

# Dysfunctional Uterine Bleeding - Will Dilatation & Curettage, Suffice or Will Need A Hormonal Support?

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**Abstract:** *Dysfunctional uterine bleeding (DUB) is abnormal genital tract bleeding from the uterus and found in the absence of demonstrable structural [1] or organic disease. Dilatation and curettage (D & C) is commonest gynecological procedure and those pts. who were treated by hormonal support, & did not improve required hysterectomy, as the final modality of treatment.*

**Keywords:** D & C, Dysfunctional uterine Bleeding, Hysterectomy, Hormonal Supports

## 1. Introduction

Dysfunctional uterine bleeding (DUB) is abnormal genital tract bleeding from the uterus and found in the absence of demonstrable structural[1] or organic disease. Diagnosis must be made by exclusion, since organic pathology must first be ruled out.

*Dilatation and curettage (D & C)* is commonest gynecological procedure, employed as a management protocol, in which the cervix is dilated (expanded) and the lining of the uterus (endometrium) is scraped away.[2]D & C serves a dual purpose, diagnostic as well as therapeutic, in cases of heavy or irregular bleeding from the uterus. Possible reasons for abnormal uterine bleeding include:[3,4]

*Hormonal imbalance.*—Often, women with abnormal bleeding, are first treated with hormones, in an attempt to normalize the HPO axis, & control bleeding. D & C is performed, to determine the cause of bleeding by histological examination.

*Endometrial polyps.*—Polyps are benign growths, that protrude from the uterus, through cervix, by a stem or stalk. D & C is done to remove them, & curette endometrium.

*Uterine fibroids.* --Also called leiomyomas, fibroids are benign growths of the smooth muscle of the uterus. Abnormal bleeding is often the only symptom of fibroids. D & C is done to scrape the hypertrophied endometrium, ; additional surgery may be needed to remove more extensive growths.

*Endometrial hyperplasia (EH).* --Endometrial hyperplasia is a condition where the endometrium grows excessively, becoming too thick and causing abnormal bleeding. Tissue samples procured during D & C can be assessed for early signs of cancer.,& degree of hyperplasia for hormonal aberration, & to assess any atypia.

*Cancer.* D & C is used to obtain tissue for microscopic evaluation to rule out cancer. Women over the age of 40 are at an increased risk of developing endometrial cancer.

*Miscarriage, incomplete abortion, or childbirth.* -- Abnormal bleeding may result if some of the products of pregnancy remain in the uterus after a miscarriage or induced abortion, or if parts of the placenta are not expelled naturally after childbirth. These retained products can be scraped out by D & C.

### Alternatives for D & C

Endometrial biopsy, serves a diagnostic purpose only.

Vacuum scraping.

Hysteroscopy, to diagnose intrauterine pathology,

Hysterectomy, as a final procedure

### Aim

To assess, - will simple D&C suffice, or will a hormonal support also be required?

### Objectives

To study the effect of Dilatation and Curettage.To study requirement of hormonal support after D&C.

## 2. Material and Methods

### Interventional study

The study will consist of operative procedure & management of women with inclusion & exclusion criteria mentioned. 30 patients with the diagnosis of DUB, based on clinical and ultrasound findings, which underwent endometrial sampling/curettage recruited for this study.

However after reviewing the histopathology report of the sampled endometrium, depending on histology, further management, about necessity of hormone therapy will be decided. Proliferative endometrium will require hormonal correction, while secretory endometrium, -- a result of normal hormonal milieu, & rhythm can do without any such support.

### Inclusion Criteria

All women having dysfunctional uterine bleeding

**Exclusion Criteria**

Women on hormonal support.  
 Patients with heavy bleeding necessitating emergency treatment.

Women with a known, suspected or with a history of genital tract malignancy

**3. Results & Analysis**

30 DUB patients were analysed for their relation to age, parity, type of bleeding, pattern of bleeding, clinical presentation, type of endometrium on Histopathology and hormonal support.

