

PATTERN OF GYNAECOLOGICAL CONSULTATIONS AT LADOKE AKINTOLA UNIVERSITY OF TECHNOLOGY TEACHING HOSPITAL

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ABSTRACT

Aims: A descriptive study to determine the pattern of gynaecological consultations at Ladoke Akintola University of Technology Teaching Hospital, and to know the factors that determine the pattern as well as the outcome of such consultations.

Material and Methods: The case notes of all the patients that attended the gynaecology clinic between 1st January 2004 and 31st December 2005 were studied.

Results: Two hundred and fifty patients attended the gynaecology clinic during the study period, however, 208(83.2%) case notes were available for analysis. Most of the patients that had gynaecological consultations during the study period were married (88.0%), and infertility (48.1%) was the commonest reason for the consultations. Many of the patients (60.1%) did not receive definitive treatment for their consultation.

Conclusion: Infertility being the commonest reason for gynaecological consultations, and tubal factor the commonest cause of infertility, there is need to establish assisted reproductive technology in public health institutions to render services at a highly subsidized rate in helping this population of patients who could not afford this treatment which is presently being offered by private health institutions.

Key Words: Gynaecology, Consultations, Pattern, Outcome.

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INTRODUCTION

Ladoke Akintola University of Technology (LAUTECH) Teaching Hospital (LTH), Osogbo, jointly owned by Oyo and Osun states, was established in 1998 as the teaching hospital complex for the college of health sciences, LAUTECH, Osogbo, and it had since been accredited for the training of both undergraduates and postgraduates.

It is a 280-bedded hospital, which serves Osun state and its neighboring states. The Obstetrics and Gynaecology department provides services in the areas of general gynaecology, including reproductive health and infertility, gynaecological oncology, urogynaecology and family planning. The general gynaecology clinics are run twice weekly, while emergency gynaecology clinic is run 24-hour. Additional clinics for family planning are held daily at the family planning clinic.

Being a young teaching hospital there is need for a review of pattern of gynaecological consultation to provide the necessary data needed for planning, budgeting, and effective running of the hospital gynaecological services.

The objectives of this descriptive study, therefore, are to determine the pattern of gynaecological

consultations during the period between 1st January, 2004 and 31st December, 2005, and the factors that determine the pattern, as well as the outcome of such consultations.

METHODS

The case notes of the patients that attended the gynaecology clinic during the period 1st January, 2004 and 31st December, 2005 were retrieved from the medical records department of the hospital. Relevant information were extracted from the case notes and recorded in a data sheet for the individual patient. The data was entered into SPSS work sheet and analyzed using SPSS version 11.

RESULTS

Two hundred and fifty patients attended the gynaecology clinic during the study period, but 208(83.2%) case notes were available for analysis. The age range of the patients was between 1 and 76 years, with a mean age of 34.8±9.7 years; 111(53.4%) of the patients were Christians, while 96(46.2%) were Moslems. 183(88.0%) of the patient attending the gynaecology clinic were married, while 17(8.2%), and 7(3.4%) were single and widowed, respectively. Twenty-eight (15.7%) of the patients had no formal education, 19(10.7%) had primary education,

25(14.0%) had secondary education, and 106(59.6%) had tertiary education. One hundred and one (48.8%) of the patients were self employed, 74(35.7%) were government employed, 11(5.3%) were unemployed, and students constituted 14(6.8%) of the patients (Table 1). Nulliparous patients were 81(38.9%), patients with parity between 1 and 4 were 99(47.6%), and 27(13.0%) were para 5 and above. (Table 2)

The gynaecology department received most, 118(56.7%) of the referral from within the hospital, especially from the general outpatient department, 12(5.8%) patients were referred from private health institutions within Osogbo, 9(4.3%) each were referred from government and private health institutions outside Osogbo, while only 4(1.9%) patients were referred from government health institutions within Osogbo. Many, 137(65.9%) of the patients attending the gynaecology clinic had one or more investigations done, while 71(34.1%) had no investigation done. Infertility, 100(48.1%) was the commonest diagnosis, this was followed by benign gynaecological tumours 34(16.3%), menstrual disorders constituted 23(11.1%), while abortions accounted for 13(6.3%), pelvic infections was the diagnosis in 11(5.3%) of the patients; malignant gynaecological tumours, utero-vaginal prolapse, vesico-vaginal fistula accounted for 9(4.3%), 7(3.4%) and 3(1.4%), respectively; others(vulva itching, non-specific vaginal discharge, urethral mass) constituted 8(3.8%). (Fig 1)

Many of the patients 125(60.1%) did not receive definitive treatment, while only 83(39.9%) received definitive treatment; of those who had treatment, 45(54.2%) had surgical treatment, and 38(45.8%) had medical treatment.

