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CAUSES INCIDENCE AND EVALUATION IN PATIENTS WITH PERIMENOPAUSAL BLEEDING

Obstetrics & Gynaecology

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ABSTRACT

Introduction: Present study was conducted to To study the etiopathology and incidence of benign and malignant causes of of perimenopausal bleeding.

Methodology: The was a prospective Study in the Department of Obstetrics and Gynecology, P.B.M. Hospital, S.P. Medical College, Bikaner on 300 patients. Ultrasonographic evaluation of the patient was performed to look for endometrial thickness, anatomical lesion-polyp, fibroid etc. Endometrial Biopsy was done and specimen was sent for histopathologic report (HPE).

Results: We found that Polymenorrhoea was present in 53.7%, followed by Menorrhagia + intermenstrual bleeding (menometrorrhagia) (13%). 54% females were having Thickened endometrium, 14% had Uterus size increased with no specific feature, 11.3% had endometrial polyp, 10% had fibroid uterus, 6.7% had ovarian cyst and 4% had adenomyosis. 35.7 % have normal size uterus and 64.3% have bulky uterus. 35.3% patients had uterus size of 6-8 week, 49% had Proliferative endometrium followed by 32.7% patients had endometrial hyperplasia, 13.6% had Secretory endometrium.

Conclusion: We concluded that menorrhagia and intermenstrual bleeding are mostly correlated with abnormal endometrial histopathological findings.

KEYWORDS

Dysfunctional uterine bleeding, Perimenopause, Hysteroscopy, Histopathological examination

INTRODUCTION

Heavy menstrual bleeding affects up to 30% of women throughout their reproductive lifetime.[1] This leads to surgical intervention like hysterectomy,[2] and ultimately have a significant impact on the health care system.

One of the most common presenting gynecological complaints in the perimenopausal woman is changes in menstrual bleeding patterns. Diagnosis and management of perimenopausal dysfunctional uterine bleeding (DUB) requires an understanding of the physiology of the perimenopause as well as an awareness of the possible organic causes of abnormal bleeding in this age group[3].

Abnormal uterine bleeding (AUB) before the menopause accounts for 20% of visits to the gynaecology clinic and almost 25% of gynecological operations. Menorrhagia, polymenorrhagia, intermenstrual bleeding and metrorrhagia are common menstrual disorders at perimenopause. Dysfunctional uterine bleeding (DUB), fibroid uterus and adenomyosis are the common hyperoestrogenic conditions[4].

Diagnosis and treatment of endometrial pathology can benefit from well-established techniques, ranging from clinical examination to TVS, saline infusion sonohysterography (SIS), hysterosalpingography, hysteroscopy (HYS), and endometrial biopsy[5].

The major challenge to address is to decrease the worries about possible uterine cancer while treating a lady for AUB in peri-menopause and post-menopause.

Chronic endometritis also leads to AUB in 5-15% of all AUB. The classic clinical symptoms of pelvic inflammatory disease, such as low abdominal pain, mild fever, and heaviness might be present. Specific Hysteroscopic findings have been described and immuno-histochemical stains are also developed for an accurate diagnosis[6].

A Hysteroscopic evaluation of the endometrial cavity and visually directed biopsy for histo-pathological evaluation is considered the gold standard for assessing the endometrium and detecting or ruling out endometrial cancer in current practice. It is necessary to evaluate the endometrial histopathology in a woman who has no improvement in her bleeding pattern following a course of therapy of 3 months[7].

Though evaluation of AUB in perimenopause women is challenging. Here, the patient who presents with abnormal bleeding poses two distinct but important challenges for the clinician. The first is the exclusion of cancer or hyperplasia; the second is dealing with the annoyance as well as the fear that the bleeding engenders in the patient. The most important step in the management of abnormal uterine bleeding is an accurate diagnosis[8]. Depending upon the clinical diagnosis therapy is offered to the patient. Medical treatment is the primary mode of treatment for perimenopausal bleeding when malignancy is ruled out.

In this study, an attempt has been made to analyze the different causes, incidences and evaluation of uterine bleeding in perimenopausal women.

MATERIALS AND METHODS

The was a prospective Study in the Department of Obstetrics and Gynecology, P.B.M. Hospital, S.P. Medical College, Bikaner on 300 patients.

