

Overview of Gynecological and Breast Pathologies in Older Women: A Report of 176 Outpatient Cases at Angre Teaching Hospital in 2025

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Abstract

Objective: To evaluate the epidemiological and clinical aspects of gynecological and breast pathologies in older female patients at Angre Teaching Hospital. **Patients and Methods:** This was a retrospective, descriptive study conducted from January 1 to December 31, 2025, in the outpatient clinic of the Department of Obstetrics and Gynecology at Angre Teaching Hospital. The study included all female patients aged 60 years or older who consulted the clinic during the study period. Sociodemographic and clinical parameters were analyzed. Data analysis was performed using SPSS software. **Results:** Out of a total of 4226 patients seen in the gynecology outpatient clinic, 176 were female patients aged 60 years or older representing a prevalence of 4.2%. The mean age of the patients was 64 years (60 to 76 years). Grand multiparity was observed in 29.5% of cases. Patients presented via direct admission in 78.4% of cases and by referral in 21.6% of cases. A history of hysterectomy was noted in 5.7% of patients. The primary reasons for consultation were abnormal genital bleeding (13.1%), followed by leukorrhea (vaginal discharge) and vulvar pruritus (7.9% each), and breast masses (7.4%). The established diagnoses were non-malignant pathologies in 71% of cases (including 33.5% postmenopausal disorders) and malignant pathologies in 29% of cases (comprising 37.2% breast cancers and 62.8% gynecological cancers). Notably, 9.1% of the patients required transfer or specialist referral. **Conclusion:** The reasons for consultation in this demographic are highly varied. Malignancies, particularly cervical and

breast cancers, are highly prevalent in the postmenopausal period. To improve prognoses and ensure appropriate management for postmenopausal women, we strongly advocate for the implementation of organized, large-scale screening campaigns.

Keywords

Gynecological Pathology, Breast Pathology, Menopause, Older Women

1. Introduction

The physiological and psychological transformations associated with menopause and perimenopause have a considerable impact on the physical, emotional, mental, and social well-being of women, affecting their quality of life and daily activities. Gynecological care is traditionally perceived as being centered on reproductive health. However, as women transition into a non-reproductive phase of life, other indications for gynecological consultation gain prominence [1] [2].

Age-related gynecological pathologies are often characterized by prolonged delays in seeking medical care, particularly in African settings. Furthermore, the onset of menopause is sometimes erroneously assumed to explain any emerging gynecological or breast symptom, which can further delay appropriate diagnosis [3].

Few studies have specifically investigated this demographic in African regions. Through this study, we aim to report our experience with gynecological consultations for older women at Angre Teaching Hospital and to highlight their specific epidemiological and clinical characteristics.

2. Patients and Methods

This was a retrospective, descriptive study conducted over a 12-month period, from January 1, 2025, to December 31, 2025, in the Department of Obstetrics and Gynecology at Angre Teaching Hospital.

The study population comprised all older female patients admitted to the outpatient gynecology clinic during the study period. Inclusion criteria consisted of female patients aged 60 years and older who were actively evaluated during a consultation. Patients with incomplete or unusable consultation records that failed to meet the requirements of the data collection form were excluded. An exhaustive sampling method was employed, yielding a final sample of 176 patients over the study period.

Consequently, records lacking identification documents to verify patient age and those lacking results from diagnostic workups were excluded; only cancers confirmed by histopathological examination were selected. An exhaustive sampling approach was used: 13 records failing to meet the criteria were rejected, and 176 patients were included in the study.

Data were collected from patient consultation files, outpatient clinic registers,

and patient transfer logs. The variables studied included sociodemographic characteristics, clinical data, reasons for consultation, established diagnoses, and ancillary diagnostic tests performed. Data analysis was performed using SPSS software.

The study was approved by the institution's medical and scientific leadership through its ethics committee. Patient consent was not required to conduct the study; however, anonymity was maintained in accordance with applicable laws regarding scientific research.

3. Results

3.1. Frequency

Out of a total of 4226 patients seen for gynecological consultations in 2025, 176 were older women, representing a prevalence of 4.2% (**Table 1**).

3.2. Socio-Occupational Status

The vast majority of patients (96.6%) were retired, out of the workforce, or homemakers, while only 3.4% were still actively employed.