**Table 1:** Frequency of distribution of DUB among different age groups

Age Group	No. of Patients	Percentage (%)
15-24	4	13
25-34	11	37
35-44	15	50

The above table (table 1) shows age distribution of DUB. The maximum incidence of DUB was in the age group 35-44. (n-15, 50%)

**Table 2:** Relationship of DUB with age and parity

PARITY	15-24	25-34	35-44	TOTAL
0	2	0	0	2(7%)
I	2	2	2	6(20%)
II	0	4	3	7(23%)
III	0	5	7	12(40%)
> III	0	0	3	3(10%)
TOTAL	4	11	15	30

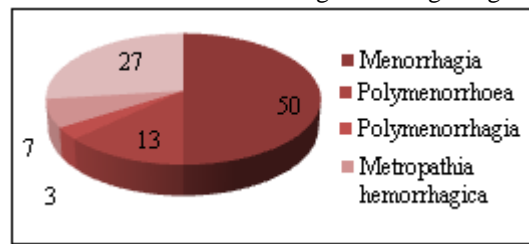
Above table shows relation between frequency of DUB and parity. Cases of DUB increased with increasing parity. Maximum incidence was found with higher parity ( n-12, 40%), & in 4<sup>th</sup> decade of life,( previous table).

**Table 3:** Pattern of bleeding in DUB

Pattern of Bleeding	No. of Cases	Percentage
Menorrhagia	15	50
Polymenorrhoea	4	13
Polymenorrhagia	1	3
Metropathia Hemorrhagica	2	7
Metrorrhagia	8	27
Menometrorrhagia	0	0
Oligomenorrhoea	0	0

Menorrhagia was the most common type of DUB it was seen in 15 patients (n=15, 50%), 8 patients (n=8, 27%) came with the complaint of metrorrhagia, 4 patients (n=4, 13%) with Polymenorrhoea, 2 patients (n=2, 7%) presented with metropathiahemorrhagica.

**Table 4:** Pattern of bleeding according to age



AGE	Menorrhagia	Polymenorrhoea	Polymenorrhagia	Metropathia hemorrhagica	Metrorrhagia	Menometrorrhagia	Oligomenorrhoea	TOTAL
15-24	1	1	1	-	1	-	-	4
25-34	5	2	-	1	3	-	-	11
35-44	9	1	-	1	4	-	-	15
TOTAL	15	4	1	2	8	0	0	30

The pattern of bleeding among the 30 patients varied with different age groups. Maximum incidence was found with 4<sup>th</sup> decade of life, in which menorrhagia was most common bleeding pattern.

**Table 5:** Endometrial pattern in 30 DUB patients

Endometrial Pattern	Total	Percentage
CGH(CYSTIC GLANDULAR HYPERPLASIA)	13	43
Secretory endometrium	5	17
Proliferative endometrium	3	10
Irregular shedding	6	20
Hyperplasia without Atypia	2	7
Adenomatous hyperplasia	0	-
Granulomatous endometritis	0	-
Hyperplasia with Atypia	1	3
TOTAL	30	100

**Table 6:** Correlation of Endometrial Pattern With Age Group

Endometrial Pattern	15-24	25-34	35-44	Total
CGH(CYSTIC GLANDULAR HYPERPLASIA)	0	1	12	13
Secretory endometrium	1	4	0	5
Proliferative endometrium	0	1	2	3
Irregular shedding	0	4	2	6
Hyperplasia without atypia	0	1	1	2
Adenomatous hyperplasia	0	0	0	0
Granulomatous endometritis	0	0	0	0
Hyperplasia with atypia	0	0	1	1
Total	1	11	18	30

Above table shows relation between frequency of DUB and parity. Cases of DUB increased with increasing parity. Maximum incidence was found with higher parity ( n-12, 40%), & in 4<sup>th</sup> decade of life,( previous table).

In the age group of 15-24year only 1 pt showed secretory endometrium.In the age group of 25-34year 1 pt showed CGH, 4 pts. showed secretory pattern ,1 pt proliferative pattern,4 pts. showed irregular shedding and 1 pt showed hyperplasia without atypia.In the age group of 35-44years, 12 pts. showed CGH, 2 pts. proliferative, 2 pts. irregular shedding and 1 with each hyperplasia with and without atypia.Among all the age groups Cystic glandular Hyperplasia was the most common endometrial pattern seen

in 13 patients (n=13, 43.0%), followed by irregular shedding in 6 patients(n-6, 20%)

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In the age group of 35-44years, 12 pts. showed CGH, 2 pts. proliferative, 2 pts. irregular shedding and 1 with each hyperplasia with and without atypia.

