OBS + GYNAE

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Nepal Electives Objectives

Paroprakar Maternity and Women's Hospital

1. What are the prevalent O&G issues encountered in Nepal and how do they differ to the UK?

The second part of my electives was carried out at Paroprakar Maternity and Women's Hospital in Kathmandu, Nepal. This was a government hospital dedicated exclusively to obstetrics and gynaecology issues. After spending time in the gynaecology outpatient, the most common issues that I encountered were vaginal prolapses, sexually transmitted infections and polyps. The cases of prolapses that I came across were a lot more severe than the ones that I saw in the UK as very often the Nepalese women did not seek help till quite late. One of the reasons for this might be that they feel extremely embarrassed to discuss this type of issue with a doctor. The patient turnover in the outpatient clinics were a lot greater than in the UK which means that doctors in Nepal had to be very quick and efficient in seeing patients. Diagnosis is based mostly on clinical examination by visualizing the cervix with a speculum and doing a per vaginal examination.

I was also lucky to see a patient with an ectopic pregnancy in the emergency department and later followed her up to the Operating Theatre. In Nepal, breech babies are delivered by C-section which is similar to the UK.

2. How is antenatal care managed in Nepal and how does this compare to the UK?

Antenatal care in Nepal consists of four focused visits. The first visit is carried out as soon as pregnancy is suspected, the second visit is at 24-28 weeks, third visit is at 30-32 weeks (8months) and the last visit is at 36-38 weeks. Women are advised to seek medical help is they suspect any problem during the pregnancy.

The first visit is ideally done when the patient is less than 12 weeks pregnant. A detailed obstetrics and gynaecology history is taken. The Gestational Age and Expected Date of Delivery (EDD) is calculated using the Last Menstrual Period (LMP). A clinical examination is carried out where the patient's height, weight, blood pressure breast and cardiovascular system are examined. In terms of investigations, blood samples are taken to determine haemoglobin levels, blood group, Rhesus status and to test for venereal disease (VDRL test). A urine test is also performed for albumin. The patient is also given the first dose of tetanus toxoid vaccine and prescribed iron and folic acid supplement.

During the second visit, the patient is examined again, assessing particularly the uterine height and foetal heart rate. Weight and blood pressure is also measured. In nulliparous women or those with a previous history of pre-eclampsia, a urine test is carried out to look for protein.

At the third visit, the patient is given a second dose of tetanus toxoid vaccine and tested for anaemia. The patient is advised about delivery options at home or in a hospital. Contraception after delivery is also discussed at this point.

The fourth visit is mostly to assess foetal lie and presentation to allow detection of breech presentation.

In the UK, antenatal care is mostly community-based and is led by midwives. Nulliparous women are offered a total of 10 antenatal appointments and multiparous women have 7, but should any complication arise during the pregnancy then the patient is offered more frequent visits.

The first appointment is the booking visit carried out at 9-10 weeks gestation. A full history and examination is carried out to screen for any possible complications. The following investigations are also carried out: Urine, Full Blood Count, antibody screen, glucose, serology test for syphilis, HIV, Hepatitis B and rubella. An ultrasound scan is also carried out. Folic acid and Vitamin D supplement is prescribed and the patient is advised on nutrition and lifestyle factors affecting pregnancy.

At 11-13 weeks gestation, an early pregnancy ultrasound scan is performed to confirm gestation and viability of pregnancy and diagnose multiple pregnancy. The combined test is offered to screen for genetic abnormalities such as Downs syndrome. A nuchal translucency scan is performed together with blood test to calculate the risk. The results of these tests should be reviewed by 16 weeks.

Another ultrasound scan is offered at 20 weeks to detect any structural foetal abnormalities and the position of the placenta. From 25 weeks, only nulliparous women have serial measurement of the fundal height to identify pathologically small babies. Haemoglobin and antibodies testing is repeated at 28 weeks.