3.3. Medical History

In 83.5% of cases, the patients' medical history was unremarkable; 5.7% had undergone a hysterectomy, and grand multiparas accounted for 29.5% of the cases.

Table 1. Distribution according to main clinical history.

Clinical history	Number (n)	Frequency (%)
Medical history		
Sickle cell disease (major form)	13	7.4
Hepatitis B virus infection	12	6.8
HIV infection	4	2.2
Surgical history		
Caesarean section	52	29.5
Myomectomy	21	11.9
Hysterectomy	10	5.7
Parity (n = 176)		
Nulliparous (0)	21	11.9
Primiparous (1)	36	20.4
Pauciparous (2)	28	15.9
Multiparous (3 - 4)	39	22.2
Grand multiparous (≥5)	52	29.5

3.4. Primary Reasons for Gynecological Consultation

Patients presented via direct admission in 78.4% of cases and by referral in 21.6% of cases (**Table 2**).

Table 2. Distribution according to the main reasons for consultation.

Reason for consultation	Number (n)	Percentage (%)
Vaginal discharge	14	7.9
Breast mass	13	7.4
Nipple discharge	5	2.8
Sexual dysfunction	6	3.4
Urinary incontinence	10	5.7
Pelvic pain	12	6.8
Abnormal uterine bleeding	23	13.1
Vulvar pruritus	14	7.9
Mastodynia (breast pain)	19	10.8
Pelvic organ prolapse	7	3.9
Gynaecological cancer	16	9.1
Breast cancer	7	3.9
Other*	30	17.0
Total	176	100.0

Other*: Routine annual visit, screening, request for a gynecological opinion, ascites, and abdominopelvic pain.

3.5. Primary Ancillary Investigations Requested (Table 3)

Ultrasound was a routine examination for 81.8% of the patients, and a pelvic MRI was performed in 14.8% of the patients.

Table 3. Distribution according to paraclinical investigations.

Investigation	Frequency (n)	Percentage (%)
Ultrasound (pelvic and/or breast)	144	81.8
Mammography	35	19.9
Pelvic MRI	26	14.8
Computed tomography (CT)	22	12.5
Histopathological examinations	34	19.3
Laboratory investigations	138	78.4

3.6. Distribution of Established Diagnoses

Specialist Referrals (9.1%): Oncology (n = 8), rheumatology (n = 1), urology (n = 5), gastrointestinal surgery (n = 1), and geriatrics (n = 1) (**Table 4**).

Table 4. Distribution according to final diagnoses.

Final diagnosis	Frequency (n)	Percentage (%)
Postmenopausal disorders*	59	33.5
Lower genital tract infection**	16	9.1
Isolated pelvic pain	8	4.5
Genital prolapse	7	4.0
Endometrial hyperplasia	10	5.7
Benign breast disease	12	6.8
Gynaecological cancers	32	18.2
Breast cancer	19	10.8
Other diagnoses***	13	7.4
Total	176	100.0

*Post-menopausal disorders: a range of physical and psychological manifestations linked to estrogen deficiency (climacteric syndrome, mood disorders, dyspareunia); **Lower genital tract infections: a group comprising cervicitis, vaginitis, and vulvitis; Other*: Routine visit, screening, isolated pruritus, uterine fibroids (myomatosis), and isolated ascites.

3.7. Overall Frequency of Pathologies (Gynecological and Breast)

Gynecological conditions accounted for 41.5%, and breast conditions for 17.6%. Overall, 71% of cases were non-malignant pathologies, while 29% were malignant pathologies. Among the malignancies, breast cancers accounted for 37.2% and gynecological cancers for 62.8%.

Distribution by Cancer Type (n = 51):

Breast cancer: 37.2% (n = 19)

Cervical cancer: 27.5% (n = 14)

Endometrial cancer: 19.6% (n = 10)

Ovarian cancer: 13.7% (n = 7)

Vulvar cancer: 1.9% (n = 1)

4. Discussion

This retrospective, single-center outpatient study conducted at the Angre University Hospital in Abidjan has limitations that could introduce methodological bias specifically, a lack of key data, which reduces the statistical power of the analysis. Furthermore, the single-center nature of the study precludes the generalization of its findings.

