

Clinical Presentation of Adolescent Problem

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Puberty is shrouded with Secrecy, Suspicion, and Superstition.

A gynaecological complaint in a young girl is not discussed openly. Firstly the girl patient is hesitant to tell anyone, even to a close friend, for fear of being called abnormal. She may confide her complaint in her mother who becomes very anxious and hesitates to even discuss with the family physician. She is worried that the story might leak out and family members would look at the young girl with suspicion.

The mother feels most comfortable talking to her own gynaecologist, to whom she takes her daughter. Interestingly, even in the waiting room, mother does not like to mention that her daughter is the patient. She would tell the secretary or any known person who happens to be in the waiting room that she herself has come for a "gynaec check up".

It is only when the gynaecologists see them that the truth comes out. Sometimes even at this stage, they mention about some other complaints than what they have come for. This is commonly seen when young girl has problem with breast.

Various clinical presentations of adolescent problem have been assessed by analysing 100 cases.

Table I: Age wise number of cases

Years.	10-12	12-16	16-18	>18*
No.	5	19	38	39

Symptoms presented at age 18+. But existed since the previous 4 to 6 yrs.

Table II: Symptoms: Adolescent Problems

Height problem	2
Weight problem	22
Acne / Hirsutism	26
Breast Problem	12
Vaginal Discharge	13
Urinary symptoms	6

Menstrual problem	79
Primary amenorrhoea	12
Secondary ammenorrehea	6
Irregular periods	27
Menorrhagia	8
Dysmenorrhoea	6

One-Third Girls Had More Than One Symptom



Fig 1. Hirsutism: Young lady age 18. Extremely anxious about increasing Hirsutism for past 2 years. Diagnosed PCOD. Hormonal therapy was suggested. But in view of anxiety of starting a job she opted for laparoscopic drilling of the follicles to reduce the androgenic effect.

Height problem, vaginal discharge, and urinary symptoms are frequently seen in younger adolescent girls below the age of 13-14. The latter two are invariably associated with itching and burning in urine.

Acne, hirsutism, and breast problems are seen in girls between 13 to 16 yrs of age. (Figure 1)

Menstrual problems such as menorrhagia and menstrual irregularities are seen in early adolescent girls. But older adolescent girls(>16), come more often for irregular periods, primary and secondary ammenorrhoea. Hirsutism, acne and obesity may be associated with menstrual irregularities. Six out of 8 menorrhagia cases had dysmenorrhoea. In 3 there was endometriosis with bilateral chocolate cysts.



Fig 2. Testicular Feminizing Syndrome (xy) Age 18 years. C/o Primary Ammenorrhoea. Well developed breasts. Normal vulva with just a vaginal dimple. Vagina was stretched since she was married for 2 years. No clitoral enlargement. At laparoscopy she had bilateral small gonads (testicles) intra-abdominally. Removed by mini laparotomy

Table III

Primary Amenorrhoea	12
• Testicular Feminizing(XY)	2
• Gonadal Dysgenesis-(45XO/46)	1
• Absent Uterus Normal(XY)	1
• Hypoplastic Uterus	7
• Undiagnosed Gender	1

Table III gives detail of primary amenorrhoea cases.

Chromosomal, and mullerian agenesis are invariably the causes of primary ammenorrhoea.(Figure 2) We have seen a case of undiagnosed gender. An adolescent girl of age 16-18 complained of primary ammenorrhoea, acne hirsutism. On investigation the diagnosis confirmed that the girl was actually a male, having hypospadias and partially or completely undescended testicles. The child at birth had hypospadias and undescended testicles. Thus reared as female child having enlarged clitoris. As puberty approached there was no breast development. Acne & hirsutism appear and even there was a change in the voice. On genital examination she was found to have an enlarged clitoris which actually was severe hypospadias. She had just undergone bilateral removal of lumps in both inguinal regions. These were testicles. This particular patient was happy being a fourth wife of an Arab man. (Photo-3)

But in few cases we have helped them to have surgery to bring down the testicles and correct hypospadias. And then they have been helped to get their name and sex changed to be male.



Fig 3. Undiagnosed Gender (xy) Age 19 years. An individual brought up as female, was actually a male, no breasts development, severe hypospadias, looking like enlarged clitoris, empty scrotal sac, with bilateral undescended testicles in the groin. She was recently operated and undescended testicles were removed.

Remark: 2 and 3 both have chromosome xy. But one is classical testicular feminizing syndrome with intra-abdominal testicular (small) gonad, married since 2 years and complaining of primary amenorrhoea / sterility. Second is undiagnosed gender well groomed as a women. No breast developments, severe hypospadias, empty scrotal sacs and well formed undescended testicles.

