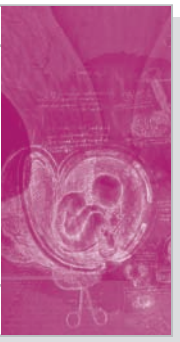
# The necessity of incorporating gynaecological tests in antiretroviral therapy packages – case observations



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**To the Editor:** In resource-limited settings, patients on antiretroviral therapy (ART) often do not have access to gynaecological tests and consultations. A number of these patients have gynaecological problems that require attention, and since most of the doctors taking care of the patients are not specialist gynaecologists, important gynaecological conditions are not taken care of adequately. Consequently, some of the patients present with advanced gynaecological disease.

The prognosis of Ugandan patients with HIV infection has improved with increased access to free ART. Cervical cancer is the most frequent cancer of women in sub-Saharan Africa and the most common cause of cancer-related death.[1] The age-standardised incidence of cervical cancer in sub-Saharan Africa is 30 - 67/100 000, which is 2 - 10 times higher than that in developed countries.[1] Globally, cervical cancer ranks second as a cause of cancer-related deaths in women.[2]

Low- and middle-resource countries, where women have been hit hardest by the AIDS epidemic, have historically also had a very high prevalence of human papillomavirus (HPV) infection and a high incidence of cervical cancer.[3,4]

Women who are HIV-infected are at a 4 times higher risk of developing cervical intra-epithelial neoplasia (CIN), a pre-malignant condition, compared with their HIV counterparts, with rates as high as 95% in HIV-infected women as opposed to 22% in uninfected women.[2,5]

Table I summarises two cases seen at the Infectious Diseases Institute, Kampala, Uganda, of women presenting with cervical cancer despite relatively high CD4 counts.

## Discussion

These cases demonstrate the importance and necessity of incorporating simple gynaecological tests and consultations as part of routine examination of HIV-infected women attending care settings. The majority of cervical cancer cases can be prevented by screening, and countries that have high coverage of cervical cancer screening have reduced the incidence of invasive cervical cancer by about 70 - 90%.[6]

Several studies conducted in developed countries have demonstrated an increased risk of invasive cervical cancer among HIV-positive women.[6]

**Table I. Two cases of cervical cancer in the presence of high CD4 counts**

| Age (yrs) | Parity | WHO stage | Weight (kg) | CD4+ counts (cells/µl) | EUA | Biopsy and H&E | Follow-up weight (kg) | Follow-up CD4+ counts (cells/µl) |
|---|---|---|---|---|---|---|---|---|
| 40 | P 3+0 | II | 50 | 506 | IA | Dysplastic cervicitis CIN III | 52 | 367 |
| 52 | P 3+0 | II | 79 | 451 | IIIB | Malignant squamous cell infiltrating the stroma | 84.5 | 336 |

EUA = examination under anaesthesia; H&E = haematoxylin and eosin.

Cervical cancer screening programmes in low-resource countries are difficult to implement and maintain for a variety of reasons, including cost, lack of trained personnel, inadequate laboratory support, and low patient follow-up rates. However, the scale-up of ART in low-resource countries provides an unprecedented opportunity to develop cervical cancer screening programmes. It also provides opportunities for the provision of broader gynaecological and other health care for women.

With regard to cost-effectiveness, the costs and clinical benefits of cervical cancer screening of HIV-infected women in low- and medium-resource countries have not been evaluated.

The above cases illustrate that there is a need to incorporate routine Pap smears in HIV/AIDS care programmes. HIV-positive women should have a cervical smear when they are first diagnosed with HIV, 6 months after this, and then every year.


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# Early discharge from hospital after caesarean section at Chris Hani Baragwanath Hospital

**To the Editor:** It has become common practice to discharge women from hospital early after caesarean section, to satisfy their wishes or to reduce workload. This practice has not been evaluated in South Africa. We undertook this study to find out if discharge from hospital on the 2nd postoperative day after uncomplicated caesarean section was acceptable to women, and to what extent it was followed by adverse clinical outcomes. Only one such study has been performed in Africa, in which Nigerian women were discharged on the 3rd instead of the usual 7th postoperative day, with good results.[1] No studies from Africa have investigated discharge from hospital on the 2nd postoperative day, although there have been reports of good outcomes from high-income countries.[2,3] The objectives of this study were to determine women's satisfaction, and rates of wound infection, maternal readmission, infant readmission and early postnatal depression.

We performed a cohort study of women discharged on the 2nd postoperative day after caesarean section at Chris Hani Baragwanath Hospital, with the permission of the University of the Witwatersrand's Human Research and Ethics Committee. The 2nd postoperative day was defined as 'day 2' on the postnatal morning round, from the date of delivery. This corresponds to a surgery-to-discharge interval of 33 - 57 hours. Women were discharged with no arrangement for home visits from nurses, and with routine follow-up only for removal of sutures. The following categories of women were excluded from the study: (*i*) age <18 or >45 years; (*ii*) hypertension, cardiac disease, diabetes mellitus, or antenatal anaemia (haemoglobin <10 g/dl); (*iii*) high risk of postoperative infection (rupture of membranes ≥24 hours, cephalopelvic disproportion, labour duration ≥20 hours, pyrexia in labour; (*iv*) surgical difficulties such as vertical or upper-segment uterine incision or suspected bladder injury, or excessive intra-operative or peripartum bleeding requiring packing, draining or blood transfusion; (*v*) stillbirth; (*vi*) evidence of infection after 24 hours postoperatively (heart rate ≥110 beats/min, temperature ≥37.5°C); (*vii*) poor clinical condition on the 2nd postoperative day, such as not getting up, not eating, vomiting, evidence of ileus, purulent wound discharge or dehiscence; (*viii*) infant not yet discharged from the hospital; (*ix*) unwillingness to be discharged; and (*x*) no telephone contact number for follow-up.

We used a consecutive sampling method. The researcher (NP) collected data from the case notes and conducted a short interview, and then arranged a follow-up telephonic interview 14 days after discharge. At follow-up, the researcher asked the woman her experience of early discharge, and about evidence of wound dehiscence or purulent discharge, bleeding from the wound, pain associated with the wound, and readmission of the woman or her infant. Postnatal depression was assessed using a simple early postnatal depression tool described by Whooley *et al*.[4] Two questions were used as markers of postnatal depression. These were: 'Since the birth, how often have you been down, depressed, or hopeless?', and 'Since the birth, how often did you have little interest or pleasure in doing things?' If the responses to either question were 'often' or 'always', the woman was classified as having self-reported postnatal depression. Data analysis was done using Epi-Info software. Statements of descriptive statistics included frequencies with percentages, means and ranges. Differences in