As a secondary referral hospital, the gynecology clinic at Angre Teaching Hospital frequently receives patients seeking specialized or expert opinions, particularly for age-related pathologies. In this study, gynecological consultations were performed in 4.2% of cases in patients aged 60 years and older. Their sociodemographic characteristics are comparable to those of similarly aged patients in a series focusing on sexuality among 519 postmenopausal women at Cocody Teaching Hospital in Abidjan [4]. Grand multiparity was observed in 29.5% of cases, and 96.6% of patients were retired, out of the workforce, or homemakers. During this stage of life, sociocultural taboos and burdens persist regarding pathologies affecting women's intimacy, as these conditions require patients to undress and expose their intimate body parts. Notably, in contemporary clinical practice, a physical examination must never be imposed on a patient during a gynecological consultation [5].

Menopause is a physiological stage of normal aging that exposes women to numerous pathologies, particularly genital cancers [1]. Consequently, the reason for consultation can sometimes be complex, masked, or only partially disclosed because it is difficult for the patient to articulate; in such instances, the tact, professional experience, and demeanor of the practitioner become of paramount importance [6] [7]. In our study, the primary reasons for consultation were dominated by abnormal bleeding (13.1% of cases), followed by leukorrhea (vaginal discharge) and vulvar pruritus (7.9% each), and breast masses (7.4%). According to Dreisler [7], abnormal uterine bleeding is a frequent symptom during perimenopause. The causes are multifactorial, ranging from physiological responses related to the decline in ovarian function to precancerous or malignant conditions. Endometrial tissue sampling in women presenting with abnormal uterine bleeding is of paramount importance [8]. Indeed, such postmenopausal bleeding is highly suggestive of gynecological malignancies, particularly endometrial cancer. This possibility represents a major source of anxiety for both the patient and her family in the African context.

In a study by Krause [9], cancer screening and menopause were the most frequent reasons for consultation among older women. Other reasons included inflammatory and non-inflammatory conditions of the external genitalia, uterine prolapse, breast cancer, and other gynecological cancers. In our study, we identified a 9.1% rate of lower genital tract infections confirmed by biological sampling. In Ghana, Effah [10] demonstrated that the overall prevalence of high-risk HPV (HR-HPV) infection was 27.9% (95% CI, 25.1 - 31.0) among women aged 60 years and older. The study indicated a higher prevalence of HR-HPV infection in older women compared to younger community-dwelling women, with similar rates of cervical lesions on colposcopy. Given the increasing life expectancy in Ghana, the author concluded that it is premature to recommend age-based cessation of precancerous cervical cancer screening in older women in Ghana.

International studies estimate the prevalence of uterine prolapse at approximately 30% [11] [12]. However, these results are based on data from gynecological examinations; the proportion of women who are actually symptomatic was not

accounted for in these studies. In Krause's study [9], patients aged 60 to 69 years consulted for urinary incontinence (30.1%), osteoporosis (12.7%), prolapse (4.6%), breast cancer (5.4%), and gynecological cancers (3.6%). More than a third of the women (35.5%) reported using menopausal hormone therapy for postmenopausal disorders. In a study by Walker GJ [13] on pelvic floor disorders across thirty developing countries, the average prevalence of urinary incontinence was 28.7%, pelvic organ prolapse was 19.7%, and fecal incontinence was 6.9%.

In our study, sexual disorders accounted for 3.4% of the reasons for consultation. As highlighted by Ruault [5], the onset of sexual activity is a fundamental temporal milestone in gynecological follow-up. Sexual disorders were rarely mentioned by our patients, as sexual activity is often considered a thing of the past at this age in our African societies. In a study in Nigeria, approximately one-third of women in the older age group considered sex at their age to be taboo and did not perceive themselves as having sexual disorders. Furthermore, the same study revealed that women are less likely than men to discuss these topics with their physicians [14]. The sociocultural background and age of the patient significantly influence their experience of the gynecological examination [4] [6].