INCLUSION CRITERIA: Women in perimenopausal age group (40-55 years) presenting with complaint of bleeding PV.

EXCLUSION CRITERIA: Female less than 40 & more than 55 years with complaints of bleeding PV, Women with coagulation abnormalities and bleeding disorder, Patient taking anticoagulant drugs, and Pregnancy & related complications

A detailed history was taken regarding age, parity, past menstrual history, past obstetric history, past medical history, present menstrual complaints (Length of cycle, Duration of cycle, Number of pads used per day, Associated clots), and changing pattern of bleeding. Ultrasonographic evaluation of the patient was performed to look for endometrial thickness, anatomical lesion-polyp, fibroid etc. Endometrial Biopsy was done and specimen was sent for histopathologic report (HPE). These reports was analysed and the patients was further managed conservatively or surgically depending upon the report. Clinical findings & HPE findings was correlated. Ultrasonographic and HPE findings of endometrial hyperplasia, fibroid polyp and adenomyosis was correlated. Data was analyze using SPSS version 22 and a 'p' value < 0.05 will consider significant

OBSERVATIONS

The mean age of patients was 46.05±2.34 years with the most common affected age group was 45-49 years. The mean of parity in out sample size is 2.88±0.93 with 45.6% females were having parity of 3 (Fig: 1).

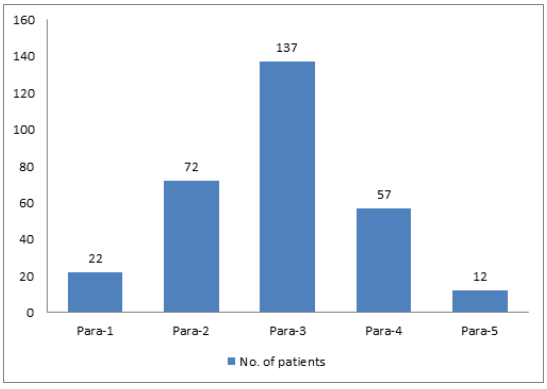

Fig: 1 Distribution of patients with respect to parity.

Here, the most common bleeding pattern was found to be Polymenorrhoea (53.7%), followed by Menorrhagia + intermenstrual bleeding (menometrorrhagia) (13%), Menorrhagia (12%), Intermenstrual bleeding (8.3%), Oligomenorrhoea (6%), Post-coital bleeding (6%), Amenorrhoea followed by menorrhagia (metropathica haemorrhagica) (1%) (Table:1).

Table: 1 Distribution of patients with respect to bleeding patterns.

BLEEDING PATTERN	No.	%
Intermenstrual bleeding	25	8.3
Menorrhagia + intermenstrual bleeding (menometrorrhagia)	39	13
Menorrhagia	36	12
Post-coital bleeding	18	6
Amenorrhoea followed by menorrhagia (metropathica haemorrhagica)	3	1
Oligomenorrhoea	18	6
Polymenorrhoea	161	53.7
Total	300	100

On USG finding we found that maximum (54%) females were having Thickened endometrium, followed by 14.0% had increased Uterus size with no specific feature, 11.3% had endometrial polyp, 6.7% had ovarian cyst, fibroid uterus (10%) and adenomyosis (4%) (Fig: 2).

Table: 2 Distribution according to clinical assessment of uterine size.

Uterus Size		No.	%
Bulky Uterus	6-8 week size	106	35.3
	8-10 week size	65	21.7
	10-12 week size	13	4.3
	12-14 week size	9	3
Normal uterus		107	35.7

On **Histopatholgical examination (HPE) of endometrium we found that** 49% had Proliferative endometrium followed by 32.7% patients had Endometrial hyperplasia, 13.6% had Secretory endometrium, 1% had Benign endometrial and cervical polyp, 1.3% had Carcinoma endometrium on histopathological examination, 1% had dilation of gland and 1.3% dilation of gland+Proliferative endometrium (Fig: 3).

