

Management of Acute Abnormal Uterine Bleeding in Nonpregnant Women

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Abstract: Chronic abnormal uterine bleeding (AUB), a term that refers to menstrual bleeding of abnormal quantity, duration, or schedule, is a common gynecologic problem, occurring in approximately 10 to 35 percent of women. We report the outcome of the treatment. This is a prospective cohort study of 87 women aged 28-46 years who attended the outpatient gynecology department over the period 2013-2014 to the Obstetric Gynecologic University Hospital "Queen Geraldine", in Tirana, Albania with complaint of heavy menstrual flow. 66.7% of patients had regular normal menses at 3 months follow up, 10% had amenorrhea and 6% were having regular scanty menses. Failure of medical management requires further investigation, including imaging or hysteroscopy. The choice of treatment of AUB is guided by the goals of therapy, which may be to stop acute bleeding, avoid future irregular or heavy bleeding, simultaneously provide contraception, and prevent complications, such as anemia, unnecessary surgical intervention, and diminished quality of life.

Keywords: abnormal uterine bleeding, management, treatment

1. Introduction

Chronic abnormal uterine bleeding (AUB), a term that refers to menstrual bleeding of abnormal quantity, duration, or schedule, is a common gynecologic problem, occurring in approximately 10 to 35 percent of women [1-3]. Chronic heavy or prolonged uterine bleeding can result in anemia, interfere with daily activities, and raise concerns about uterine cancer. AUB is a common reason for referral to a gynecologist, and 5 percent of women between the ages of 30 and 49 years consult a clinician for evaluation of menorrhagia [4-6]. About 1-2% of women with improperly managed anovulatory bleeding eventually may develop endometrial cancer. AUB should be suspected in patients with unpredictable or episodic heavy or light bleeding despite a normal pelvic examination. Typically, the usual minimal symptoms that accompany ovulatory cycles will not precede bleeding episodes. Because AUB is considered a diagnosis of exclusion, the presence or absence of signs and symptoms of other causes of anovulatory bleeding must be determined. Patients who report irregular menses since menarche may have polycystic ovarian syndrome (PCOS). PCOS is characterized by anovulation or oligo-ovulation and hyperandrogenism. These patients often present with unpredictable cycles and/or infertility, hirsutism with or without hyperinsulinemia, and obesity. Iron deficiency anemia develops in 21 to 67 percent of cases [7,8]. Most women with chronic AUB require medical attention but can be managed in an outpatient setting. Occasionally, an exacerbation of chronic AUB is severe enough to necessitate emergency medical care. The choice of treatment of AUB-O is guided by the goals of therapy, which may be to stop acute bleeding, avoid future irregular or heavy bleeding, simultaneously provide contraception, and prevent complications, such as anemia, unnecessary surgical intervention, and diminished quality of life. Because AUB-O is an endocrinologic abnormality, the underlying disorder should be rarely indicated for the treatment of AUB-O, unless medically rather than surgically. Surgical therapy is rarely indicated for the treatment of AUB-O, unless medical therapy fails, is contraindicated, is not tolerated by the

patient, or the patient has concomitant significant intracavity lesions.

2. Materials and Methods

This is a prospective cohort study of 87 women aged 28-46 years who attended the outpatient gynecology department over the period 2013-2014 to the Obstetric Gynecologic University Hospital "Queen Geraldine", in Tirana, Albania with complaint of heavy menstrual flow. All the women were multiparous having completed their families. Exclusion criteria: (1) Postmenopausal bleeding (2) Endometrial biopsy suggestive of atypical hyperplasia or malignancy (3) Cervical dysplasia (4) Fibroid uterus, adenomyosis, endometrial poly. (5) Bleeding dyscrasia (6) Clinical evidence of jaundice or hepatic dysfunction (7) Hypersensitivity to the drug (8) Uterine size >6 weeks gestational pregnant uterus. (9) Women desirous of fertility. Subjects were recruited at random from outpatient Department of Obstetric and Gynecology after informed consent. A detailed history regarding the age, menstrual irregularities like frequency of cycle, duration of flow and amount of flow were enquired and were recorded. General examination was done to assess the anaemia obesity and to rule out any signs and symptoms of bleeding disorders, hypothyroidism and jaundice. Body Mass Index (BMI) was calculated from patient's height and weight to study the relation of DUB with obesity. A pelvic examination was done to rule out pregnancy, fibroid, adenomyosis or any other pathology. Baseline investigations were conducted for hemoglobin levels. TLC, DLC, bleeding time, clotting time platelet count, prothrombin time and peripheral smear for cell morphology were done to rule out bleeding dyscrasias. TSH levels were advised to rule out occult hypothyroidism. Pap smears were taken and endometrial biopsy was taken [9]. The drug was administered orally in the form of 60 mg tablet twice weekly (every Sunday and Thursday) for the first 12 weeks and then once a week (every Sunday) for another 12 week. Patients were told to keep a record of their menstrual blood loss including the interval at which the menses were coming, number of days of bleeding, number

