MENORRHAGIA IN THROMBOCYTOPENIC PURPURA REPORT OF 3 CASES

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INTRODUCTION

Uterine bleeding may be one of the first manifestations of the blood dyscrasias particularly those that impair the blood coagulation mechanism. Thus thrombocytopenic purpura, leukaemia, aplastic anaemia etc frequently cause menorrhagia.

Three cases of Thrombocytopenic purpura are being presented here. In two cases menorrhagia was secondary to thrombocytopenic purpura. In one case, it was a result of viral infection and in the second case, it was a result of drug allergy. The third one was labelled as a case of idiopathic purpura.

CASE NO.1

Mrs. J, a 40 years old multiparous woman came with complaints of profuse bleeding per vagina for the past 10 days and fainting attacks in the month of March 1988. She had viral fever a week before for which she had been treated. She had her periods three days prior the onset of fever. Her previous cycles had been irregular with moderate flow for 5-6 days and not as profuse and prolonged like this episode.

Clinical examination revealed a normal uterus and adnexae. Other systems were normal except for anaemia. Urine examination was normal. Blood examination showed a low platelet count of 20,000 cells/cml. and a haemoglobin of 5.8 gms%. Bleeding time and clotting time were normal and the WBC count was high normal. The tourniquet test was positive.

A diagnosis of secondary thrombocytopenic purpura secondary to viral fever was made. The case was referred to the Physician who concurred with the diagnosis. She was put on corticosteroids, styptics and blood transfusion was given to improve her condition. She recovered completely, the platelet count returned to normal. Later, she had fractional curettage to rule out any other local pathology. Endometrium was in proliferative phase and there was no malignancy. She did not have repeat episode of abnormal bleeding thereafter.

CASE NO.2

Mrs. S, a 35 year old multiparous woman came with irregular profuse bleeding per vagina and abdominal pain for the past one month in the month of August 1988. She had treatment at a local hospital with styptics and chloromycetin. Her menstrual cycles were irregular profuse and

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health centres, rural hospitals, schools, bunglows and government offices or quarters. Patients were motivated by the tea garden authorities, field staffs of the health and family welfare departments and broadcast of the camp programme through All India Radio in this district. All patients were provided with transport facility before and after operation. Preliminary history was taken by the health staffs as regarding menstruation, child birth, number of children: male or female, but routine pelvic examination was not done in many cases.

ANALGESIA AND PREMEDICATION

In 70% cases Inj atropine 0.6mg, pethidine 100 mg, phenargan 50mg was given intramuscularly half an hour before operation after voiding urine. In the rest of the 30% cases Inj atropine 0.6mg, diazepam 10mg, and pentazocine 30mg were given. I.M. or I.V. slowly on the O.T. table. Infra umbilical transverse incision made. Verres needle introduced. Oxygen used for pneumoperitoneum. Trocar and canula introduced. Adequate loop of fallopian tube taken and falope rings applied. All patients were discharged half to one hour after the operation.

OBSERVATIONS

TABLE I

DISTRIBUTION OF CASES

Types of cases	No	%
Interval cases	5826	95.11
Interval cases without previous abdominal surgery = 5773.		
Interval cases with previous abdominal surgery = 53.		
Post partum cases	176	2.87
8 to 14 days = 51		
15 to 21 days = 60		
22 to 45 days = 65		
Early pregnancy cases	123	2.00

Table I shows that majority (95%) of the patients were interval cases 2.8% were post partum and 2% in early pregnancy. The early pregnancy cases were referred to the nearest hospital for M.T.P.

TABLE II

AGE WISE DISTRIBUTION

Age	No.of Cases	%
Below 20	205	3.34
21 to 25	2295	37.46
26 to 30	2258	36.86
31 to 35	1051	17.15
36 to 40	298	4.86
41 and above	18	0.29

Table II shows that maximum number of acceptors (37%) belonged to the age group of 21 to 25 years. 74% of the cases are in the age group of 21 to 30 years,

TABLE III

Religion wise distribution

Religion	No.of Case	%
Hindu	4916	80.26
Buddhist	1041	16.99
Christian	130	2.12
Muslim	38	0.62

Table III shows majority (80%) cases belonged were Hindus and 16% were Buddhists

TABLE IV

According to Occupation

Occupation	No.of Cases	%
Labourer	3370	55.02
House wife	2695	44.00
Govt. Service	60	0.97

Table IV shows majority of the cases 55% were labourers, mainly tea garden workers 44% house wife, and 0.97% in government service.

