At first sight it is difficult to account for the marked disparity in the incidence of sensitization between the 2 series, even when the considerable difference in numbers has been taken into account. When searching through the records certain sources of error were revealed, which in turn would be transmitted to the laboratory records, and might explain some of the discrepancies.

Sources of Error

1. Some patients with Bantu names, and classified as Bantu, were found to be of mixed descent. This includes those Coloured women who had Bantu husbands and who regarded themselves as Bantu.

2. The racial group of the husband was a considerable source of error. In urban areas Bantu women are often found married to Coloured husbands, of whom some, together with the newborn infant, were classified as Bantu in the records.

3. The most significant factor was the high proportion of single women (33% in this series), indicative of the number of fathers of unknown racial origin.

It may be appropriate to point out at this stage that to compare Rh sensitization in American Negroes with that in West African Negroes or in the Bantu of Southern Africa can be misleading. According to the latest estimate, only 10% of American Negroes are of pure Negro descent and that is the only section that should be compared with its African counterpart.

Low Incidence of Rh Sensitization

When, as far as possible, all the above sources of error have been excluded, it is nevertheless remarkable that in this series of 500 Rh-negative Bantu mothers, the incidence of sensitization should be so low. That out of 504 children born to these women, 492 were alive and well; that not a single infant required a blood transfusion for Rh haemolytic disease; that 6 out of the 7 sensitized mothers were below the critical level of the antibody titre and that only 1 infant (stillborn) could be described as an unconfirmed case of erythroblastosis, is further evidence of the low frequency of Rh sensitization in the Bantu.

It is not disputed that severe cases do occur and it is agreed that many a sensitized mother can have a succession of unaffected children, but the higher incidence of sensitization in Zoutendyk’s series requires an explanation. It possibly lies in the manner in which the material was gathered. After the elimination of several sensitized and non-sensitized Rh-negative patients from the present series due to incorrect racial classification, it can definitely be stated that the material collected is a true reflection and a typical sample of the unselected local Bantu population.

In the period under review (1960 - 62) there were no sensitized Rh-negative patients admitted from other towns or rural areas, consequently there was no loading of statistics. In Zoutendyk’s series all sensitized Bantu women were admitted to the Bridgman Memorial Hospital at 38 weeks, not only from the antenatal clinic of the hospital itself but also from ‘neighbouring municipal native clinics, townships and from distant rural areas’. This does suggest an undue proportion of Rh-sensitized patients, which would naturally result in a higher incidence, unless all the antenatal patients from these various clinics, townships and rural areas during that period (1946 - 1960) were included in the over-all series.

Future investigations on this subject should give accurate and conclusive results, if they are carried out in an area with a homogeneous Bantu population.

SUMMARY

1. In an unselected consecutive series of 8,946 Bantu patients delivered in hospital, 500 (5.6%) were Rh(D)-negative, of whom 7 (0.8%) were sensitized.

2. Six of the 7 sensitized patients had an antibody titre below the level of 1/16 - 1/32.

3. Six of the 7 babies born to these sensitized mothers were totally unaffected.

4. The gross perinatal mortality for the group of 500 Rh-negative patients was 2.38%.

5. Not a single baby required a blood transfusion for Rh haemolytic disease.

6. The view that the Bantu have a high degree of immunity to Rh sensitization and that on the whole the children of Bantu parents are little affected is given additional support.

REFERENCES


A FURTHER CONTRAINDICATION TO ORAL CONTRACEPTION

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One of the first cases of thrombophlebitis occurring in a woman taking oral contraceptive pills was described by Jordan in Great Britain in 1961. Since then there have been further reports of thrombophlebitis followed by pulmonary embolism, some of which have been fatal. Cerebrovascular accidents and coronary thrombosis have also been reported. Recently a case of erythema nodosum has been described.

In my own practice I have had one patient who developed a spontaneous central artery occlusion of the right optic nerve with complete blindness in that eye. Recently Eisalou et al. have reported on liver damage and impairment during the intake of contraceptive pills.

Some of the contraindications as listed by the Family Planning Association in Britain are: gross overweight, liver dysfunction, jaundice, recent catarrhal jaundice or gallstones, menopausal irregularity, lactation.

The following is a report where rapid enlargement and red degeneration occurred in a fibromyoma in a woman taking oral contraceptive tablets.

