

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

Table I. Women's answers at the 2-week follow-up telephone call (N (%), N=98)

Would choose early discharge again	88 (89.8)
Wound open	9 (9.2)
Wound draining pus	8 (8.2)
Wound bleeding	4 (4.1)
Pain associated with the wound	13 (13.2)
Early postnatal depression	7 (7.1)
Maternal readmission	3 (3.1)
Infant readmission	0 (0.0)
No problems reported	57 (58.2)

proportions were assessed using the chi-square test or Fisher's exact test with a p -value <0.05 suggesting statistical significance.

Of 107 women recruited, 9 (8.4%) were lost to follow-up, with no reply at their telephone numbers despite repeated efforts to contact them. Among the 98 who were followed up, the mean age was 26.5 years, with a range of 18 - 43 years. Most women ($N=69$, 70.4%) had emergency caesarean sections. Seventy-eight (79.6%) had transverse abdominal incisions and the remainder had vertical midline incisions. The mean birth weight was 3 164 g. The most frequent primary indications for caesarean section were fetal distress ($N=48$, 49.0%) and elective operation for previous caesarean section ($N=20$, 20.4%). At the 2-week follow-up telephone call, 88 women (89.8%) said they would choose early discharge again. Wound complications were described in a minority of women. Most women ($N=57$, 58.2%) reported no problems (Table I). Comparison of HIV-infected ($N=26$) and uninfected women ($N=72$) showed no statistically significant differences in terms of wound dehiscence, bleeding, pain, postnatal depression or readmission.

Three women were readmitted. One suffered a sprained ankle on the 7th postoperative day. A second was HIV infected and was admitted on the 12th day for endometritis, which was successfully treated with

intravenous antibiotics. A third woman was admitted to a private hospital with eclamptic convulsions on the 4th day. There had been no evidence of a hypertensive disorder during her confinement at Chris Hani Baragwanath Hospital. Following treatment for eclampsia, she had a good clinical outcome.

Discharge from hospital on the 2nd postoperative day after caesarean section was found to be acceptable to the majority of women. The 3 maternal readmissions were all for complications that occurred after our standard 3rd-day discharge protocol, suggesting that the standard 3rd-day discharge would probably not have prevented their readmissions. The self-reported wound problems were not serious enough to require professional help, and were managed or tolerated by the women at their homes. A question mark remains over the 9 women who could not be contacted. None of them could be traced in other hospital wards in other institutions in the district, or in maternal death records. Their characteristics on recruitment into the study were not significantly different from those who were successfully followed up. The results of this study cannot be extended to women who had caesarean section for prolonged or obstructed labour, a common indication at this hospital. These women were excluded because of the high associated risk of subsequent infection.^{5,6} In conclusion, discharge from hospital on the 2nd postoperative day after uncomplicated caesarean section without home visits in this setting appears to be acceptable and safe.

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