

PATHOLOGICAL PICTURE IN HYSTERECTOMY DONE FOR ABNORMAL UTERINE BLEEDING

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SUMMARY

This is a retrospective study of 518 hysterectomies carried out for the clinical diagnosis of DUB without any obvious uterine pathology. A histopathological analysis of the hysterectomy specimens revealed 192 (37%) to have organic pathology. These ranged from fibroids (29%) and adenomyosis (52.5%) to placental polyps and embedded IUDs. In uteri without organic pathology, anovulatory endometrium was found in 65% of the patients. The role of hysterectomy in the management of the patients with DUB is evaluated.

Uterine bleeding in the absence of any palpable pelvic finding or histopathology continues to be one of the most frequently encountered, perplexing gynaecological complaint. It is estimated that more than 20 million Indian women could be suffering from menorrhagia. One of the commonest modes of treatment for this complaint is dilatation and curettage for its diagnostic and questionable therapeutic value. Hormonal treatment aims at correcting the endocrinological imbalance and produces a favourable endometrial milieu. However, undetected associated pathology in the uterus would continue to cause irregular bleeding for which the patient may seek de-

finite treatment in the form of a hysterectomy.

MATERIAL AND METHODS

This study was performed to correlate gross and histopathological findings in hysterectomy specimens with the clinical diagnosis of dysfunctional uterine bleeding. In this study, we have used the terms abnormal uterine bleeding synonymously with dysfunctional uterine bleeding. This work is a retrospective analysis of the 518 patients who underwent hysterectomy for the clinical diagnosis of DUB over a one year period at the K. E. M. Hospital, Bombay. (April 90 to March 91) None of these patients had any palpable benign or malignant abnormality detected preoperatively. Data was also collected regarding age, parity, type and du-

ration of menstrual irregularity, associated symptoms, previous hormonal or operative treatment taken. A note was also made regarding preoperative examination findings, type of hysterectomy and intra and post operative complications. None of the patients in our series had any major intra/post operative complications and there was no operative mortality.

OBSERVATIONS

All the 518 patients were above the age of 35 and more than 65% of the patients fell in the age group of 40 to 50. 14% of patients had spasmodic dysmenorrhoea and intermenstrual bleeding was a troublesome symptom in 8.5%. Dilatation and curettage was the commonest first line of treatment in 45.9%. It was combined with hormones in 23.9% of patients while 19.1% of patients had been given hormones alone prior to hysterectomy. Failure of these modalities increased the acceptance of hysterectomy. A small group of 57 patients (11.1%) refused to undertake any conservative therapy and therefore underwent hysterectomy primarily. The vaginal route was more preferred if there was good mobility and adequate descent.

Gross examination of the hysterectomy specimens revealed a variety of pathological lesions which were missed. This is shown in Table I. 192 out of 518 (37%) of patients diagnosed to have DUB had undetected abnormalities. Of these, adenomyosis and fibromyomas were the major contributory factors. These are the cases which probably contribute to the unexplained failures of conservative therapy for DUB. All the 3 cases of carcinoma endometrium had not been diagnosed on a preoperative curettage and were sent for radiotherapy postoperatively. An analysis of histopathology of the remaining 326 patients revealed proliferative endometrium clearly outnumbering the other types suggesting that anovulation is the main cause of DUB. Pro-

Table I

Organic Pathologies Encountered in Uteri removed for DUB (N = 192)

	No.	%
Adenomyosis	101	52.5
Fibroid	55	29.0
Endometrial polyp	10	5.0
Endometritis tubercular	4	2.0
Endometrial carcinoma	3	1.5
Fibroid + Adenomyosis	11	6.0
Fibroid + Endometrial Polyp	4	2.0
Embedded IUCD	1	0.5
Placental polyp	3	1.5

liferative endometrium was found in 66.3%, secretory in 20.6%, hyperplastic in 7% and atrophic in 6.1% of uteri with no organic pathology.

DISCUSSION

An ACOG bulletin defines DUB as 'Bleeding from the uterine endometrium unrelated to anatomic lesions of the uterus.' Disruption of normal ovarian function or anovulation was considered part of the definition. Uterine bleeding secondary to blood dyscrasias, submucous myomas, endometrial polyps, uterine carcinoma and accidents of pregnancy were not considered as DUB. DUB, therefore is a diagnosis of exclusion.

In patients where histopathology corroborated the clinical diagnosis of DUB, the endometrial patterns observed were similar to those reported in other studies as shown in Table II. The endometrial patterns, in relation to organic pathology in the uterus found in our study is compared with a similar one by Sanyal

Table II

Comparison of Histopathological Status of Endometrium in DUB Patients with no Organic Pathology

STUDY	PROL %	SERC. %	HYPER %	ATROPHIC %
Present Study	66.3	20.6	7.0	6.1
Patel et al	63.0	7.5	29.5	0.0
Das & Chugh	41.5	26.1	30.6	1.8
Sutherland	45.0	20.9	29.2	4.9

Table III

Comparison of Endometrial Patterns in Relation to Organic Pathology

		Fibroid %	Adenomyosis %	Fibroid + Adenomyosis %	Tuberculosis %
Proliferative	Sanyal	51	56	55	100
	K. E. M.	83	79	55	100
Secretory	Sanyal	33	21	45	-
	K. E. M.	12	14	27	-
Hyperplastic	Sanyal	8	1	-	-
	K. E. M.	5	1	-	-
Atrophic	Sanya'	8	22	-	-
	K. E. M.	-	6	18	-

et al (1981) in Table III. Abnormal uterine bleeding due to organic disorder was mostly associated with proliferative endometrium though atrophic, secretory and hyperplastic could be seen to a variable degree. This is especially true of tuberculous endometritis which was

almost always associated with proliferative endometrium.

CONCLUSION

The risk of missing intrauterine pathology by blind curettage has been reiterated. A