The incidence of breast and endometrial cancers increases with age, and after menopause, conditions such as urinary incontinence, osteoporosis, and uterine prolapse become more frequent [9]. In our gynecological practice, osteoporosis is underdiagnosed, and the rare cases identified are managed exclusively by rheumatologists or geriatricians. However, malignancies are predominant; among the 51 cancer cases identified, breast cancer accounted for 37.2%, cervical cancer for 27.5%, endometrial cancer for 19.6%, ovarian cancer for 13.7%, and vulvar cancer for 1.9%. These cancers were diagnosed based on histopathological examination. Specifically, 23 patients were referred with a pre-established cancer diagnosis, while 28 underwent core needle biopsy (for breast cancer) or biopsy (for other gynecological cancers). Imaging studies provided diagnostic and, at times, prognostic guidance. However, these often-costly tests sometimes delayed the management of these elderly women.

In a series of 749 cases of gynecological cancers in postmenopausal women collected in Rabat, Khatib [3] found that cervical and breast cancers represented 37% and 33% of cases, respectively. These were followed by ovarian (15%), endometrial (11%), and vulvar (3%) cancers.

Lower gynecological cancers (excluding ovarian cancer) present with fairly specific symptomatology, such as metrorrhagia or abnormal discharge in postmenopausal patients with endometrial cancer [15], and pruritus in vulvar cancer [16]. Lower gynecological cancers peak in incidence after the age of 65, precisely when systematic screening typically ceases [17]. Endometrial involution can be followed by reactivation, as well as benign or malignant pathological dysfunctions in the postmenopausal period [18].

Conversely, in a study by Burelli [19] regarding gynecological consultations among young women aged 15 to 25 years, out of 4,161 respondents, 46.1% con-

sulted for contraception, 21.8% for menstrual disorders, 11.5% for routine check-ups, 7.5% for sexuality-related issues, and 7.0% for cancer screening examinations.

In our series of 176 cases, lower genital tract infections accounted for 9.1% of confirmed diagnoses, while postmenopausal disorders represented more than one-third. These disorders primarily involved climacteric syndromes, mood disorders, and dyspareunia, and only rarely long-term complications such as osteoporosis and cardiovascular disease.

Given improving living conditions, a probable increase in surgical activity and the management of cardiovascular complications among older female patients at Angré University Teaching Hospital is anticipated. According to Mikkola [20], most postmenopausal women are poorly informed about their cardiovascular risk profile. Therefore, gynecologists and cardiologists should collaborate to identify and manage these risk factors early.

5. Conclusion

The reasons for consultation in this demographic are highly varied. Gynecological and breast malignancies, particularly cervical and breast cancers, are highly prevalent in the postmenopausal period and represent a significant public health challenge. To improve prognoses and ensure the optimal management of postmenopausal women, we strongly advocate for routine screening and, ideally, the implementation of organized, population-based screening campaigns, which remain a highly effective strategy for the prevention and control of these cancers.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

- [1] Racodon, M. and Duvilliers, V. (2026) L'impact d'une éducation à la santé sur la qualité de vie des femmes ménopausées ou en périménopause: Revue systématique de la littérature. *Gynécologie Obstétrique Fertilité & Sénologie*, **54**, 32-40. <https://doi.org/10.1016/j.gofs.2025.10.011>
- [2] Mandon, M., Macé, J.M., Dreyfus, M. and Berger, L. (2015) Effet de l'augmentation et du vieillissement de la population de Basse-Normandie sur l'activité de gynécologie-obstétrique. *Journal de Gynécologie Obstétrique et Biologie de la Reproduction*, **44**, 818-824. <https://doi.org/10.1016/j.jgyn.2014.09.029>
- [3] Khatib, S. (2009) Gynecological Cancers in Postmenopausal Women about 749 Cases (Publication No. 832). Doctoral Dissertation, Mohammed V University of Rabat. Institutional Repository of Mohammed V University.
- [4] Adjoby, C.R., Effoh, N.D., Koffi, S.V., Gbary-Lagaud, E., *et al.* (2020) Sexuality in Postmenopausal Women in Africa: 519 Case Reports. *International Journal of Development Research*, **10**, 34442-34446.
- [5] Ruault, L. (2015) La force de l'âge du sexe faible. Gynécologie médicale et construction d'une vie féminine. *Nouvelles Questions Féministes*, **34**, 35-50. <https://doi.org/10.3917/nqf.341.0035>