TABLE V

Number of Children

No.	Cases	%
2	2085	34.04
3	2026	33.07
4	1104	18.02
5 & above	910	14.85

About 34% of the patients were mothers of 2 children and 33% were the mothers of 3 children as it is seen in Table V. It was also noted that 188 cases (3%) accepted sterilisation without a male child.

Difficulties occurred and more caution was needed for the obese patients and in patients with previous abdominal surgery. However, patients with past history of caesarean section, appendicectomy and other abdominal surgery for pelvic pathology were undertaken without any complication. Patients with good abdominal tone also needed more caution during pneumoperitoneum. In one case with post burn contracture of the anterior abdominal wall pneumoperitoneum could not be done. Difficultics were also observed to pick up the thick and oedematous tubes in early puerperal and P.I.D. cases. In puerperal cases rings were applied near the cornual ends of the tube after a slow milking process. Here extra precaution waas taken while introducing that the trocar and canula (directed backwards only) avoiding injury of the puerperal uterus. One leprosy case with crippled extremities was also included in this series.

Some of the coincidental findings were as follows - Fibroid uterus 1.5% cases, ovarian tumour 1% case, P.I.D. 4% cases, unicornuate and bicornuate uterus 3 and 2 cases respectively and unilateral absence of tube in 3 cases.,

COMPLICATIONS

Some of the minor complications were as follows- Perforation of the uterus 97 cases (1.5%), tubal transaction 15 cases, bleeding from abdominal wound 13 cases, bleeding from cervical tear 9 cases, subcutaneus emphysema 11 cases and omental prolapse 2 cases. Only 2 omental prolapse cases needed hospitalisation for reposition of the omentum.

Follow up-

Few patients complained of vague pain in the lower abdomen which is possibly psychological. No case reported for method failure till date.

DISCUSSION

53 cases done with history of previous abdominal surgery without any complication. Chauhan et al (1987) are in the opinion that well trained laparoscopy surgeon can perform laparoscopy sterilisation in cases of previous abdiminal surgery in camp. In 26 markedly obese patients long verres needle used without lifting the anterior abdominal wall. Mehta (1982) also suggests to use long needle in cases of markedly obese patients. He also suggests that in such cases anterior abdominal wall should not be lifted upwards as this increases the distance between the skin and paritoneum. I Cheng Chi et al (1985) are in the opinion that surgical difficulties are more in obese patients.

CONCLUSION

1. Laparoscopy is a safe, simple and effective method of sterilisation in well trained and experienced hand. It is a door to door method to control population explosion. So every effort should be made to keep up its popularity. Only the devoted, interested and well trained persons should undertake such camps because major complication and method failure adversely affects its popularity and demand. Already it has come to our notice that some sort of false propaganda is spreading against laparoscopy sterilisation. It is being said that there will be

maximum failure in this type of operation. There will be pregnancy after few years. Of course it depends upon the quality of the falope rings used. It is very urgent to stop this kind of propaganda. Publicity media like press, A.I.R., T.V. should be utilised for this purpose.

2. Quality of the drugs used for premedication should be good.

3. Surgeon should be well trained in his work.

4. Post operative complications should be managed with utmost care and sympathy.

5. Gradual pneumoperitoneum, unhurried technique, gentle manupulation of the uterus prevents many complications like cardiac arrest, subcutaneous emphysema, uterine perforation, transection of tubes, omental prolapse and haemorrhage and cervical tear. Authors are very much aware of this because they have to perform camps in the most remote hilly places where people live away from easily accessible medical care. In those places any major complication means death without any adequate medical assistance. This cautious attitude prevented any maternal death in camps upto present date.

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