occurs worldwide and is the third most frequent cause of vaginally bleeding in early pregnancy after abortion and ectopic pregnancy [2]. The disease is of considerable importance not only as a cause of pregnancy wastage but because of the malignant sequelae that are associated with a proportion of these moles. Many human conceptions are genetically abnormal and end in miscarriage, which is the commonest complication of pregnancy [8].

Ectopic pregnancy can become a life-threatening situation. As the gestation enlarges, it creates the potential for organ rupture because only the uterine cavity is designed to expand and accommodate foetal development [3]. It is a condition that occurs in all races, in all countries and in any socio-economic class of women during the reproductive years. Hydatidiform mole is common complication of gestation [9].

Ovarian cyst is a cause of morbidity in women. The ovary is a frequent site for the occurrence of neoplastic tumours that could be either benign or malignant [2]. Among cancers of the female genital tract, the incidence of ovarian cancer ranks below only to carcinoma of the cervix and the endometrium. Most of these tumours are cystic and in the early stage may not be easily distinguishable from some functional cysts of the ovary. Uterine fibroids are common benign tumours of the female reproductive tract. Other reasons why women are admitted for gynaecological problems are pelvic inflammatory disease, vagina bleeding of various causes, uterine prolapse, sexually transmitted disease, tumours of the genital tract etc. 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, pelvis sepsis including bartholin's abscess, ectopic pregnancy, and accidents to ovarian cyst [10]. 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.

The main objective of this study is to review the pattern of gynaecological admissions at a rural hospital in northern Nigeria. Also to determine the admission pattern and outcome of patients admitted with gynaecological problems at General Hospital, Aliero.

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 and high vagina swab 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. A total of 726 women were admitted into the female medical and surgical wards during the period of study of which 189(26.o%) had gynaecological problems. 189 patients were admitted with gynaecological problems during the period of study. 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%). Surgery was carried out on patients with uterine fibroid, ectopic pregnancy, and ovarian cyst. One of the patients had torsion of ovarian cyst co-existing with a 20 weeks pregnancy. She was referred to the tertiary hospital at the capital city for expert management. The ages of patients ranged from fifteen to fifty-five years with a mean of thirty-five years. Length of hospital stay ranged from 24 hours to fourteen days with a mean of 3.5 days and median of four days. All patients recovered after management and were discharged home. No mortality was recorded.

DISCUSSION

Women from time to time are admitted as inpatients in hospitals with gynaecological problems both in big and small hospitals. There are different gynaecological problems that may need admission. It may be because of vaginal bleeding, pain, malaise, fever etc. Despite along list of aetiological factors, the cause of most abortions is uncertain [11.] In this study, abortions constitute majority of the reason for admission.

The delayed diagnosis of ruptured ectopic pregnancy is an important cause of death in women [12]. Women with ectopic pregnancy continue to present late reducing early diagnosis and use of conservative modalities of management morbidity remains high but mortality has declined. Technological advances have led to earlier diagnosis of ectopic pregnancies with a decline in morbidity and mortality in developed countries. Early identification and prompt management of what can still be a life threatening condition remains a complex task.

The ovarian cysts are harmless but some may cause problems such as rupturing, bleeding, and pain and may be require removal the cyst. Torsion is the commonest complication of ovarian cyst. In young women, suspicion of pregnancy may be very strong particularly when they are seen for the first time with abdominal swelling. All patients with ovarian cyst presented with abdominal swelling. Improved quality of ultrasonography has a measurable effect on the management of patients[13]. It is necessary in the diagnosis of abortion, hydatidiform mole, and other forms of

abdominopelvic swelling.

Termination of pregnancy is required once a diagnosis of hydatidiform mole is made with emptying of the uterus of its abnormal contents. Follow up is essential because of the risk of choriocarcinoma developing.

Anaemia was corrected in anaemic patients by the use of haematinics and blood transfusion. Blood products are not available at the centre therefore patients requiring blood transfusion are transfused with fresh whole blood. Patients are encouraged to eat nutritious diet. Analgesics are prescribed for pain. At General Hospital Aliero, oral paracetamol and non-steroidal anti-inflammatory drugs (piroxicam, diclofenac, and ibrupufen) are used. Parenteral analgesics used are paracetamol and diclofenac. Fentanyl and morphine are not available at the centre. Triple regimens of antibiotics are used comprising of gentamycin, metronidazole, and ampiclox.

Early presentation, high index of suspicion and use of modern diagnostic techniques will improve overall clinical outcome of patients. Transportation to an appropriate health facility can be a cause of late presentation. Antibiotics and analgesics are necessary in the management of most gynaecological problems. Transportation to an appropriate health facility can be a cause of late presentation.

References

1. www.find-health-articles.com
2. Akinkugbe A. A Textbook of Obstetrics and Gynaecology. Ibadan, Evans Brothers (Nigeria Publishers) Ltd; 1996: 248-423
3. Sepilian VP, Wood SE. Ectopic Pregnancy. www.emedicine.com/med/topic3212htm. 2007
4. Airele IR, Ekele BA. Ectopic Pregnancy in Sokoto, Northern Nigeria. Malawi Med J, 2005; 17(1): 14-17
5. Farquhar CM. Ectopic Pregnancy. The Lancet, 2005; 366: 583-591
6. Iyioke C, Nwagha TU, Nwagha UI. Current Trends in the Management of Ectopic Pregnancy: A Review. J College Med, 2007; 12(2): 67-75
7. Adesiyun GA, Adze J, Onwuhafua A, Onwuhafua PO. Ectopic Pregnancies at the Ahmadu Bello University Teaching Hospital, Kaduna, Northern Nigeria. Trop J Obstet and Gynaec, 2001; 18(2): 82-86
8. Raj R, Rgan I. Recurrent Miscarriage. The Lancet. 2006; 368: 601-611
9. Collins T, Cotran RS, Kumar V. Robbins Pathologic Basis of disease. Philadelphia. WB Saunders Company; 1999: 1085
10. Monoghan JM. Common Gynaecological Emergencies. Wright, London; 1998:3
11. Chamberlain Geoffrey(Ed). Gynaecology by Ten Teachers. Britain. Arnold. Sixteenth Edition. 1997:194-204
12. Fowler PBS. Ectopic Pregnancy. The Lancet, 2006; 367: 27
13. Ayoubi J, Fanchin R. Ectopic Pregnancy: Which Side to Operate? The Lancet. 2003. 367: 1183

Author Information

Dabota Yvonne Buowari, MBBS