Among all the age groups Cystic glandular Hyperplasia was the most common endometrial pattern seen in 13 patients (n=13, 43.0%), followed irregular shedding in 6 patients(n-6, 20%)

Bleeding pattern of clinical presentation co-relates well with the histological finding.

it is very clearly apparent that menorrhagia was the most common presentation (n=15, 50%) in the following sequence of histological patterns, like CGH (n/N=9/15, 60%), secretory endometrium (n/N=5/15) and proliferative endometrium (n/N=1/15).

**Table 8:** Requirement of Hormonal Support and Hysterectomy according to Endometrial Pattern

Endometrial Pattern	Total Cases	Hormonal Support	Hysterectomy
CGH(CYSTIC GLANDULAR HYPERPLASIA)	13	8	5
Secretory endometrium	5	0	0
Proliferative endometrium	3	3	0
Irregular shedding	6	3	1
Hyperplasia without atypia	2	1	0
Adenomatous hyperplasia	0	0	0
Granulomatous endometritis	0	0	0
Hyperplasia with atypia	1	0	1
TOTAL	30		16(53%)

Table 8 shows requirement of Hormonal support in different endometrial pattern. In case of CGH(13 cases) in 8 pts. Hormonal sufficed, and 5 pts. Required Hysterectomy.

Hormonal support was also effective in case of proliferative endometrium, Irregular shedding and hyperplasia without atypia.

In case of CGH, 10 pts. had endometrial thickness between 10-16mm, and 3 pts. had >16mm thickness.

**Table 9:** Correlation of Uterine Size as Determined Clinically and by USG

Size	Clinical Findings (Uterine Size)	USG Based (Uterine Size)	Endometrial Thickness
1. Normal	23	25	<10mm -10
			10-16mm -6
			>16mm -0
2. Bigger Than Normal	7	5	<10mm -1
			10-16mm -10
			>16mm -3

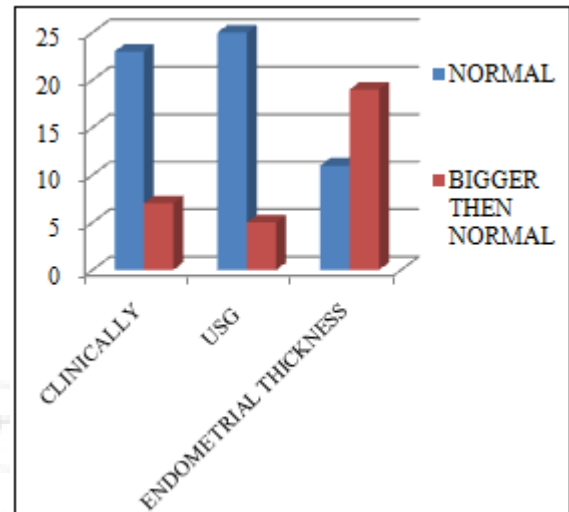


TABLE-9 shows correlation of uterine size clinically and by USG. Clinically 7 pts. showed uterine size bigger than normal, while on USG, only 5 pts. had bigger than normal size.

#### 4. Discussion

D.U.B. Is the most common menstrual aberration seen clinically in 3<sup>rd</sup> & 4<sup>th</sup> decades of life.

As the name suggests, being functional deficiency, it is equally innocuous per se, but, the clinical presentation makes the woman quite unhappy, & hence the need to investigate & treat it with due vigilance.

In 80 to 85% cases, actually simple D&C, usually suffice, as can be ascertained from previous tables, few need a hormonal support, to revert or nullify the effect of prolonged un-opposed oestrogen, with a progesterone, with really satisfying control, there are a few select unfortunate patients, who ultimately need a hysterectomy, due to histology, that is not exactly normal, or do they opt for it, voluntarily, with their own ideas, regarding their problems, which, though, can be successfully treated conservatively, select a "so called," final solution, once & for all.

#### 5. Conclusion

DUB is a common gynecological complaint, predominantly seen in the age group 35-44 years.

Menorrhagia was commonest bleeding pattern seen in multiparous women.

Cases of DUB increased with increasing parity.

Hyperplastic endometrium (CGH) was the commonest type of endometrium observed, followed by Irregular shedding.

Proliferative and secretory endometrium were commonly seen in the age group of 25-34 years and hyperplastic endometrium in the age group 35-44 years.

Menorrhagia was commonest bleeding pattern seen in Hyperplastic endometrium(CGH).Hormonal support mainly required in case of CGH, Irregular shedding and Proliferative pattern of endometrium.

Those patients who were treated by hormonal support, & did not improve required hysterectomy, as the final modality of treatment.

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