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continuous X-ray imaging. Spongostan standard gelatin sponge (Johnson and Johnson Medical, Skipton, UK) was cut into small blocks (< 1 cm diameter), suspended in a saline solution with heparin and injected into the uterine arteries with an immediate and marked reduction in uterine blood flow. Following the procedure, a single dose of 50 mg methotrexate was given intramuscularly.

Three days after embolisation the patient experienced mild suprapubic pain with a haemorrhagic vaginal discharge. An ultrasound examination performed on the fourth day showed an absent gestational sac with only a thickened endocervical epithelium. On discharge from hospital the patient received contraception in the form of depo-medroxyprogesterone acetate 150 mg intramuscularly.

Two weeks later she presented again with acute pain just below the umbilicus. She acknowledged having had coitus during these 2 weeks. Her temperature was 37.5°C, pulse rate 100/minute, blood pressure 119/63 mmHg and respiratory rate 28/minute. The lower abdomen was tender on palpation without guarding. Excitation tenderness of the cervix was present on vaginal examination, but the cervix itself was closed and of normal size. The adnexae were moderately tender on both sides.

An ultrasound examination revealed a normal cervix without other pathology in the pelvis. Analysis of her blood gases revealed a mild respiratory alkalosis with the carbon dioxide pressure (pCO2) 26 mmHg, oxygen pressure (pO2) 95 mmHg and pH 7.5. Her haemoglobin value was 10.6 g/dl with a leucocytosis of 14.9 x 10^9/l. The human chorionic gonadotropin (HCG) level had decreased from 39 to less than 10 mIU/l.

The patient was admitted with the clinical diagnosis of pelvic inflammatory disease (PID) and treated with clindamycin intravenously. The next day she improved significantly and on the second day she was discharged from hospital on oral clindamycin.

Discussion

There are different treatment options when a cervical pregnancy is diagnosed. Surgical evacuation is no longer the first line of treatment since it is impossible to remove the trophoblast completely. Medical treatment with methotrexate is the current first option in the management of a cervical pregnancy, with a 94% success rate. An important contraindication is acute haemorrhage which is present in about 30% of cases. The remaining treatment options include abdominal hysterectomy, endocervical tamponade and uterine artery embolisation. Although embolisation results in acute hypoxia of the uterus, collateral blood supplies will restore normal blood flow within 5 - 6 weeks. Due to the hypoxia, methotrexate should be given before embolisation if the two methods are applied together.

Methotrexate is not the ideal first line treatment in HIV-positive patients as it suppresses immunity in patients who are already immune compromised. Our patient, with a normal CD4 count of 330 x 10^9/l, received methotrexate before her HIV status was known and she developed pelvic inflammatory disease afterwards. Owing to the risk of infection, immunosuppressants should be limited in patients with a CD4 count of more than 200 x 10^9/l.

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Changes in the patient population attending a primary health care clinic in rural South Africa between 1991 and 2001

To the Editor: Serosurveys in the last decade indicate that the prevalence of HIV infection has risen in Hlabisa district, KwaZulu-Natal, from 4% in 1992, to 14% in 1995 and 35% in 2002. The impact of the HIV epidemic on the patient population attending local hospitals has been reported previously. In particular, there has been a marked increase in admissions for tuberculosis and other HIV-associated conditions. However, there are few data on the impact of the epidemic on the burden of illness seen at primary health clinic level. Furthermore, in 1996, primary health care became free for all in South Africa, whereas previously patients paid a nominal fee to see clinic staff. The impact of this change on the attendance at primary care clinics is unknown. Such information is needed for planning effective responses aimed at reducing unnecessary referrals and admissions to hospital and to enable more effective deployment of health care workers.

To investigate possible changes in the patient population...
attending a rural primary health clinic we reviewed a proportion of the records of patients attending Inhlwathi clinic in Hlabisa district, KwaZulu-Natal, in 1991 and in 2001. The clinic, situated about 250 km north of Durban and 60 km from the nearest paved road, is staffed by nurses and is one of 15 clinics in the district. No other health care facilities have been opened or closed within 30 km and staffing levels within the clinic have not changed. Between 1991 and 1996 the population of Hlabisa district is estimated to have grown at a rate of 2.6% per year and was about 220 000 in 1996.4 Clinic registers, completed by nurses for every patient consultation, were examined in more detail for July 1991 and 2001. The month of July was chosen as it is not affected by seasonal fluctuations in epidemic diseases such as malaria, cholera and dysentery. Details of the patients’ age, sex and presenting syndrome were recorded.

The total number of patient consultations at the clinic was 9 969 in 1991 and 18 723 in 2001. This 88% increase in clinic attendance is comparable to the 81% increase in admissions (from 6 562 to 11 872) to the local hospital between 1991 and 1998 reported elsewhere.3 The number of patient consultations in July was 836 in 1991 and 1 546 in 2001. The increase was evident in all age groups, and for most but not all presenting complaints. The proportion of men attending the clinic for the month of July was stable at 33% (N = 273) in 1991, and 33% (N = 513) in 2001. Respiratory symptoms were the most frequently reported reasons for attendance both in July 1991 (18%, 149/836) and in 2001 (28%, 438/1 546), but the number of patients seen with these symptoms increased threefold over that time. There has also been an increase in attendance for family planning services (41 people in July 1991 and 146 in July 2001) and a corresponding decrease in attendance for antenatal care (141 in July 1991 and 96 in July 2001). Over the same time period there has been a campaign in KwaZulu-Natal to educate the population with regard to family planning, and injectable contraceptives have become more widely available.

Although it is not possible in these data to separate the effects of the HIV epidemic from other factors impacting on health-seeking behaviour in the community served by this rural clinic, measures need to be taken to manage the growing demand for health care services and to determine who needs referral and who can be treated at the primary health clinic level.

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