concluded that: (i) FA was under no obligation to disclose the fact that he had been treated for a sexually transmitted disease more than 12 months before applying for membership; (ii) information relating to the treatment of ‘acute conditions treatable immediately’ and not related to a chronic condition, is not material and need not be disclosed; and (iii) chronic conditions may be regarded as material for purposes of disclosure.

The scheme was therefore ordered to reinstate FA’s membership retrospectively.

Although it is still not clear from this case what exactly does constitute material information for purposes of the Act, this decision makes clear what does not. Members cannot be penalised for not disclosing information about a condition that was diagnosed or treated 12 months before applying for membership and that is not present at the time of application. In effect, this ruling means that medical schemes can no longer require applicants to disclose full details of all medical conditions suffered by them at any period before joining the scheme. The Council does not appear to regard failure to disclose a medical condition present more than 12 months before joining the scheme, as material. Furthermore, acute conditions present at the time of application need not be disclosed if they are treatable immediately and do not relate to a chronic condition.

In terms of Section 29A(2) (a) of the Act, a scheme may only impose a 12-month condition-specific waiting period on new members in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period ending on the date on which an application for membership was made. It will not assist a scheme to argue, as Compcare did in the present case, that it is entitled to impose a condition-specific waiting period in respect of a particular condition unless there is clear evidence that the member received medical advice, diagnosis, care or treatment for that condition within the 12-month period ending on the date on which an application for membership was made.

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Endnotes
2. The South African Medical Association’s Human Rights and Ethical Guidelines on HIV: A Manual for Medical Practitioners clearly states that: ‘A patient’s HIV status may only be disclosed to a person or group if that patient consents to it being made known to that person or group of persons....’
3. In the case Jansen van Vuuren and Another NNO v Kruger, case no. 1993 (4) SA 733, the Appellate Division ruled that it is vital to keep a patient’s HIV status confidential.
4. The judgement is available on the AIDS Law Project website: http://www.alp.org.za

Cervical pregnancy in an HIV-infected patient treated by uterine artery embolisation and methotrexate

To the Editor: Cervical pregnancy, first described by Rubin in 1911,1 is a rare but dangerous type of ectopic pregnancy with an incidence ranging from 1:1 000 to 1:18 000 pregnancies.2 Initially, cervical pregnancy was usually diagnosed at the time of evacuation in the operating room with severe to haemorrhage. Early diagnosis by ultrasound3 led to an improvement in morbidity, but the next breakthrough was in the early 1980s when methotrexate was introduced as a method of treatment.2 Although internal iliac artery ligation has been used in some cases, uterine artery embolisation came into use during the 1990s and proved to be very effective in controlling acute bleeding.3 In this report we describe the first case of cervical pregnancy in an HIV-infected patient, treated by uterine artery embolisation and methotrexate.

Case report
A 24-year-old woman, gravida 2, para 1, presented with 16 weeks’ amenorrhoea followed by lower abdominal pain and a mild, dark vaginal bleeding of 2 days’ duration. The history did not reveal any information of importance.

Her temperature was 36.7°C, pulse rate 54 beats/minute, blood pressure 127/78 mmHg and respiratory rate 20/minute. There was no detectable lymphadenopathy. The abdomen was soft with normal bowel sounds and the uterus was not palpable. Vaginal examination revealed a barrel-shaped cervix with membranes visible within the external cervical os, which was 1 cm dilated.

An ultrasound examination revealed an hourglass-shaped uterus with the gestational sac within the cervix. A fetal pole was visible without a heartbeat and the size of the gestational sac was compatible with a pregnancy of 8 weeks’ duration. The patient tested positive for HIV infection with a CD4 count of 530 x 10^9/L.

Primary treatment consisted of uterine embolisation via catheterisation of the femoral arteries, with the aid of
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 10⁹/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.2 An important contraindication is acute haemorrhage which is present in about 30% of cases.3 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 10⁹/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 10⁹/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 2002.1 The impact of the HIV epidemic on the patient population attending local hospitals has been reported previously.2 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 care 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...