DYSFUNCTIONAL UTERINE BLEEDING

(Age group under 20 years)

by

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Introduction

Dysfunctional uterine bleeding is strictly defined as excessive menstrual loss with or without the disturbance of cyclical rhythm in absence of palpable pelvic lesion. It reflects a disorder in the physiological interrelationship between the hypothalamus, pituitary and ovaries. Many a time the condition is misdiagnosed and the diagnosis is altered after a pathological condition like a solitary submucous fibroid, mild pelvic endometriosis or a tiny granulosa-cell tumour is discovered.

The study covers the years 1961-62. There were 122 cases of dysfunctional uterine bleeding and of these 20 were below the age of twenty — incidence 16.3%.

Age of Menarche

There was only one case aged 10 at menarche, 8 were 12 years old, 6 between the ages of 13 and 14 and 3 between 15 and 16 years. Two cases could not give their ages at menarche.

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Significant Past History

One patient gave history of *haemoptysis* (no definite cause detected), one case had moderate *hyperthyroidism*, one case of *mitral stenosis* and one case with history of *puerperal sepsis*.

Obstetric History

Nine girls were single and 11 married; eight of these had not conceived. Two patients gave history of normal deliveries and one had a caesarean section.

TABLE I

Type of Bleeding

	No. of cases
1. Menorrhagia—from menarche ..	4
2. Menorrhagia with regular cycle ..	14
3. Menorrhagia preceded by a period of amenorrhoea of 2-3 months ..	1
4. Polymenorrhoea	1

All the 4 cases who got haemorrhage from the first menstruation were 12 at menarche.

As it is difficult to find out the amount of bleeding, the cases whose haemoglobin level was below 9 gms% were taken to be suffering from this condition. These patients being below 20 years, the chance of misinterpretation on their part was possible, due to lack of experience, over-anxiety and apprehension.

TABLE II

Endometrial biopsy or curettings—13 cases

(During the premenstrual phase or on the first day of bleeding)

	No. of cases
1. Proliferative endometrium—without any hyperplasia	9
2. Scanty hypoplastic endometrium—with occasional straight, tubular glands	1
3. Hyperplastic nonsecretory endometrium with stromal hyperplasia and endometrial polyposis ..	2
4. Secretory endometrium	2

plasia was the common finding. Hyperplasia was present in only one case, which is the major characteristic endometrial picture in later life.

Diagnosis was based mainly on the clinical history, general examination and interrogation of the parents and family practitioner wherever available. Pelvic examination per rectum was done in single women wherever found necessary.

In this group of cases all the patients' treatment was started with assurance, encouragement and correction of anaemia and improvement of general health.

TABLE III

Treatment, Result and Follow-up

Treatment	No. of cases	Cured	Improved	No improvement	Recurrence	Remarks
General measures Iron, vitamins, blood transfusion, antihistaminics & laxative	10	7	1	1	1	Duration of treatment—3-9 months. Response usually after 3 months.
Hormone therapy Anovular, Primolut N.	3	2	1			
Curettage	4	2		2		
Antimenorrhagic factor (Amfac)	3	1	1	1		
Curettage & hormone therapy [Patients who had no improvement or recurrence after treatment were subjected to curettage and hormone therapy]	5	1	2		2	Treatment being continued. All the patients are under follow-up study.

Study of the endometrium was done in 13 patients. Proliferative endometrium without any hyper-

Curettage was done in married patients to study the character of the endometrium and to get a therapeu-

tic effect as well. It may be observed that from the therapeutic point of view it was successful in only 2 cases.

Hormones were used in a good number of cases and new progestogenic agents (Primolut N) were the drugs of choice.

Discussion

In this group of cases of dysfunctional uterine bleeding below 20 years it is better to leave the charge of the patient with the family practitioner. Environment of gynaecological outpatient may inflict permanent psychological trauma.

Menorrhagia at this age group may arise from general ill health, chronic debilitating diseases, naso-pharyngeal infections, heart disease, nephritis, pelvic congestion caused by chronic constipation lack of exercise and sedentary habits. Emotional strain due to migration, unhappy family life, sexual dissatisfaction and overwork may be the aetiological factors. These factors are best tackled by the family practitioner. If none of these conditions are found the gynaecologist's advice should be sought for.

One should always start with the general line of treatment and if that does not help, other lines of treatment should be started after investigations rule out other lesions.

Though all types of endometria have been found, proliferative endometrium without hyperplasia is the commonest finding as against the hyperplastic non-secretory endometrium in the later age group. Anovulation might have some relationship with this abnormal bleeding and this further demonstrates the in-co-ordination in the endocrine relationship.

Best result has been obtained by general line of treatment in the form of mental adjustment and careful supervision in the improvement of general health and correction of anaemia. Complications resulting from pregnancy, labour and puerperium should always be remembered. Careful postpartum treatment could avoid many of these cases in succeeding years. Failure on the part of the attendant to bring back the blood picture to normal level starts a vicious circle aggravating the condition further.

Though curettage is claimed to cure 20-30% in an unknown manner, at this age it may not be of much therapeutic value but it reveals the endometrial picture and excludes tuberculosis.

Hormone therapy at this age is generally not done at the onset. It is usually started after the general lines of treatment fail or immediate stoppage of bleeding is necessary. Androgens are best avoided because of the individual sensitivity to undesirable side-effects. Heavy doses of oestrogenic preparation to gain haemostasis give rise to distressing symptoms. Progesterone injections have been used to get secretory transformation of the endometrium. Recurrence of the abnormal bleeding is an indication for progesterone therapy. Cyclical combined oestrogen-progesterone therapy for three to four months is claimed to promote the establishment of normal pituitary ovarian mechanism. Gonadotrophins are generally valueless. Combined use of injections of progesterone and

testosterone propionate has been advocated.

The steroid Norethisterone has been extensively used and it has been proved to produce good secretory response in oestrogen-primed endometrium. Nausea, bloating, headache, breast discomfort are sometimes experienced with high dosage. Among all the preparations in this group Norethynodrel is less likely to give rise to break-through bleeding perhaps because of its contamination with ethynyloestradiol-3 methyl ether.

Norethisterone derivatives have been useful in the treatment of this condition. As a rule bleeding is promptly controlled in a dose of 10-20 mgm. daily, and withdrawal bleeding occurs a few days after stoppage. Cyclical treatment from 5th to 25th day of the cycle given for a few months is often followed by regular spontaneous menstruation.

It is perhaps not entirely true that complete secretory transformation is essential for satisfactory clinical effect. The action of neoprogestogens continues in the stroma till proper decidual reaction is attained but less typical change is observed in the epithelium as compared with the normal premenstrual endometrium.

Summary

1. Selection of cases to be included within dysfunctional uterine bleeding has to be carefully done and diagnosis may have to be changed when investigations reveal some other pathological cause for abnormal bleeding.

2. Incidence of dysfunctional uterine bleeding in patients below 20 years in total number of cases was 16.3%.

3. Significant history, type of bleeding, endometrial pictures, lines of treatment and the result have been shown.

4. General line of treatment has been successful in most of the cases. Scope of curettage and hormone therapy has been discussed. Good prospect of norethisterone derivatives has been indicated.

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