Burden of Gynaecological Disease in a Tertiary Hospital: two years audit of Outpatient Department at PIMS

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Abstract

Objective: To estimate the pattern of gynaecological morbidity in women seeking services.
Methods: All women seeking advice for gynaecological problems in the outpatients department of Obstetrics and Gynaecology, Pakistan Institute of Medical Sciences Islamabad, from January 1997 to December 1998 were included.
Results: The total reproductive morbidity presenting at the outpatients department was 29,196.Of these 18,289 (62.7%) presented with obstetric morbidity and 10,851 (37.2%) with gynaecological morbidity. Menstrual irregularity was the commonest gynaecological problem encountered (41.1%). The rest included reproductive tract infections (27.8%), subfertility (18.2%), urogynaecological problems (5.3%), menopausal symptoms (4%), benign genital tract tumors (2. 8%), gynaecological malignancies (0.7%) and others (0.1%, including sexual dysfunction, congenital malformations and genital tract injuries)
Conclusion: A number of women are seeking help for the varying severity of gynaecological morbidity, ranging from mild discomfort to overt disability. The major gnaecological morbidities identified are menstrual irregularities and reproductive tract infections. This study highlights the need for addressing and prioritising resources towards these women health issues which affect women's ability to fulfill a wide range of diverse roles (JPMA 54:513;2004).

Introduction

Women health has always remained neglected, because of the traditional reductionistic approach to women health research. In developing countries reproductive morbidity greatly affects the quality of a woman's life and until recently this form of ill health has been ignored by woman herself1, planners and researchers. Lack of awareness of the extent and effect of reproductive morbidity on the health and quality of life of women in developing countries is evident at national, community and individual levels.2 The first step towards achieving the needs of women as consumers and providers is to do baseline research so that the nature and magnitude of the problem is assessed. Various conceptualizations of reproductive health3-6 consider reproductive morbidity as inclusive of conditions of physical ill-health related to 'successful childbearing' and 'freedom from gynaecological disease and risk'. In line with these conceptualizations, we define reproductive morbidity to encompass obstetric morbidity including conditions during pregnancy, delivery and the post-partum period; and gynaecological morbidity including conditions of the reproductive tract not associated with a particular pregnancy such as reproductive-tract infections, cervical cell changes, prolapse and infertility. In addition, an interest in reproductive morbidity is also considered to encompass related morbidity including such conditions as urinary-tract infections, anemia, high blood pressure, obesity and syphilis as a systemic condition. Obviously this framework of reproductive morbidity is based on a biomedical model of health (unpublished data).

The purpose of this facility based study is to evaluate the extent and nature of gynaecological morbidity by women's self reported experiences as well as on findings from clinical and laboratory examinations. These studies will help us to direct our resources according to the burden of the disease.

Patients and Methods

This hospital based study was carried out at the Outpatients Department of Obstetrics and Gynaecology, Pakistan Institute of Medical Sciences Islamabad, from January 1997 to December 1998. Data was collected from the Gynaecology

outpatient's records, in which the presenting symptoms, clinical diagnosis and investigations were recorded. The Outpatients Department was organized into different clinics, and a specific doctor was in charge of each clinic rotating on monthly basis. Scrutiny of the data was done on monthly basis while the statistics for each clinic were presented in the monthly departmental statistical meeting by the doctor incharge. Data of all women seeking help for gynaecological problems was included in the study. Women reporting to the outpatients department with non-gynaecological problems were excluded. As abortions are part of obstetric morbidity they were not included. Information on various symptoms, ages, clinical findings and diagnosis of 10,861 women were recorded. Gynaecological morbidity was classified into reproductive tract infections, menstrual irregularities, infertility, gynaecological cancers, menopausal symptoms and others. Frequency of each morbidity was calculated separately.

Statistical Analysis

Descriptive statistics were used to analyze the data with SPSS version 10.6

Results

Patients presenting at the outpatients department with gynaecological problems were less than with obstetric morbidity, but their proportion (37.2%) cannot be ignored. The gynaecological outpatients load included three major groups: menstrual irregularity, reproductive tract infections and sub fertility. A small proportion of women presented with menopausal symptoms and women seeking help for genital tract cancers were 0.7% of the gynaecological morbidities (Table 1). Menstrual irregularity was the commonest morbidity; metrorrhagia and menorrhagia were the most frequent menstrual problems (Figure).