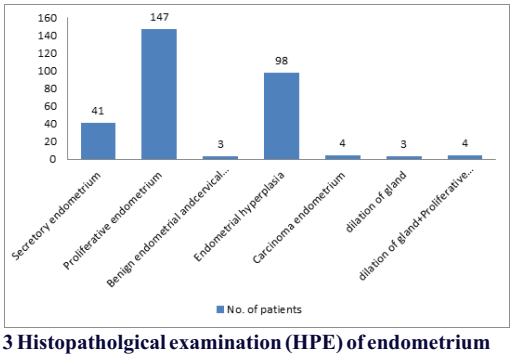

Fig: 3 Histopatholgical examination (HPE) of endometrium

Here, 68.3% patients had no history of any associated medical history. 16% patients had hypertension, 1.3% had diabetes mellitus and 16.7% had hypothyroidism. 89.6% cases had no urinary symptoms, 4% had burning micturation, 3.7% had increase frequency of urination and 2.7% had difficulty in urination.

Here, 61.3% had undergone medical treatment, 38.7% had both medical and surgical treatment. 69.9% cases had Hysterectomy with BSO and 30.1% had Hysterectomy only. Iron tablets were given to 43.7% cases, tranexmic were given to 32% and hormones were given to 66.6% patients.

DISCUSSION

Abnormal uterine bleeding is a common gynecological problem. Dilatation and curettage is a useful and cost effective method of detecting intrauterine pathologies. Histopathological evaluation of the curettage specimen helps in identifying the cause of abnormal uterine bleeding.

The study was conducted to study the etiopathogenesis of perimenopausal bleeding and determine the incidence of benign and malignant causes of perimenopausal bleeding.

In our study majority of females (71.3%) were in age group 45-49 years with mean age 46.05±2.34 years. The mean of parity in out sample size is 2.88±0.93. Sreelakshmi et al[9] found maximum number of patients with abnormal uterine bleeding presented in age group 45-50 years. The mean age of participants was 46.68±2.03 years. They also found that majority of patients had parity of 2 (51.85% patients) and 3 (28.8% patients).

In our study most common bleeding pattern was found to be Polymenorrhoea (53.7%), followed by Menorrhagia + intermenstrual bleeding (menometrorrhagia) (13%), Menorrhagia (12%), Intermenstrual bleeding (8.3%), Oligomenorrhoea (6%), Amenorrhoea followed by menorrhagia (metropathica haemorrhagica) (1%) and Post-coital bleeding (6%). In concordance with study done by Jain and Gorania[10] the most common abnormal uterine bleeding is menorrhagia in 42.16% cases.27.61% cases had continuous bleeding per vaginum. Menorrhagia is a common complain reported in literature between 51.9% and 53.3%. Metrorrhagia seen in 18% is the second commonest clinical presentation[10].

In our study on USG findings 54% females were having Thickened endometrium, followed by 14.0% had increased Uterus size with no specific feature, 11.3% had endometrial polyp 6.7% had ovarian cyst, 10.0% had fibroid uterus and 4% had adenomyosis.

Nargis et al study was complaining of different patterns of AUB and the majority of them presented clinically with menorrhagia (52%). Similar findings were reported by others. Fibroids are common finding in women with menorrhagia. Menorrhagia in fibroid is due to increased in size of the uterine cavity thereby increasing the surface area of the endometrium, hyperestrogenemia cause endometrial hyperplasia , vascular alteration of the endometrium and obstetric effect of fibroid on uterine vasculature leading to endometrial venule ectasia which causes proximal congestion in the myometrium and the endometrium. Majority of women with uterine fibroid associated with menorrhagia are treated by hysterectomy (58%). In Nargis et al study , Fibroid uterus was responsible for abnormal uterine bleeding (AUB) in 58% of women and the data concurs with the results from the studies performed in DHQ Hospital and Nishtar Hospital Multan –54.8% and Bombay Hospital –54%[11].

In our study out of 64.3% of bulky uterus out of which 35.3%patients had uterus size of 6-8 week, 21.7% patients had uterus size of 8-10 week. In consistent with this study by Jain and Gorania found 37.68% patients had clinically normal size uterus but were symptomatic and 62.3% patients had bulky uterus[10].

In our study on Histopathological examination 49% patients had Proliferative endometrium followed by Endometrial hyperplasia (32.7%), Secretary endometrium (13.6%).

