Dysfunctional Uterine Bleeding - Will Dilatation & Curettage, Suffice or Will Need A Hormonal Support?

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Abstract: Dysfunctional uterine bleeding (DUB) is abnormal genital tract bleeding from the uterus and found in the absence of demonstrable structural [1] or organic disease. Dilatation and curettage (D & C) is commonest gynecological procedure and those pts. who were treated by hormonal support, & did not improve required hysterectomy, as the final modality of treatment.

Keywords: D & C, Dysfunctional uterine Bleeding, Hysterectomy, Hormonal Supports

1. Introduction

Dysfunctional uterine bleeding (DUB) is abnormal genital tract bleeding from the uterus and found in the absence of demonstrable structural[1] or organic disease. Diagnosis must be made by exclusion, since organic pathology must first be ruled out.

Dilatation and curettage (D & C) is commonest gynecological procedure, employed as a management protocol, in which the cervix is diluted (expanded) and the lining of the uterus (endometrium) is scraped away.[2]D & C serves a dual purpose, diagnostic as well as therapeutic, in cases of heavy or irregular bleeding from the uterus. Possible reasons for abnormal uterine bleeding include:[3,4] Hormonal imbalance.–Often, women with abnormal bleeding, are first treated with hormones, in an attempt to normalize the HPO axis, & control bleeding. D & C is performed, to determine the cause of bleeding by histological examination.

Endometrial polyps.–Polyps are benign growths, that protrude from the uterus, through cervix, by a stem or stalk. D &C is done to remove them, & curette endometrium. Uterine fibroids. –Also called leiomyomas, fibroids are benign growths of the smooth muscle of the uterus. Abnormal bleeding is often the only symptom of fibroids. D & C is done to scrape the hypertrophied endometrium, ; additional surgery may be needed to remove more extensive growths.

Endometrial hyperplasia (EH).--Endometrial hyperplasia is a condition where the endometrium grows excessively, becoming too thick and causing abnormal bleeding. Tissue samples procured during D & C can be assessed for early signs of cancer, & degree of hyperplasia for hormonal aberration, & to assess any atypia.

Cancer. D & C is used to obtain tissue for microscopic evaluation to rule out cancer. Women over the age of 40 are at an increased risk of developing endometrial cancer.

Miscarriage, incomplete abortion, or childbirth. -- Abnormal bleeding may result if some of the products of pregnancy remain in the uterus after a miscarriage or induced abortion, or if parts of the placenta are not expelled naturally after childbirth. These retained products can be scraped out by D &C.

Alternatives for D & C
Endometrial biopsy, serves a diagnostic purpose only.
Vacuum scraping.
Hysteroscopy, to diagnose intrauterine pathology.
Hysterectomy, as a final procedure

Aim
To assess, - will simple D&C suffice, or will a hormonal support also be required?

Objectives
To study the effect of Dilatation and Curettage. To study requirement of hormonal support after D&C.

2. Material and Methods

Interventional study
The study will consist of operative procedure & management of women with inclusion & exclusion criteria mentioned. 30 patients with the diagnosis of DUB, based on clinical and ultrasound findings, which underwent endometrial sampling/curettage recruited for this study.

However after reviewing the histopathology report of the sampled endometrium, depending on histology, further management, about necessity of hormone therapy will be decided. Proliferative endometrium will require hormonal correction, while secretory endometrium, -- a result of normal hormonal milieu, & rhythm can do without any such support.

Inclusion Criteria
All women having dysfunctional uterine bleeding

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**Exclusion Criteria**
Women on hormonal support.
Patients with heavy bleeding necessitating emergency treatment.

Women with a known, suspected or with a history of genital tract malignancy

3. Results & Analysis

30 DUB patients were analysed for their relation to age, parity, type of bleeding, pattern of bleeding, clinical presentation, type of endometrium on Histopathology and hormonal support.

