



CLINICAL STUDY OF ADOLESCENT GYNAECOLOGICAL PROBLEMS

Gynaecology

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ABSTRACT

AIM OF THE STUDY : To take up a clinical study of the gynaecological problems in adolescent girls attending OPD and admitted in the wards of government general hospital, Kurnool over a period of 6 months, to analyse the causes to carry out the necessary investigations on these girls and offer the appropriate management modality

KEYWORDS

INTRODUCTION

Adolescents make upto 10-15 % of our population. Health wise they are the healthiest section of the society, still a number of health problems are peculiar to this age group. Most girls tend to be shy and often do not share their problem with their parents or friends, yet they may suffer making them often skip their teaching classes or jobs. It is only recently that we have acknowledged the need for a speciality for adolescence to handle their medical, social, psychological, sexual problems or ailment, whether it is their menstrual disorder, contraceptive advice, pregnancy/abortion counseling, or the more serious matter of malignancy. They need to be heard and understood patiently by a non-judgmental professional and be given friendly practical advice.

It is also the responsibility of the parents, teachers, social workers, politicians and administrators and personnel of the medical and education and empowerment, and the change from the adolescent girl to the adult women is smooth and streamlined with nil or least medical, social or psychological problems.

Normal puberty starts by age 8 to 12 years in Indian girls and development of secondary sexual characteristics is completed in 3-4 years (Shah 1991). The average age of menarche has decreased 2-3 months per decade. Has ceased in developed countries over the past 150 years. However this trend has ceased in developed countries since 1940. Since this is influenced by factors such as socioeconomic conditions, nutritional status and state of improvement in the above conditions.

Nutrition influences the age of puberty. Moderate obesity (up to 20% above normal weight for age) is associated with earlier menarche, but pathological obesity is associated with delayed menarche delayed puberty may result from chronic disease, malnutrition and strenuous physical activity especially when associated with thinness.

MATERIALS AND METHODS

A total of 430 girls presenting to Gynaecological outpatient department, Government General Hospital, Kurnool.

All girls had detailed history of gynaecological problems, menstrual problems and history of any associated problems.

A thorough clinical examination including breast, thyroid, cardiovascular system, respiratory system, central nervous system was done. Height was taken in standing position without footwear and was recorded in centimeter. BMI was recorded after noting the weight.

The presence of thyroid, hirsutism was noted, pubertal stages were graded according to Marshall and Tanner.

Abdominal examination was done to rule out any mass. External genitalia were examined. Per rectal and bimanual examination were done whenever indicated.

Depending on the case diagnosed clinically the patients were subjected to various biochemical, microbiological and pathological investigation. Few investigative procedures were carried out as indicated.

Cases of menstrual disorders were subjected to ultrasonogram and hormonal assay when needed.

In cases of leucorrhoea vaginal discharge was examined for moniliasis and trichomonal infection.

DISCUSSION

Out of 21,855 Gynaecological cases, 430 adolescent girls were analysed. Out of which 196 patients needed inpatient care, rest of cases were evaluated on outpatient basis.

In the present study it was found that the incidence of adolescent gynecological problem is 1.97 per 1.7 year.

Maximum incidence was seen in the age group of 17 years (27.44 %). 36.28 % of the adolescent populations were uneducated. Majority belonged to low socioeconomic status 60.69% were coming from rural areas. Majority of the study group were unmarried (70%).

Table 1 : Presenting complaints in adolescent girl.

Complaints	No.of patients	Percent
Menstrual problems	227	52.79
Vaginal discharge	105	24.41
Lower abdominal pain	28	6.51
Urinary problem	29	6.74
Mas per abdomen	17	3.95
Mass per vaginum	6	1.39
Others	18	4.18
Total	430	100

Majority of the patients came for menstrual problems (52.79 %) vaginal discharge (24.41 %). Of these one third had more than one symptom.

Table 2 : Frequency distribution of various menstrual irregularities

Menstrual irregularity	No. of patients	Percent
Dysmenorrhoea	90	39.65
Puberty menorrhagia	74	32.60
Primary amenorrhoea	12	5.29
Secondary amenorrhoea	8	3.52
Oligomenorrhoea	35	15.42
Polymenorrhoea	8	3.52
Total	227	100

Out of 227 girls with menstrual problems 39.4% presented with dysmenorrhoea 32.59% presented with puberty menorrhagia, 5.28%

with primary amenorrhoea 3.52% with secondary amenorrhoea, 15.41 % with oligomenorrhoea, 3.52 % with polymenorrhoea.

DYSMENORRHOEA

Dysmenorrhoea is the most common complaint among adolescents having menstrual disorders.