CASE REPORT

History

Mrs. F. U., para 3, gravida 4, aged 36 years, was seen as an urgent case presenting with acute abdominal pain. The patient was a White woman who had had 3 normal pregnancies delivered 14, 12 and 8 years before, respectively. Her second pregnancy ended in an abortion at 4 months and a dilatation and curettage was done. There was nil contributory in her history.
Her present complaint was that of acute lower abdominal pain which had commenced a few hours previously. There was no nausea or vomiting. Her house doctor was called, who gave her an injection of 100 mg. of pethidine and she was referred for specialist attention.

The last menstrual period was 20 days previously. During the past 14 days she had been taking oral contraceptive tablets containing 2.5 mg. of norethisterone acetate and 50 μg. of ethinyl oestradiol. She had previously been told that there was a uterine 'fibroid' which was slightly smaller than a tennis ball.

Examination


On abdominal examination a tender, regular, firm, smooth mass was found to be arising out of the pelvis filling the lower abdomen and extending to the level of the umbilicus. The abdomen appeared distended. This mass was dull to percussion. There was no free fluid detected in the abdominal cavity. Bowel sounds were present.

On vaginal examination this mass filled the pelvis and appeared to be a large uterine tumour. The cervix appeared healthy. There was some albuminuria present.

The blood. The haemoglobin was 11 G/100 ml. The blood count showed a neutrophil shift to the left. The red cells showed slight polychromasia. A straight X-ray examination of the abdomen showed a soft-tissue tumour with no irregularities or calcification.

Diagnosis. A tentative diagnosis of a large fibromyoma, which had degenerated, was made. A twisted ovarian cyst or a haemorrhage into a large ovarian cyst was also considered.

Operative Findings

At laparotomy, under general anaesthetic, this mass was found to be a large and distorted uterus. This was due to the presence of a large intramural fibromyoma which showed the appearance of red degeneration (Fig. 1).

The right ovary was replaced by a cyst 3 inches in diameter. This was removed. The left ovary was healthy.

Microscopic examination confirmed the observation that the fibroid had undergone 'red degeneration'. The ovarian cyst was a simple follicular one. Postoperative recovery was uneventful.

DISCUSSION

Red degeneration or so-called carious degeneration occurs most frequently and most characteristically in pregnancy. Aetiology of this form of necrosis is unknown and the frequent occurrence in pregnancy unexplained. Some say that arterial venous thrombosis is the basis of this and that the lesion is essentially the result of infarction. It is claimed that the taking of oral progestogens produces the physiological effect of pregnancy. It is thus not unreasonable to assume that fibromyomata in persons who are taking oral progestogens are liable to undergo the same degenerative changes that occur in pregnancy. The above case is described with this point in mind and the author is strongly of the opinion that the presence of fibromyomata are a contraindication to the taking of oral contraceptive tablets.

SUMMARY

A case of red degeneration occurring in a fibromyoma where the patient was on oral contraceptive tablets is described. It is assumed that the presence of fibromyomata should be regarded as a contraindication to the taking of oral contraceptive tablets.

I should like to thank the Photographic Unit, Department of Medicine, University of the Witwatersrand, for the photograph.

REFERENCES


PASSING EVENTS : IN DIE VERBYGAAN

University of Cape Town and Association of Surgeons of South Africa (M.A.S.A.), Joint Lectures. The next meeting will be held on Wednesday 8 September at 5.30 p.m. in the E-floor Lecture Theatre, Groote Schuur Hospital, Observatory, Cape. Prof. P. E. S. Palmer will speak on 'Tumoural calcinosis'.

D. P. de Villiers Clinical Club, Monthly Meeting. The next meeting will be held on Tuesday 14 September at 8.30 p.m. in the Recreation Hall, Conradie Hospital, Pinelands, Cape. Dr. W. P. U. Jackson will speak on 'Oral agents in the treatment of diabetes'.


Klinies besprekings word ook gereeld om 9.00 nm. elke Saterdagmiddag gehou in die Groot Voorleesaal, Karl Bremer-hospital, en is oop vir bywoning deur dokters.

South African Institute for Medical Research, Johannesburg, Staff Scientific Meetings. The next meeting will be held on Monday 13 September at 5.10 p.m. in the Institute Lecture Theatre. Dr. P. A. Basson will speak on 'Infestation with fly maggots (Gedoelstia) in antelopes and domestic animals'. All interested persons will be welcome.

OvuLen advertisement — see page xxiv