Univariate analysis showed that patients who were married and widowed were more unlikely to receive treatment compared to those who were not married (OR=3.1, 1.83, 95% CI, 1.10-8.76; 0.33-10.10). Patients with the diagnosis of infertility and gynaecological tumours were unlikely to receive treatment compared to patients with other gynaecological problems (OR=6.0, 1.19; 95% CI, 2.99-12.05, 6.54-2.59). Those who had investigations done were more likely to get treated compared to those who had no investigations done (OR=17.45, 95% CI=6.62-46.02). Patients who were self employed, government employed, private employed and unemployed were unlikely to get treated compared to those who were schooling (OR 5.65, 2.64, 3.75; 95% CI, 1.64-19.40, 0.76-9.17 and 1.14-38.83, respectively). Multivariate analysis revealed that patient with infertility and those who had no investigations done were unlikely to receive treatment compared with patients with other

gynaecological problems and those who had investigations done, respectively (OR=8.14, 17.75, 95% CI=3.24-20.46, 6.22-50.66). (Table 3).

Table 1: Socio-Demographic Status of Patients Seeking Gynaecological Consultations.

Variable	Frequency	%
Religion		
Christianity	111	53.4
Islam	96	46.2
Not applicable	1	0.4
Marital Status		
Married	183	88.0
Single	17	8.2
Widowed	7	3.4
Not applicable	1	0.5
Educational Status		
None	28	15.7
Primary	19	10.7
Secondary	25	14.0
Tertiary	106	59.6
Employment Status		
Self Employed	101	48.8
Government Employed	74	35.7
Private Employed	5	2.4
Unemployed	11	5.3
Schooling	14	6.8
Not Indicated	2	1.0

Figure 1:

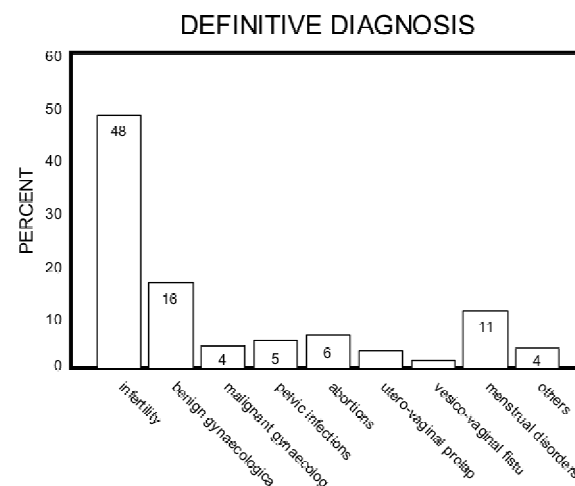


Table 2: Parity of the Patients Seeking Gynaecological Consultations

Parity	Number	Percentage
Nullipara	82	39.4
Para 1	44	21.2
Para 2	21	10.1
Para 3	19	9.1
Para 4	15	7.2
Para 5 and Above	27	13

Table 3: Logistic Regression on Factors Associated with Failure to Receive Treatment.

Variables	Crude OR	Adjusted OR
Marital Status		
Married	3.10(1.10-8.76)*	0.86(0.21-3.54)
Widowed	1.83(0.33-10.10)	0.90(0.10-8.30)
Single	1	1
Definitive Diagnosis		
Infertility	6.00(2.99-12.05)***	8.14(3.24-20.46)***
Gynaecological Tumours	1.19(0.54-2.59)	1.97(0.74-5.26)
Others	1	1
Investigations		
Not Done	17.45(6.62-46.02)***	17.75(6.22-50.66)***
Done	1	1
Employment Status		
Self-employed	5.65(1.64-19.40)**	4.80(0.78-29.61)
Government employed	2.64(0.76-9.17)	2.12(0.35-13.09)
Private employed	3.75(0.45-31.62)	2.09(0.13-33.89)
Unemployed	6.67(1.14-38.83)*	4.31(0.39-47.20)
Schooling	1	1

*P<0.05

**P<0.01

***P<0.001

DISCUSSION

The pattern of gynaecological consultation in this study reflects the pattern of diseases among women in the community because the bulk of the female health problems (with the exception of a few medical and surgical conditions) are tackled by the gynaecologist¹. Infertility was the commonest reason for gynaecological consultation during the study period; this follows the trend in other tertiary institutions where infertility had been the reason for consulting a gynaecologist², and it had been estimated that 40-50% of women attending the gynaecology clinic in Nigeria gave the complaint of primary and secondary infertility^{3, 4, 5}. This is not surprising, because the traditional African society places high premium on child bearing, and childlessness is regarded as an affliction, and the affected individual is viewed with disdain^{6, 7, 8}. Benign gynaecological tumours (mostly made up of uterine fibroids) followed infertility as the reason for gynaecological consultation. Uterine fibroid is the commonest tumour of the female genital tract^{9, 10}, and it had been observed that fibroid occurs more commonly among infertile women; hence it is not surprising that uterine fibroid was next to infertility in terms of frequency.

Menstrual disorders, which often times is associated with infertility was also a common presentation; irregular menses had been shown to be a major source of concern to women, especially those in the reproductive age group¹¹.

Abortions and pelvic infections accounted for a small proportion of the reason for gynaecological consultation; this was the finding in a similar study at another tertiary institution in Nigeria, in which abortions contributed a small proportion of admission to gynaecological ward¹. The small contribution of abortions may be due to the fact that

there are many private specialist clinics where some abortion cases presented for treatment. The restrictive abortion law in Nigeria might prevent some patient from presenting in public hospitals¹².