**Table 1: Frequency of distribution of DUB among different age groups**

| Age Group | No. of Patients | Percentage (%) |
|-----------|-----------------|----------------|
| 15-24     | 4               | 13             |
| 25-34     | 11              | 37             |
| 35-44     | 15              | 50             |

The above table (table 1) shows age distribution of DUB. The maximum incidence of DUB was in the age group 35-44. (n=15, 50%)  

**Table 2: Relationship of DUB with age and parity**

| PARITY | 15-24 | 25-34 | 35-44 | TOTAL |
|--------|-------|-------|-------|-------|
| 0      | 2     | 0     | 0     | 2(7%) |
| 1      | 2     | 2     | 2     | 6(20%)|
| II     | 0     | 4     | 3     | 7(23%)|
| III    | 0     | 5     | 7     | 12(40%)|
| TOTAL  | 4     | 11    | 15    | 30    |

Above table shows relation between frequency of DUB and parity. Cases of DUB increased with increasing parity. Maximum incidence was found with higher parity (n=12, 40%), & in 4th decade of life, (previous table).

**Table 3: Pattern of bleeding in DUB**

| Pattern of Bleeding | No. of Cases | Percentage |
|---------------------|--------------|------------|
| Menorrhagia         | 15           | 50         |
| Polymenorrhoea      | 4            | 13         |
| Polymenorrhagia     | 1            | 3          |
| Metropathia         | 2            | 7          |
| Hemorrhagia         | 8            | 27         |
| Menometrorrhagia    | 0            | 0          |
| Oligomenorrhoea     | 0            | 0          |

Menorrhagia was the most common type of DUB it was seen in 15 patients (n=15, 50%), 8 patients (n=8, 27%) came with the complaint of metrorrhagia, 4 patients (n=4, 13%) with Polymenorrhoea. 2 patients (n=2, 7%) presented with metropathiahemorrhagica.

The pattern of bleeding among the 30 patients varied with different age groups. Maximum incidence was found with 4th decade of life, in which menorrhagia was most common bleeding pattern.

**Table 5: Endometrial pattern in 30 DUB patients**

| Endometrial Pattern                  | Total | Percentage |
|--------------------------------------|-------|------------|
| CGH(CYSTIC GLANDULAR HYPERPLASIA)    | 13    | 43         |
| Secretory endometrium                | 5     | 17         |
| Proliferative endometrium            | 3     | 10         |
| Irregular shedding                    | 6     | 20         |
| Hyperplasia without Atypia           | 2     | 7          |
| Adenomatous hyperplasia              | 0     | 0          |
| Granulomatous endometritis           | 0     | 0          |
| Hyperplasia with Atypia              | 1     | 3          |
| TOTAL                                | 30    | 100        |

**Table 6: Correlation of Endometrial Pattern With Age Group**

| Endometrial Pattern                  | 15-24 | 25-34 | 35-44 | Total |
|--------------------------------------|-------|-------|-------|-------|
| CGH(CYSTIC GLANDULAR HYPERPLASIA)    | 0     | 1     | 12    | 13    |
| Secretory endometrium                | 1     | 4     | 0     | 5     |
| Proliferative endometrium            | 0     | 1     | 2     | 3     |
| Irregular shedding                    | 0     | 4     | 2     | 6     |
| Hyperplasia without atypia           | 0     | 1     | 1     | 2     |
| Adenomatous hyperplasia              | 0     | 0     | 0     | 0     |
| Granulomatous endometritis           | 0     | 0     | 0     | 0     |
| Hyperplasia with atypia              | 0     | 0     | 1     | 1     |
| Total                                | 1     | 11    | 18    | 30    |

Above table shows relation between frequency of DUB and parity. Cases of DUB increased with increasing parity. Maximum incidence was found with higher parity (n=12, 40%), & in 4th decade of life, (previous table).

In the age group of 15-24year only 1 pt showed secretory endometrium.In the age group of 25-34year 1 pt showed CGH, 4 pts. showed secretory pattern ,1 pt proliferative pattern,4 pts. showed irregular shedding and 1 pt showed hyperplasia without atypia.In the age group of 35-44years, 12 pts. showed CGH, 2 pts. proliferative, 2 pts. irregular shedding and 1 with each hyperplasia with and without atypia.Among all the age groups Cystic glandular Hyperplasia was the most common endometrial pattern seen.
in 13 patients (n=13, 43.0%), followed by irregular shedding
in 6 patients (n=6, 20%)

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endometrium. In the age group of 25-34 year 1 pt showed
CGH, 4 pts. showed secretory pattern, 1 pt proliferative
pattern, 4 pts. showed hyperplasia and 1 pt showed
hyperplasia without atypia. In the age group of 35-44 years,
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In the age group of 25-34 year 1 pt showed CGH, 4 pts.
showed secretory pattern, 1 pt proliferative pattern, 4 pts.
showed irregular shedding and 1 pt showed hyperplasia
without atypia.

