GENITAL SCHISTOSOMIASIS PRESENTING AS SUSPECTED ECTOPIC PREGNANCY IN THE WESTERN CAPE

To the Editor: A 35-year-old woman was referred to Tygerberg Hospital with vaginal bleeding and lower abdominal pain. She had moved to the Western Cape 6 months previously from Gauteng. She had a 6-week history of amenorrhoea and had been bleeding for about 5 days. She had had a heavy bleed the night before admission and thought that she had passed products of conception. The referring practitioner mentioned that he had recently treated her for haemorrhagic cystitis.

On examination she was found to be haemodynamically stable. Her haemoglobin concentration was 10 g/dl. There was tenderness in the right iliac fossa as well as severe cervical excitation tenderness and a tender right-sided adnexal mass. The cervical os was closed and there was minimal vaginal bleeding. A urine pregnancy test was positive and a transvaginal ultrasound scan showed a right-sided complex tubo-ovarian mass ($54 \times 48 \times 66$ mm), free fluid in the pouch of Douglas and a normal uterus. The quantitative serum β-human chorionic gonadotrophin (HCG) value was 2 250 mIU/ml.

A laparotomy was done for a suspected right-sided ectopic pregnancy. Intra-operatively a right-sided adnexal mass was found, but it was impossible to distinguish the ovary or fallopian tube. An adnexectomy was performed. Extensive, dense fibrotic adhesions covered all the pelvic organs and the left ovary and tube were identified after careful dissection.

The patient had an uneventful postoperative recovery. Histological examination of the ovary showed evidence of a severe fibrotic reaction with multiple *Schistosoma haematobium* ova. There was no evidence of chorionic villi or trophoblast. A follow-up serum β-HCG value taken 48 hours postoperatively was 248 mIU/ml and the value continued to decrease to zero. The patient received a course of praziquantel and follow-up was arranged with a urologist.

Schistosomiasis of the lower female reproductive tract can manifest itself as any of a broad spectrum of clinical features.[1] Problems associated with female genital schistosomiasis in the literature include infertility, complications of pregnancy, menstrual disorders, problems related to sexual intercourse, clinical similarities to sexually transmitted diseases and cancer, chronic abdominal pain and psychological problems.[2]

The disease syndromes of established schistosomiasis are in most cases related to hypersensitivity to eggs in tissues and subsequent irreversible fibrosis.[3] The close relation between the vessels in the reproductive organs and the urinary bladder enables the parasite to migrate easily to virtually any organ in the female pelvis.[2]

Schistosomiasis of the upper genital tract is clinically indistinct and less accessible for examination. Ovarian infection accounts for only 4% of all cases of gynaecological schistosomiasis in histological material.[3]

This case highlights the difficulty in diagnosing female upper genital tract schistosomiasis. Practitioners should take note of the mode of presentation described here as well as the possibility of isolated cases presenting in the Western Cape.

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LUMBAR PUNCTURE IS DANGEROUS IN PATIENTS WITH BRAIN ABSCESS OR SUBDURAL EMPYEMA

To the Editor: The neurosurgical unit at Wentworth Hospital in Durban, which is the sole public sector referral centre for KwaZulu-Natal and half of the Eastern Cape, treats an inordinately high number of patients with intracranial suppuration.[1,2] It was our subjective impression that inappropriate lumbar punctures (LP) were being performed in patients with intracranial infective mass lesions. We therefore reviewed the records of all patients with brain abscess (BA) or subdural empyema (SDE) over a 15-year period.

Of 1 411 patients with BA (712) or SDE (699), 422 (29.9%) underwent diagnostic LP prior to computed tomography (CT) scanning, and prior to referral to our unit. The findings on examination of the cerebrospinal fluid (CSF) were normal or equivocal in 349 patients (82.7%). Clinical deterioration in association with LP occurred in 272 (65.4%), but in 81 patients (19.1%) the deterioration was directly attributed to LP. Twenty patients (4.7%) died as a result of LP.

LP in patients with BA or SDE contributes little to diagnosis, while significantly increasing the risk of clinical deterioration and even death. The risk of neurological deterioration by pressure-cone is greater in patients who harbour infratentorial BA or SDE.[3,4]

It has been our experience that a normal/equivocal CSF examination lulls the referring physician into complacency; the