The little contributions made by conditions such as malignant lesions, utero-vaginal prolapse, and urinary incontinence as was evident in this study may be due to improved obstetric care in the community (as in the case of vesico-vaginal fistula)^{13, 14} low socio-economic status coupled with ignorance and the fact that these conditions are often not fatal until the late stages.

The mean age of the patient in this study is the period of reproductive activity for women, and this observation is further buttressed by the fact that complaints relating to reproductive organ and/or its functions were the most commonly found among patients within this age group. The same explanation holds for the fact that more married women were seeking gynaecological consultations than the unmarried women.

Many of the gynaecological consultations did not end in definitive treatment; this is similar to a study done at the University College Hospital, Ibadan in which 79.1% of the patients attending the gynaecological clinic did not receive definitive treatment¹⁵. This may reflect the restless nature of the infertile women³ (which constituted largest proportion of the consultations). Also one would have expected that employment of whatever form would be an important factor in receiving treatment, but this study showed that students were more likely to receive definitive treatment, compared to the patients with employment; this might be because students were under parental care, who would ensure that their children or wards get treated.

The population size of 250 patients (over the 2 year period) that had gynaecological consultations at the LAUTECH Teaching Hospital belies the tertiary and specialist nature of the institution. This may be due to the presence, in the same town, as the teaching hospital, of the state specialist hospital, where free health is being provided, and patients only come to the teaching hospital as a last resort. However, with increased awareness of the specialist nature of the institution, and quality of services, it is believed that more patients will be patronizing the teaching hospital.

In conclusion, infertility still remain the commonest reason for gynaecological consultations, and tubal factor, being the commonest cause of infertility in our environment⁶, there is need for the establishment of assisted reproductive technology in public health institutions at subsidized rate to help this population of patients who could not afford this treatment which is presently being offered by private health institutions at a very high cost. However pending the

time this will be feasible, there is need to lay emphasis on prevention and prompt treatment of sexually transmitted infections, safe delivery practice, educating the health care givers on dangers of unnecessary vaginal instrumentation which has been used in the treatment of menstrual disorders.

REFERENCES

1. **Lamina MA, Odusoga OI.** Pattern and Outcome of Gynaecological admissions at a Nigerian Tertiary Care Centre. *Tropical Journal of Obstetrics and Gynaecology.* 2004; 21(1): 52-55.
2. **Giwa-Osagie OF, Ogunyemi D, Emuvyan E E, et al.** Aetiological Classification and Socio-cultural Characteristics of Infertility in 25 Couples. *Int. J. Fertility.* 1984; 29: 104-108.
3. **Ladipo OA, Adeleye JA, Ojo OA.** Laparoscopy versus Hysterosalpingography in Infertility. *Nig. Med. Journ.* 1977; 7: 452-455.
4. **Chukwudebelu WO.** The male factor in Infertility: Nigerian experience. *Int. J. Fert.* 1978; 23:238-239.
5. **Otolorin EO.** Evaluation of the infertile couple. *Nig. Med. Pract.* 1981; 1: 20-23.
6. **Adetoro OO, Ebomoyi EW.** The prevalence of infertility in a rural Nigerian community. *Afri. J. Med & Med. Sci.* 1991; 20(1): 23-27.
7. **Ebomoyi EW, Adetoro OO.** Socio-biological factors influencing infertility in a rural Nigerian community. *Int. J. Gynecol. Obstet.* 1990; 33(1): 41-47.
8. **Okonofua FE.** The management of infertility in Africa. *Proceeds of the 1997 Annual Symposium of DOKITA editorial board, University College Hospital, Ibadan.*
9. **Fox H, Buckey CH (Ed).** Benign neoplasm of the genital tract. In: *Pathology for Gynaecologists.* 2nd edition. London Chapman and Hall. 1991: 95-101.
10. **Ogunniyi SO, Fasuba O.** Uterine fibromyomata in Ilesha, Nigeria. *Nig. Med. Pract.* 1990; 19: 93-95.
11. **Silberstein T.** Complications of Menstruation; Abnormal Uterine Bleeding. In: *Current Obstetric and Gynecologic Diagnosis and Treatment.* DeCherney AH, Nathan L (editors). McGraw-Hill Companies, Inc. 2003; 9: 37-70
12. **Oye-Adeniran BA, Adewole IF, Umoh AV, Iwere N, Gbadegesin A.** Induced Abortion in Nigeria: Findings from Focus Group Discussion. *Afr J Reprod Health.* 2005; 9(1): 133-141.
13. **Gharoro EP, Abedi HO.** Vesico-vaginal Fistula in Benin City, Nigeria. *Int. J. Gynecol. Obstet.* 1997; 64(3): 313-314.
14. **Katton SA.** Maternal Urological Injuries Associated with Vaginal Deliveries: Change of Pattern. *Int. Urology & Nephrology.* 1997; 29(2): 155-161.
15. **Adeyemi AS.** One- Year Review of the Pattern of Gynaecological Consultations at the University College Hospital, Ibadan. *West African College of Surgeons Part 11 Gynaecological Long Commentary.* 2003