

MENSTRUAL REGULATION

by

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Introduction

Menstrual regulation is a novel idea that has been recently introduced in medical practice. In general terms it means bringing about vaginal bleeding (menstruation) and evacuation of uterine contents, if any, in regularly menstruating women, who have missed their menstrual period upto 15 days. Thus, her menstruation is regulated and so the term 'Menstrual Regulation'. Clinically, it is difficult to definitely diagnose a pregnancy in a woman who has missed her menstrual period by 15 days. Also, laboratory pregnancy tests may not be conclusive in such women. This is the reason for the 15 day limit. However, there is still a controversy on the actual definition and limit of 'Menstrual Regulation'. If a woman has a positive pregnancy test (Immunological), technically it becomes an abortion and not menstrual regulation. But most workers would consider it as a menstrual regulation. Menstrual regulation can thus be a camouflage for early abortion. This may help to assuage the conscience and feelings of these women.

Menstrual Regulation Procedure: This is done as an office procedure. There is no need for any premedication or anaes-

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thesia. Kessel *et al*, (1973) also state that there is no need for anaesthesia. The patient is put in the lithotomy position, painted with Savlon and draped. The cervix is exposed by a modified Martin's bivalve speculum and caught with Allis forceps. The uterine sound is passed. Then a 4 mm. Karman plastic catheter attached to a 50 ml. special plastic syringe is passed into the uterine cavity without any dilatation. The plunger of the plastic syringe is pulled out and held in that position by a special mechanism, thus creating vacuum. The plastic catheter is then moved to and fro in the uterine cavity and the contents get aspirated in the syringe. This is continued till no more contents are aspirated. A very small sharp curette is passed into uterus to remove any pieces left behind and moved around till grating is obtained.

The whole procedure could be done without the surgeon scrubbing up, as no touch technic (N.T.T.). This is also recommended by Brenner *et al*, (1973). The average blood loss is 7 ml. and average operation time is 3 minutes.

However, the plastic catheter has some disadvantages viz. plastic catheters have to be disposable and the cost. As plastic catheter is flexible, sometimes there is need for dilating the cervix before it can be introduced in the uterus. Also, as you move it up and down, it wobbles. This is especially so, when plastic catheters are reused after chemical sterilisation.

Also, its tip might break. There is need for a sharp curette check. It is not suitable for diagnostic curettage.

New Menstrual Regulation Curette: (See Figures 1 and 2). The first author devised a 4 mm. metal menstrual regulation curette to overcome these disadvantages. This menstrual regulation curette has one round terminal and 2 oval sub-terminal openings at its uterine end. The front oval sub-terminal opening has fine teeth. At its distal end is a universal mount, which is connected directly to a 50 ml. plastic aspiration syringe or by a plastic tubing to a hand pump or electrical suction machine. Near the distal end there is a thumb rest with an air hole.

This menstrual regulation curette can be repeatedly used and thoroughly sterilised. It is rigid and can be connected to regular suction machine. Its fine teeth help in breaking up the contents and its 3 openings facilitate rapid emptying. No sharp curette check is required as the fine teeth act as a sharp curette. It can be also used for a diagnostic curettage without cervical dilatation.

At the end of the procedure the patient can be sent home immediately after a few instructions.

Analysis of 201 Cases done between 1-8-1972 to 31-12-1973

TABLE I
Menstrual Regulation—201 Cases

Marital status	
Single and widows	4%
Christian (6% in population)	8.5%
age—15 to 25 years	56.5%
No living children	11%
Two or less living children	69%
Education—High School and University	62.5%
Income: More than Rs. 300	40.5%
Not pregnant	10%

Table 1 shows that only 4% were single and widows in contrast to Kessel *et al.* (1973) reporting 66.77%.

Christians present themselves in larger numbers (8.5% as compared to 6% in the population).

56.5% belong to the age group 15 to 25 years. 69% of women had 2 or less living children. Only 11% of women had no living children as against 50% reported by Kessel *et al.*, 62.5% had good education and 40.5% belonged to the middle and upper classes. In all cases, tissue was examined grossly for products of conception. In only 10%, no products were seen.

TABLE II
Analysis of 40 Cases with Pregnancy Test and Histo-pathology

Number of days over due	No. of cases	Pregnancy Test		Gross tissue estimate		Histopathology	
		Positive	Negative	Positive	Negative	Positive	Negative
5 to 7	8 (20%)	4 (50%)	4 (50%)	3 (38%)	5 (62%)	4 (50%)	4 (50%)
8 to 15	32 (80%)	30 (94%)	2 (6%)	29 (91%)	3 (9%)	30 (94%)	2 (6%)
Total	40 (100%)	34 (85%)	6 (15%)	32 (80%)	8 (20%)	34 (85%)	6 (15%)

The first 40 cases were studied more intensively to set up a baseline as regards the number of days overdue and their relation to pregnancy. In all cases a preoperative (prognosticon all in test) pregnancy test, postoperative gross tissue examination and histopathology were carried out. These 40 cases could be divided into 2 groups.

Group I: Eight cases (20%) had missed the menstrual period by 5 to 7 days. In this group, only 50% had a positive pregnancy test and in 38%, the gross tissue estimate indicated pregnancy, while in 50% histopathology confirmed pregnancy. Thus, in 50% of this group, there was no pregnancy and the procedure was unnecessary and in other 50% in fact it was an early abortion.

Group II: 32 cases (80%) had missed the menstrual period by 8-15 days. In this group, 94% had a positive pregnancy test, 91% had gross tissue indicative of pregnancy, while 94% had pregnancy confirmed by histopathology. Thus, in this group, almost all cases (except 2—i.e. 6%) were pregnant and had an early abortion.

In all these 40 cases, there is a close correlation between the pregnancy test, histopathology and gross tissue estimate.

Complications: There have been very few complications following menstrual regulation. Even, postoperative bleeding is very little. There has been 1 (0.5%) case of continuation of pregnancy, and no case of bleeding needing a re-curettage. The overall complications reported by Vlught and Piotrow, (1973) like syncope, postoperative bleeding retained products constitute only 4.7%. Only one perforation was reported by Goldsmith *et al.* A failure indicated by continuing pregnancy has been reported in 10 out of 1848 menstrual regulations reported by Vlught

and Piotrow, giving an incidence of 0.5%. Brenner *et al.*, also report one case.

TABLE III
Acceptance of Family Planning

Sterilisation	11.5%
I.U.D.	48%
Oral Pills	24%
Nirodh	7%
Nil (Single & Widows 4%)	9.5%

Menstrual regulation is a powerful trigger for acceptance of family planning as can be seen from the accompanying Table. 91.5% accepted some method of family planning.

Conclusion

Menstrual regulation is a novel idea with bright prospects for the future. It would be prudent to include early abortions in the overall definition of menstrual regulation. This would result in many women being aborted early, when it is almost free from any medical risk and mental and social overtones. It can be performed in small clinics with fewer facilities and by doctors with minimal training, thus facilitating its widespread acceptance. Also menstrual regulation is a powerful trigger for acceptance of family planning.

Summary

A comprehensive definition including early abortion is offered. The technic is described indicating its simplicity, safety (low complication rate of 0.5%) and surety. A new 4 mm. metal menstrual regulation curette is described. Analysis of 201 cases is presented and its role as a trigger of family planning (91.5% acceptance) is emphasised.

References

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See Figs. on Art Paper II