Table 1. Frequency of various gynecological morbidities.

Morbidity	No.	Percentage
Menstrual irregularity	4464	41.1
Reproductive tract infections	3015	27. 8
Sub fertility	1978	18.2
Urogynaecological problems	574	5.3
Menopausal symptoms	435	4
Benign tumors	299	2.8
Gynaecological cancers	76	0.7
Others	10	0.1
Total	10851	100

Vulvovaginitis leading to vaginal discharge was a common problem (19.1%) and 8.6% women were suffering from pelvic inflammatory disease. Out of 1978 patients with subfertility, 44.3% presented with primary and 55.6% with secondary subfertility. In some couples, the cause of sub fertility was still under investigation at the time of the study. In those with completed investigation, no cause was found, in half of the patients (58%). Female factor was two times commoner (27%) than the male factor (15%). Problems of ovulation were more frequent in female factor sub fertility; whereas oligo/asthenospermia was a common factor in males (Table 2). The average age of spontaneous menopause was 46.9 years. Premature menopause (before

Table 2. Causes of sub fertility.

Causes	No.	Percentage
Male Factor	148	7.4
Oligo/Asthenospermia	111	5.6
Azoospermia	34	1.72
Psychosexual dysfunction	3	0.15
Female factor	277	14
Anovulation	214	10.8
Tubal	63	8.65
No cause found	594	30
Under investigation	959	48.5

Discussion

Gynaecological morbidity has implications for a range of interrelated aspects of women's lives. This study shows that a large number of women are seeking help for gynaecological problems, hence emphasizing the importance of research in this area. Such studies have a pronounced impact in settings where no information on gynaecological morbidities exists and where there is an absence of consensus on the extent of such morbidity. The two most commonly used study designs to assess the prevalence of gynaecological morbidity are community-based approaches and facility-based studies. Facility based studies (like ours) which include women who visit clinics, focus on a well-defined target population which is already in direct contact with an established service programme with wide coverage levels. The findings from this study are likely to suggest interventions that have the potential to improve the quality of existing service programmes but cannot be generalized to the broader population because of potential sample selection bias, as these clinics represent a population at higher risk of gynaecological morbidity relative to the general population. We have documented various categories and subcategories of gynaecological morbidity according to WHO recommendations so that findings across studies can be compared easily.

A considerable number of women with gynaecological problems (37.2%) were seen in the outpatients department and the prevalence was similar to other studies, in rural West Bengal, Mumbai, Baroda, rural Karnataka and rural Gujarat, (26% to 74%).7 Menstrual problems were the major load on the facility, reaching a peak at the premenopausal age (40-45 years). Metrorrhagia and menorrhagia were the most frequent symptoms. As pointed out in previous studies in Asian regions8, reproductive tract infections were a major health problem encountered9-11 these being the second largest problem in our study highlighting the need for

improving the preventive and curative aspects of this issue. A significant number of PID cases were identified, which not only affect the quality of life, but also impair the future fertility. Sub fertility has a psychological impact as well, and considering the proportion of women coming to us with this morbidity, attention has to be given to improve the diagnosis of this problem. Unlike a high percentage of couples with primary sub fertility in other Asian countries (unpublished data), the ratio of primary and secondary sub fertility was the same in our study. Ovulation disturbances followed by tubal blockade was the most frequent cause of female factor sub fertility similar to previous results.12 It is important to note that in quite a number of couples no cause could be determined. Age at menopause was consistent with the finding of other studies in our country. Benign ovarian neoplasms are more frequently diagnosed due to an easy access to ultrasound. Cervical carcinoma is the second commonest female cancer worldwide, whereas in our population ovarian and uterine carcinomas were more frequently encountered .This difference may be due to the cultural and religious differences. This study not only gives us a baseline data about the most prevalent gynaecological problems, it may help us modify our resources to the diagnosis and treatment of the three major morbidities identified.

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