In the age group of 35-44 years, 12 pts. showed CGH, 2 pts.
proliferative, 2 pts. irregular shedding and 1 with each
hyperplasia with and without atypia.

Among all the age groups Cystic glandular Hyperplasia was
the most common endometrial pattern seen in 13 patients
(n=13, 43.0%), followed irregular shedding in 6 patients (n=6, 20%)

Bleeding pattern of clinical presentation co-relates well with
the histological finding.

It is very clearly apparent that menorrhagia was the most
common presentation (n=15, 50%) in the following sequence
of histological patterns, like CGH (n=N=9/15, 60%),
secretory endometrium (n=N=5/15) and proliferative
endometrium (n=N=1/15).

Table 8: Requirement of Hormonal Support and
Hysterectomy according to Endometrial Pattern

| Endometrial Pattern          | Total Cases | Hormonal Support | Hysterectomy |
|------------------------------|-------------|------------------|--------------|
| CGH (CYSTIC GLANDULAR HYPERPLASIA) | 13          | 8                | 5            |
| Secretory endometrium       | 5           | 0                | 0            |
| Proliferative endometrium   | 3           | 3                | 0            |
| Irregular shedding           | 6           | 3                | 1            |
| Hyperplasia without atypia  | 2           | 1                | 0            |
| Adenomatous hyperplasia     | 0           | 0                | 0            |
| Granulomatous endometritis  | 0           | 0                | 0            |
| Hyperplasia with atypia     | 1           | 0                | 1            |
| TOTAL                        | 30          | 16*53%           |              |

Table 8 shows requirement of Hormonal support in different
endometrial pattern. In case of CGH (13 cases) in 8 pts.
Hormonal sufficed, and 5 pts. Required Hysterectomy.

Hormonal support was also effective in case of proliferative
endometrium, Irregular shedding and hyperplasia without
atypia.

In case of CGH, 10 pts. had endometrial thickness between
10-16mm, and 3 pts. had >16mm thickness.

Table 9: Correlation of Uterine Size as Determined
Clinically and by USG

| Size                  | Clinical Findings (Uterine Size) | USG Based (Uterine Size) | Endometrial Thickness |
|-----------------------|----------------------------------|--------------------------|-----------------------|
| 1. Normal             | 23                                | 25                       | <10mm -10             |
|                       |                                  |                          | 10-16mm -6            |
|                       |                                  |                          | >16mm -0              |
| 2. Bigger Then Normal | 7                                 | 5                        | <10mm -1              |
|                       |                                  |                          | 10-16mm -10           |
|                       |                                  |                          | >16mm -3              |

TABLE-9 shows correlation of uterine size clinically and by
USG. Clinically 7 pts. showed uterine size bigger then
normal, while on USG, only 5 pts. had bigger than normal
size.

4. Discussion

D.U.B. Is the most common menstrual aberration seen
clinically in 3rd & 4th decades of life.

As the name suggests, being functional deficiency, it is
equally innocuous per se, but, the clinical presentation makes
the woman quite unhappy, & hence the need to investigate &
treat it with due vigilance.

In 80 to 85% cases, actually simple D&C, usually suffice, as
can be ascertained from previous tables, few need a
hormonal support, to revert or nullify the effect of prolonged
un-opposed oestrogen, with a progesterone, with really
satisfying control, there are a few select un fortunate patients
who ultimately need a hysterectomy, due to histology, that
is not exactly normal, or do they opt for it, voluntarily, with
their own ideas, regarding their problems, which, though,
can be successfully treated conservatively, select a "so
called,” final solution, once & for all.

5. Conclusion

DUB is a common gynecological complaint, predominantly
seen in the age group 35-44 years.

Menorrhagia was commonest bleeding pattern seen in
multiparous women.
Cases of DUB increased with increasing parity.

Hyperplastic endometrium (CGH) was the commonest type of endometrium observed, followed by Irregular shedding.

Proliferative and secretory endometrium were commonly seen in the age group of 25-34 years and hyperplastic endometrium in the age group 35-44 years.

Menorrhagia was commonest bleeding pattern seen in Hyperplastic endometrium (CGH). Hormonal support mainly required in case of CGH, Irregular shedding and Proliferative pattern of endometrium.

Those patients who were treated by hormonal support, & did not improve required hysterectomy, as the final modality of treatment.

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