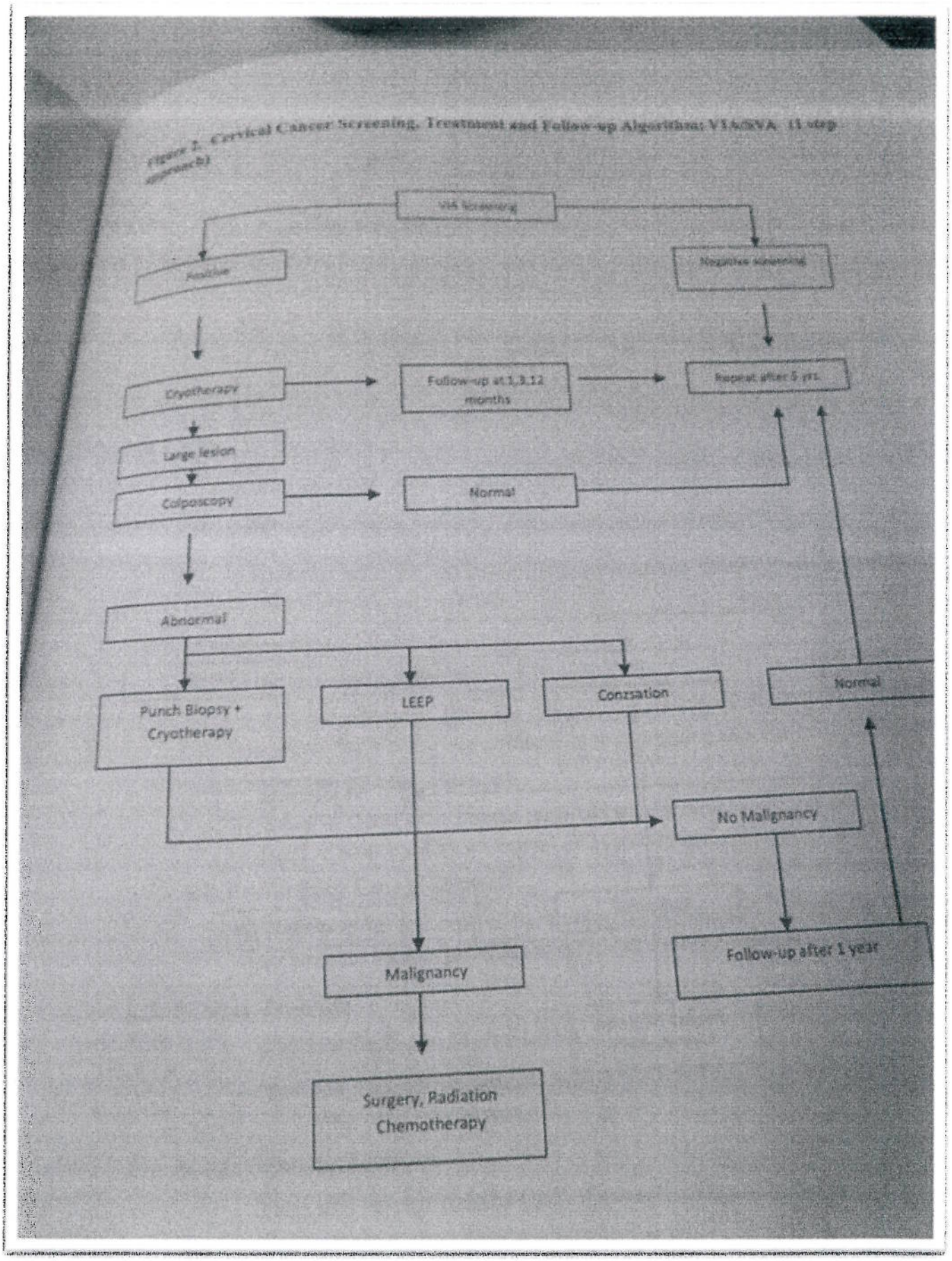
From 28 weeks onwards, delivery options are discussed with the patient (i.e. the patient may give birth in a hospital, at home or a birthing centre which is mostly midwife-led). Fundal height is measured and if patient is Rhesus negative then anti-D is given.

The fundal height is measured at each visit onwards and at 34 weeks, a second dose of anti-D is given to Rhesus negative patients. At 36-40 weeks, the foetal lie and presentation is assessed and in case of breech then cephalic version may be offered but is only carried out by experts and not routinely offered.

3. Discuss Cervical Screening and its management in Nepal compared to the UK.

Cervical cancer is the number one cancer in women in Nepal and makes up 21.4% of all cancers in women. It is most common in women aged 35-64. The method used is Visual Inspection with Acetic acid (VIA) which involves looking at the cervix with the naked eye and look for any white areas which will give a positive result.

If the VIA test is negative then screening is repeated every 5 years but if VIA is positive then the algorithm in figure 1 is used to further manage those patients.


VIA Screening
Positive
Negative screening
Cryotherapy
Follow-up at 1,3,12 months
Repeat after 5 yrs
Large lesion
Colposcopy
Normal
Abnormal
Punch Biopsy + Cryotherapy
LEEP
Conzsation
Normal
No Malignancy
Follow-up after 1 year
Malignancy
Surgery, Radiation Chemotherapy

In the UK, the cervical screen is offered to all women from the age of 25 (or after first intercourse if later) to 64. Those aged 25-49, the test is repeated every 3 years and those aged 50-64 are offered the test on a 5-yearly basis. The most common method of testing is using a brush to collect cells on the cervix and cytology is performed to look for dyskaryotic cells. The results are reported as mild dyskaryosis (CIN I), moderate (CIN II) or severe (CIN III).

If the smear result is normal then smear is repeated every 3 years. In cases of mild dyskaryosis or borderline changes, a smear test is repeated after 6 months and if dyskaryosis is still present then patient is referred for colposcopy. Patients with moderate dyskaryosis, colposcopy is required and those with severe dyskaryosis are referred for urgent ccolposcopy. In moderate and severe dyskaryosis, large loop excision is carried out and a biopsy id taken for histological analysis.

4. Further improve clinical and communication skills and reflect on activities and experiences in Nepal

Being in a hospital specialising in obstetric and gynaecology enabled me to see a wide variety of cases including ruptured ectopic pregnancy and dermoid cyst. During outpatient clinics, I performed a number of bimanual and vaginal examinations which allowed me to further improve my clinical skills.

On the wards and in clinics, the most striking issue was the lack of privacy patients had. There were no curtains around each patient's bed resulting in vaginal examinations being done very openly and even in clinics, up to three women were being examined in one cubicle at a time. I felt very uncomfortable with this idea as I believe that an intimate procedure such as vaginal examination can be quite distressing to the patient and therefore great care must be taken to ensure that the patient is at ease and treated with respect and dignity. However, due to lack of funding, Nepalese government hospitals cannot afford things like curtains. The patient turnover in Paroprakar Hospital is very quick with each doctor seeing approximately 30 patients in one clinic and consequently, doctors have very limited time to spend with each patient. Very often, patients were not adequately consented to being examined and no chaperone was available. When carrying out examinations, I tried my best to get someone to translate and obtain consent but this was not always possible and frustrating at times. However, I persevered and eventually received helped from a nursing student to translate.

Those were a few things that marked me during the time I spent doing my electives in the hospital. It made me think about my own bedside manners and I realised how important it is to explain procedures to patients as well as ensuring that they understand all information given. I also truely realised the importance of maintaining patient's privacy and dignity. This is something I will always bear in mind when dealing with patients for the rest of my life.