OBS + GYNAE

Amelie Morin/ Elective report/ May 2011-06-01

I have chosen to organise my elective at the department of Obstetrics and Gynaecology of University of Cape Town. I am seriously considering a career in this specialty and I thought of reinforcing my knowledge while getting a different experience of clinical gynaecology. I have spent most of my time at Groote Schuur Hospital in the Gynaecology Department. But I also had the opportunity to spend a week at The Mowbray Maternity Hospital where I gained experience in assessment and management of labour.

The Western Cape department of health delivers a comprehensive package of health services to people of the province. As one of the richest of the nine provinces of South Africa, they provide one of the best health care in the country. The wealthiest part of the population is covered by medical aid and access health care through private doctors and private hospitals. Nationally, the private sector serves 20% of the population, and absorbs 60% of health-care spending and 70% of the doctors in the country. Patients seen in public hospital are usually from the poorest part of the population. Around 64% of the population of the Western Cape live in the biggest informal settlements on the Cape Flats, a part of Cape Town metropolitan. This population is mostly formed of black and coloured people. Family planning, infectious diseases management, ending of pregnancies, immunisations and antiretrovirals for AIDS patients among others, are free services for patients who do not have medical aid. Also, unemployed people and pregnant women are entitled to free medical services. There is a clear intention to encourage people to know their HIV status in order to provide treatment for affected people and to prevent transmission. The prevalence of HIV in South Africa is high: 17.8 percent among those aged 15-49 in 2009. It is estimated that 5.6 million people were living with HIV/AIDS in South Africa in 2009, more than in any other country, and the access to treatment is still low.

Groote Schuur Hospital is the main government-funded teaching hospital in Cape Town and the Western cape. It was founded in 1938 and named the « Great Barn » after the original estate laid out by Dutch settlers in the 17th century. It is an internationnally reknown centre since it became the site of the first ever heart transplant, performed by Prof. Christiaan Barnard on December the 3d 1967. It is beautifully located, on the slopes of Devil's peak, and provides tertiary care for patients of the Western Cape and further.

I joined Dr Jeffery and his team, specialised in Urogynaecology. Therefore, the commonest presentations are prolapses, causing discomfort and/or symptoms of urinary incontinence. Pathologies associated to pelvic floor weakness are commonly due to childbirth. Tears in the pelvic fascia during delivery allow the pelvic organs to descend. They mainly affect post menopausal women and involve symptoms such as incontinence, prolapse, emptying disorders, pelvic pain or overactive bladder. They are extremely distressing as incontinence and prolapses cause major psychosocial damages as well as sexual

dysfunction. Other presentations I came across were menorrhagia, pelvic pain or, irregular PV bleeding. Patients' pre-operative assessment includes full clerking and examination, including vaginal examination. I presented cases weekly on a consultant-lead academic ward round during which the most appropriate surgical procedure is discussed within the team. The discussion takes place with the patient in the room and once a decision has been made, the plan is explained to the patient. I was also responsible for seeing my patients before they go to theatre, get to assist the surgeons for the patients I clerked, and follow them up post operatively until discharge.

I had the chance to assist a variety of procedures. A diagnostic laparoscopy, during which endometriosis was found, a vaginal hysterectomy, operative hysteroscopy with mirena insertion, and a few prolapses' repair. Prolapses can be caused by weakness of the anterior or the posterior vaginal wall or both. They are fixed using different techniques depending on the degree of cystocoele, enterocoele and/or rectocoele as well as the utero-vaginal descent. Some necessitate the insertion of a mesh to reinforce the strength of the anterior or posterior vaginal wall. The mesh is anchored to the sacrospinous ligament bilaterally. In some cases, the wall is repaired via surgical plication. These techniques are very delicate and technically challenging due to the restrited access through the vaginal introitus. The risk of damage to the bladder or bowel is significant. Repair through the vaginal route is ideal as it is minimally invasive, which reduces the risk of post operative complications, and is also more pleasant for the patient who is left with no scar.

One of the patients I remember was a 19 year old woman who presented with irregular bleeding and right sided lower abdominal pain. An ovarian mass was detected via ultrasound scan and the MRI indicated that the mass was in keeping with a teratoma. This patient had congenital hearing impairment which rendered communication more difficult. We used a pen and paper to write down questions and answers at some point! I assisted during her surgery and the tumour was removed and thoroughly separated from the healthy ovarian tissue that could be preserved, hence not affecting her fertility.

I also attended gynae casualty. The presentations I came across were PV bleeding in early pregnancy (often miscarriage), hyperemesis gravidarum, termination of pregnancy, ectopic pregnancy, molar pregnancy. I got to perform speculum and bimanual examination as well as practice pap smear and swabs techniques. I saw a very rare case of haematocolpos due to imperforated hymen. This 13 year old patient had suffered abdominal cramping for months and was unable to pass urine for 24hours. On examination, a 16 weeks pregnacy sized uterus was felt and the vaginal introitus was completely closed by a bulging thick membrane. The ultrasound scan showed a cyst and a beaked uterine fundus (when looks like there is an opening on the fundus side). She was taken to minor surgery where an incision was made in the hymen under sedation. More than 2 litres of dark blood (2 years of retained periods) was drained out of the uterine cavity! Her symptoms were immediately relieved and she will now be able to have normal periods but she will need further surgery in the future to allow her to have intercourse.

I attended gynaecology and hysteroscopy clinics. I could observe polyps and fibroids removal. I saw 2

cases of Asherman's syndrome in which adhesions are found in the uterus, often caused by TB infection and leading to infertility.

Mowbray maternity hospital hosts 900 deliveries a month! One of the most common presentations I saw was gestational proteinuric hypertension (pre-eclampsia). I noticed a very high rate of HIV positive women often on HAART. There were a few grand multipare who were delivering their sixth or seventh baby and, sadly, some cases of intra uterine demise. It was very useful to practice examination of the pregnant abdomen and determine the fœtal lie and the engagement of the head. I had many opportunities to assess the stage of labour through vaginal examination which i had never done before! I saw some vaginal deliveries and assisted on a few cesarean sections.

I really enjoyed my elective in Cape Town and I feel more confident to perform and interpret vaginal examinations. I feel more familiar with a number of gynaecological presentations and their management including the surgical techniques involved. I have seen some extremely challenging presentations and worked with some very inspirational gynaecologists, which makes me all the more motivated to become one of them!