Table IV: Secondary Ammenorrhoea

• Pregnancy (age 15)	1
• Transsexual	1
• Psychological(enviromental changes)	1
• Systemic disease	2
• PCOD and severe Obesity	1

Table V gives details of the cases of secondary ammenorrhoea.

In the west, adolescent pregnancy is frequently seen. In our country a young unmarried girl who becomes pregnant either does not realise that she could be pregnant and / or does not let anyone know till it becomes a cause of worry to the parents. Invariable they are anxious about secondary amenorrhoea. They get a shock when they are told that the young lady is pregnant and that too beyond the time, when abortion could be done. Lot of psychological support and reassurance is required.

A young adolescent girl thinks God has made a mistake; as psychologically she thinks she is a boy. To defy, she starts taking male hormones, and of course dresses only

like a male. In turn her periods stop and she starts developing scanty beard. She desires and prepares herself for sex change operation. Here secondary amenorrhoea is not a problem. It is an iatrogenically desired effect.(Photo-4).

An adolescent girl when goes abroad to study, faces



Fig 4. Female Trans-sexual, before sex change operations. Breasts small with secondary amenorrhea due to taking of testosterone.

complete change in environment, diet etc. Her period becomes irregular initially and stops completely, even for a year or so. When she returns the menstruation becomes normal.

Hormonal evaluation & USG will rule out any obvious pathology. Reassurance more to the parents, than to the young girl, is required. We have even seen that changes in environment with sudden gain in weight result into secondary amenorrhea.

Systemic disease occurring after menarche is not an unusual cause for secondary amenorrhoea. In our country tuberculosis is the major systemic disease.

We have seen variety of cases of TB in adolescent girls. Frequently, history of TB in childhood is obtained although only after detailed questioning. Out of our 2 cases of systemic diseases, one was a classical case of TB meningitis.



Fig 5. Young Obese lady of age 17. She had menarche at age 14. She suffered from TB meningitis at the age of 15. Developed secondary amenorrhoea due to resulting hypopituitarism.



Fig 6. Young lady of 17, complained of secondary amenorrhoea following thyroid nodule.

This occurred after menarche and resulted in severe hypopituitarism. (Photo-5). The young lady of 16 needed thyroid and cortisone replacement. She was also advised to take estrogen progesterone replacement. But because of her mental faculties also being affected her family did not want her to have menses. This was inspite of explaining about the ill effects of estrogen deficiency. The second case was of thyroid nodule(photo-6). This had initially caused menorrhagia and later on secondary amenorrhoea, with treatment, the cycle re-established. History and examination as usual give a clue to diagnosis.

Vaginal discharge results in young girl with history of taking antibiotics for any infection, resulting in fungus vulvo-vaginitis. On inspection of vulva and perineum one could diagnose the fungal or Trichomonal infection in majority of cases.

Table V gives the investigation carried out.

Table V :

Investigations with the positive findings.

● Routine: CBA,	
● Routine urine,	
● Stool: Infection	6
● E. Histolytica	2
● Giardiasis	1
● Worms	2
● Bone Age: Done in adolescent girl with short stature.	
● Hormonal Evaluations	
● Anovulation	18
● Prolactinemia:	2
(2 were advised CT scan)	
● DHEA & Plasma testosterone	7
● Chromosomal evaluation	3
● (xy) Testicular feminising syndrome	2
● (45xo/xx) Gonadal Dysgenesis	1
● USG	25
● Diagnostic Laparoscopy	
Pelvic Ultra Sonography	25
● Bilateral Ovarian cysts	3
● (Confirmed chocolate cyst at Laparoscopy)	
● Multifollicular ovaries	4
● Enlarged BPO	10

- Hypoplastic uterus 5
- Absent Uterus 3

In 25% cases USG gave the diagnosis

Management:

General—Haematinics, Multivitamins, Vitamin E, Anti inflammatory,

Diet and Exercises.

Specific Exercises.

Specific:— Anti-fungal, anti-helmenthic, anti-protozoal.

Hormonal

Prednisolone,

Eltroxine

Operative laparoscopy:

Drilling of follicles

Excision of chocolate cysts

Coagulation of endometriosis

Reassurance

In majority of cases reassurance to the parents is absolutely required. In the older adolescent, proper explanation to the patient reassures her. The iatrogenic factors of anxiety and worry are lessened & relived. They need frequent proper follow up, specially in cases of irregular cycles due to anovulation. It may take a few years before their cycles get established and they may require to take progestogens for many months. Lastly, wherever obvious pathology is found, proper treatment, with regular follow up and reassurance is the answer.