In 5 to 10 % of girls it is severe in nature, in capacitation them to the extent of not attending their school, college or work (Sheil & Turner). This kind of dysmenorrhoea may lead to fear psychosis in adolescents (Dickens 1974) 20 % of the adolescents have family history of dysmenorrhoea either in mother or sisters (Sheil & Turner 1996)

Explanation and reassurance is the backbone of therapy in adolescent girls with dysmenorrhoea. Complete history is the most important aspect of the management of such cases and it should include the details of menses the uterine anomalies or some associated uterine or pelvic pathology.

Table 3 : Causes of puberty menorrhagia

Cause	No. of patients	Percent
Anovulatory		
Uterine bleeding	69	93.24
ITP	2	2.70
Evan's syndrome	1	1.35
Tuberculosis	2	2.70
Total	74	100

Anovulatory uterine bleeding is the commonest cause of puberty menorrhagia i.e 93.24 % , ITP account for 2.70 % . Tuberculosis 2.70 % , 1 case (1.35 %) was due to Evan's syndrome (Haemolytic anaemia and Thrombocytopenia)

Table 4 : Causes of Primary amenorrhoea

Condition	No. of patients	Percent
Imperforate hymen (outlet flow anomaly)	6	50
MRKH	3	25
Constitutional delay	2	16.67
T.B Genital Tract	1	8.34

Commonest cause of primary amenorrhoea in the study group was imperforate hymen (50 %). There were 3 cases of Mayer Rokitansky-Kusterer – Hauser syndrome

Table 5 : Causes of Secondary amenorrhoea

Condition	No. of patients	Percent
PCOD	4	50
T.B	2	25
Hypothyroidism	1	12.5
Severe malnutrition	1	12.5

Commonest cause of secondary amenorrhoea was PCOD (50 %).

LEUCORRHOEA

In this study 105 cases (24.4 %) of Leucorrhoea were reported. 73.94% of Leucorrhoea were physiological. 26.05% were pathological. Most common pathological cause was nonspecific vulvovaginitis 66.66% (18 cases)

Tinea cruris was present in 3 (11.11 %), candidiasis in 4 (14.81%) and Trichomoniasis in 2 (7.4 %) of cases. Miller et al 1999 found Chlamydia in 40-60%, N.Gonorrhoea in 15 to 18%. Mycoplasma hominis in 3 to 5% and unknown organisms in the remaining.

Table 6: Causes of Infection

Diagnosis	No. of patients	Percent
Non specific vulvovaginitis	18	66.66
Tinea cruris	3	11.11
Candidiasis	4	14.81
Trichomoniasis	2	7.40

In this study commonest cause of leucorrhoea was found to be nonspecific vulvovaginitis 66.66 %.

Table 7 : Adolescent girls presenting with ovarian pathology symptomology

Condition	No. of patients	Percent
Mass abdomen	3	18.75
Abdominal pain	9	56.25
Abdominal distension	2	12.5
Loss of weight and appetite	1	6.25
Vomitings	1	6.25

56.25 % had abdominal pain.

18.75 % had mass per abdomen.

Table 8 : Histopathology of Ovarian Tumors

Type	No. of patients	Percent
Immature	5	31.25
Dermoid cyst	3	18.75
Endodermal sinus tumor	2	12.5
Dysgerminoma	2	12.5
Mucinous ovarian carcinoma	2	12.5
Papillary cystadenoma	1	6.25
Granulosa cell tumor	1	6.25

Immature teratoma were the commonest (31.25 %). Endodermal sinus tumour, Dysgerminoma, Mucinous ovarian carcinoma each one of them accounted to 12.5 % of the total cases.

SUMMARY & CONCLUSION

Rural , low socio economic group of girls in the age group 13-18 years were studied maximum incidence was seen in the age group 17. Among various problems, menstrual disorders rank first. Outflow tract obstruction (imperforate hymen) was the commonest cause of primary amenorrhoea. Anovulation was the commonest cause of menorrhagia. In this study Malignant ovarian mass were most common than benign ovarian mass. HPO axis dysfunction was the commonest cause of oligomenorrhoea. Most common pathological cause of leucorrhoea was found to be non specific vulvo vaginitis. There was a rare case of Leiomyosarcoma of cervix in a 18 year old married girl.

The study reveals the profile of gynaecological disorders affecting adolescents with their aetiological profile. It also reflects ignorance and misconceptions on part of parents. There is a need to develop separate adolescent gynaecological clinic at time convenient for these adolescents and there is also need to develop adolescent gynaecology as a subspecialised branch of gynaecology speciality to manage problems which are less common and unique to this age group.'

REFERENCES

1. Shaah – 1991
2. Shilils turner
3. Dickens-1994
4. Sheil & turner 1996
5. Marshall & tanner 1969
6. Spaeoff et al 1999