In correlation with this Sreelakshmi et al found that proliferative endometrium was the most common histopathological study followed by secretory endometrium. Proliferative endometrium was observed in (30.3%) of cases which was similar to studies reported by Damle RP et al[12] (35.09%) and Bhatta S and Sinha AK (29.16%)[13]. Abdulla and Bondaji[14] found secretory endometrium was the most common histopathological diagnosis (24.9%) followed by proliferative

endometrium 21.7%. Secretory endometrium was observed in 27.4% of cases in this study, similar to Jain M et al (28.9) study[10].

Here, 68.3% patients had no history of any associated medical history. In study by Sreelakshmi et al found 5.26% had associated diabetes, 26.31% had hypertension, 26.31% had hypothyroidism[9].

In our study 61.3% had undergone medical treatment and 38.7% had both medical and surgical treatment. In study by Sreelakshmi et al found 46.8% had Hysterectomy only and 37.23% had Hysterectomy with BSO. There is little consensus on specific treatment regimens for anovulatory uterine bleeding. ACOG recommends treatment with combination oral contraceptives or cyclic progestin[9].

SUMMARY AND CONCLUSION

This is a preliminary study to evaluate the correlation of menstrual bleeding pattern on abnormal endometrial histopathological findings in perimenopausal women. We concluded that menorrhagia and intermenstrual bleeding are mostly correlated with abnormal endometrial histopathological findings. Clinicians should give attention for these abnormal bleeding patterns to not to delay the evaluation of endometrium. But it is necessary to be studied in different cohort groups with larger populations.

REFERENCES

1. Kadir RA, Economides DL, Lee CA, Sabin CA, Owens D. Frequency of inherited bleeding disorders in women with menorrhagia. Lancet 1998;351:485–9.
2. American College of Obstetricians and Gynecologists Committee on Adolescent Health Care; American College of Obstetricians and Gynecologists Committee Gynecologic Practice. ACOG Committee Opinion No. 451: Von Willebrand disease in women. Obstet Gynecol 2009:114:1439–43.
3. Metcalf MG. The approach of menopause: a New Zealand study. N Z Med J 1988;101(841):103-6.
4. Trivedi S. and Biniwale P. Evaluation and management of Perimenaopausal bleeding. IOSR Journal of Dental and Medical Sciences (IOSR-JDMS). 2014;13(9):12-20
5. Epstein E, Ramirez A, Skoog L, Valentin L. Transvaginal sonography, saline contrast sonohysterography and hysteroscopy for the investigation of women with postmenopausal bleeding and endometrium>5 mm. Ultrasound Obstet Gynecol. 2001;18:157–62.
6. Kotdawala P., Kotdawala S. and Nagar N. Evaluation of endometrium in peri-menopausal abnormal uterine bleeding. J Midlife Health. 2013 Jan-Mar; 4(1): 16–21.
7. Brand A, Dubuc-Lissoir J, Ehlen T, Plante M. Diagnosis of endometrial cancer in women with abnormal vaginal bleeding. J Soc Obstet Gynaecol Can. 2000;22:102–4.
8. Joseph C Gambone, Michael S Broder et al. Abnormal Uterine Bleeding During the Reproductive Years — Terminology and Treatment.
9. Sreelakshmi U, Bindu VT, Subhashini T. Abnormal uterine bleeding in perimenopausal age group women: a study on clinicopathological evaluation and management. Int J Reprod Contracept Obstet Gynecol 2018;7:192-7.
10. Jain M, Gorania N. Abnormal uterine bleeding: a study of menstrual patterns and histopathological patterns in perimenopausal females. Int J Reprod Contracept Obstet Gynecol 2015;4:109-12.
11. Nargis N, Karim I, Sarwar KB. Abnormal Uterine Bleeding in Perimenopausal Age: Different causes and its relation with histopathology. Bangladesh Journal of Medical Science Vol. 13 No. 02 April'14
12. Damle RP, Dravid NV, Suryawanshi KH, Gadre AS, Bagale PS, Ahire N. Clinicopathological spectrum of endometrial changes in perimenopausal and menopausal uterine bleeding. J Clin Diagnos Res. 2013;7(12):2774-6.
13. Bhatta S, Sinha AK. Histopathological study of endometrium in abnormal uterine bleeding. J Pathol Nepal. 2012;2(4):297-300.
14. Abdulla LS, Bondagji NS. Histopathological pattern of Endometrial Sampling performed for Abnormal Uterine Bleeding. Bahrain Med Bull. 2011;33(4):1-6.