of pads soiled and degree of soiling, history of passage of clots and dysmenorrhea. Patients were asked to come for regular follow up every 30 days. On each follow up, they were asked about the blood loss and any other complaints. Hemoglobin estimation was done. A TVS was done for endometrial thickness and any other pathology. We report the outcome of the treatment. The main outcomes measured were menstrual blood, blood hemoglobin levels and endometrial thickness in proliferative phase as studied by TVS.

3. Result and Discussion

The present study was conducted on 87 non pregnant patients, 40 percent of patients were in the age group of 31-40 years. Two-third patients were urban. No significant relation was found between DUB and parity of the patient, family history of abnormal uterine bleeding and history of tubal ligation. Obesity was present in 23% patients and 19% were overweight. A past history of PID was present in 24% patients that has been treated and cured before starting therapy. Fifty percent patients had taken some form of treatment in the past and were not relieved or temporarily relieved. Twenty five patients had simple hyperplasia of endometrium and 2/3 had a normal histology report. There were five case of complex typical hyperplasia. Total of bleeding days per year decreased by 81% with the treatment. Maximum decrease was seen in patients with more pre-treatment bleeding days. Decrease in bleeding days varied from 42 to 155. Total no. of pads soiled per cycle decreased by 79%. All the patients reported disappearance of clots, 71% within 1 month of the treatment only. Dysmenorrhea was relieved in 65% patients who initially had this complaint. 50% showed a decrease in endometrial thickness by 1 to 2 mm. Average decrease was 2 ± 0.3 mm. Mean increase in Hb was 0.42g%. Side effects were minimal and tolerable. The incidence of functional ovarian cysts was 25%. Two of these patients had the cyst at the beginning of treatment that persisted at the end also. In the remaining 20 patients, cysts had developed during the course of treatment. The cysts had disappeared by the end of treatment in two patients and persisted in three patients. All these patients eventually underwent hysterectomy and histopathological examination found all the cysts to be simple serous cysts. Nine patients (10%) had amenorrhea at 4-6 months follow up after completion of treatment. Neither of these patients returned for follow up with complaint of return of menses till 1 year after completion of treatment. Seventeen patients (20%) had temporary amenorrhea followed by return of normal menstrual cycle. Fig. 1 shows that 66.7% of patients had regular normal menses at 3 months follow up, 10% had amenorrhea and 6% were having regular scanty menses.

4. Conclusion

Failure of medical management requires further investigation, including imaging or hysteroscopy [10-12]. The choice of treatment of AUB-O is guided by the goals of therapy, which may be to stop acute bleeding, avoid future irregular or heavy bleeding, simultaneously provide contraception, and prevent complications, such as anemia, unnecessary surgical intervention, and diminished quality of life. Endometrial ablation is not recommended as a first line

therapy for AUB-O [13]. Physicians must provide thorough informed consent and adequate counseling to women with AUB-O who desire endometrial ablation.

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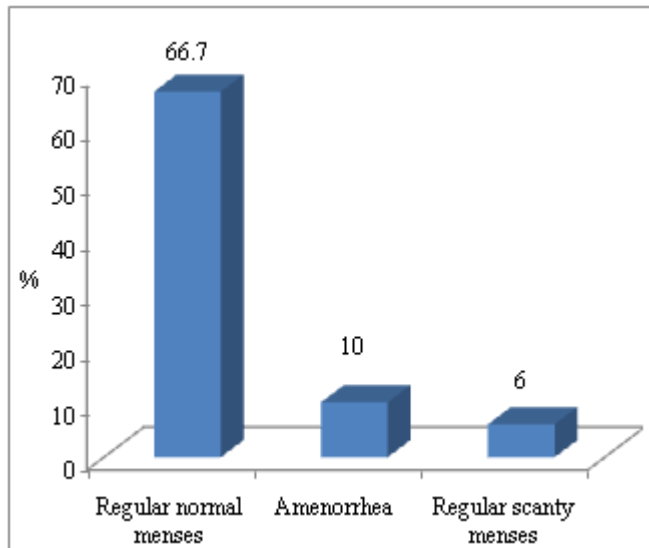


Figure 1: Menstrual cycle at 3 months follow up