- [6] Janssen, S.M. and Lagro-Janssen, A.L.M. (2012) Physician's Gender, Communication Style, Patient Preferences and Patient Satisfaction in Gynecology and Obstetrics: A Systematic Review. *Patient Education and Counseling*, **89**, 221-226.
<https://doi.org/10.1016/j.pec.2012.06.034>
- [7] Dreisler, E., Frandsen, C.S. and Ulrich, L. (2024) Perimenopausal Abnormal Uterine Bleeding. *Maturitas*, **184**, Article 107944.
<https://doi.org/10.1016/j.maturitas.2024.107944>
- [8] Papakonstantinou, E. and Adonakis, G. (2022) Management of Pre-, Peri-, and Postmenopausal Abnormal Uterine Bleeding: When to Perform Endometrial Sampling? *International Journal of Gynecology & Obstetrics*, **158**, 252-259.
<https://doi.org/10.1002/ijgo.13988>
- [9] Krause, L., Dini, L. and Prütz, F. (2020) Reasons for Women Aged 50 Years and Older to Seek Gynaecological Advice and Treatment. *Journal of Health Monitoring*, **5**, 3-14.
- [10] Effah, K., Tekpor, E., Ohene-Bredu, Y., Ibrahim, S., Engmann, S.T., Danyo, S., et al. (2025) Assessing High-Risk Human Papillomavirus-Based Cervical Precancer Screening Recommendations and Implications among Women Aged 60/65 Years and Older in Ghana. *Scientific Reports*, **15**, Article No. 31723.
<https://doi.org/10.1038/s41598-025-16409-3>
- [11] Barber, M.D. (2016) Pelvic Organ Prolapse. *British Medical Journal*, **354**, i3853.
<https://doi.org/10.1136/bmj.i3853>
- [12] Hendrix, S.L., Clark, A., Nygaard, I., Aragaki, A., Barnabei, V. and McTiernan, A. (2002) Pelvic Organ Prolapse in the Women's Health Initiative: Gravity and Gravity. *American Journal of Obstetrics and Gynecology*, **186**, 1160-1166.
<https://doi.org/10.1067/mob.2002.123819>
- [13] Walker, G.J.A. and Gunasekera, P. (2011) Pelvic Organ Prolapse and Incontinence in Developing Countries: Review of Prevalence and Risk Factors. *International Urogynecology Journal*, **22**, 127-135.
<https://doi.org/10.1007/s00192-010-1215-0>
- [14] Olatayo, A.A., Kubwa, O.O. and Adekunle, A.E. (2015) Sexuality in Nigerian Older Adults. *Pan African Medical Journal*, **22**, Article 315.
<https://doi.org/10.11604/pamj.2015.22.315.7617>
- [15] Pakish, J.B., Lu, K.H., Sun, C.C., Burzawa, J.K., Greisinger, A., Smith, F.A., et al. (2016) Endometrial Cancer Associated Symptoms: A Case-Control Study. *Journal of Women's Health*, **25**, 1187-1192. <https://doi.org/10.1089/jwh.2015.5657>
- [16] Alkatout, I., Günther, V., Schubert, M., Weigel, M., Garbrecht, N., Jonat, W., et al. (2015) Vulvar Cancer: Epidemiology, Clinical Presentation, and Management Options. *International Journal of Women's Health*, **2015**, 305-313.
<https://doi.org/10.2147/ijwh.s68979>
- [17] Sancho-Garnier, H. (2013) Epidemiology of Gynecological Cancers: Uterus, Ovary, Vulva and Vagina. In: French National College of Gynecologists and Obstetricians, *Pelvic Gynecological Cancers*, Elsevier Masson, 85-96.
- [18] Pasquier, D., Bettencourt-Pires, M.A. and Bernard, P. (2010) The Postmenopausal Endometrium, Its Normal and Pathological Aging. *Médecine de la Reproduction, Gynécologie Endocrinologie*, **12**, 273-284.
- [19] Burelli, S., Occhiminuti, H., Chamorey, E., Maccagnan, S., Delotte, J., Prax, J., et al. (2021) Principaux motifs de la première consultation gynécologique chez les jeunes femmes françaises de 15 à 25 ans. *Revue d'Épidémiologie et de Santé Publique*, **69**,

S43. <https://doi.org/10.1016/j.respe.2021.04.069>

- [20] Mikkola, T.S. (2009) Cardiovascular Risk Assessment in Postmenopausal Women: The Role of the Gynecologist. *Climacteric*, **12**, 58-61.
<https://doi.org/10.1080/13697130903011662>