
CAUSES OF MENORRHAGIA IN FEMALES BETWEEN 21-50 YEARS OF AGE ATTENDING THE OUT PATIENT DEPARTMENT OF NASEER TEACHING HOSPITAL

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ABSTRACT**OBJECTIVES:***To determine the causes of menorrhagia***MATERIAL AND METHODS:**

This case series study was conducted in the department of obstetrics and Gynecology Naseer Teaching Hospital Peshawar over a period of one year from June 2006 to May 2007. Eighty patients with menorrhagia were studied between ages of 21-50 years. All patients were thoroughly investigated for the causes of menorrhagia. All the patients having menstrual blood loss of more than eight days or history of passage of clots or having hemoglobin less than 10g/ dl were included in the study and patients having pubertal menorrhagia, less than 20 years of age or postmenopausal patients, on hormonal replacement therapy were excluded from the study.

RESULTS:

Out of total eighty patients, the commonest age group was above 40 years i.e.63.75% (n=51). The most common cause of menorrhagia was fibroid uterus in 47.5% (n=38) cases followed by adenomyosis in 25% (n=20) cases, endometrial polyp in 7.5% (n=6) cases, endometrial hyperplasia in 6.25% (n=5) cases, injectable progestogens in 6.25% (n=5) cases, intrauterine contraceptive device in 5% (n=4) cases. 30 patients (37.5%) were multipara, 25 (31.25%) were grand multipara and 25 (31.25%) were great grand multipara. All of them were anemic. Severe anemia (hemoglobin < 6 gm%) was found in one case (1.25%), moderate anemia (hemoglobin 6-8 gm%) in 45 cases (56.25%) and mild anemia (hemoglobin 8-10 gm%) in 34 cases (42.75%). Abdominal ultrasound alone was done in 63 cases (70.75%), and transvaginal ultrasound in 17 patients (21.25%). The diagnosis of fibroid uterus, endometrial polyp and endometrial hyperplasia was confirmed on ultrasound.

CONCLUSION:

In my study fibroid uterus (47.5%), adenomyosis (25%), endometrial polyp (7.5%) and endometrial hyperplasia (6.25%) were the common causes in patients presenting with menorrhagia to Naseer Teaching Hospital causing disruption and psychological problem for females.

KEYWORDS:*Menorrhagia, Fibroid uterus, endometrial polyp*

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INTRODUCTION

Menorrhagia is a grave problem of women due to lack of awareness and negligence. It can cause Disruption and psychological problems for many women. The purpose of my study was

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to find out the leading causes of menorrhagia in females and its effects on their health. Menorrhagia is defined as excessive cyclic uterine bleeding that occurs at regular intervals over several cycles, or prolonged bleeding that lasts for more than seven days¹. Average menstrual blood loss is between 30 and 40ml per cycle². An early

population based study concluded that the upper limit of normal menstrual blood loss was between 60 and 80ml, with upper limit subsequently adopted as the classic definition of

menorrhagia^{3,4}. Menorrhagia is one of the most common complaints in otherwise healthy women⁵. One in three women experienced the problem at some stage in their lives⁷. 7300 hysterectomies are performed annually in UK, of which 35-64% are for menorrhagia. In up to 50% of these cases no pathology is found on histological examination of the uterus. Causes of menorrhagia may be local, systemic or dysfunctional. Established risk factors for menorrhagia include age⁸, leiomyomata⁹ and endometrial polyp¹⁰. Parity, body mass index and smoking are not risk factors⁸. For some women, a cause of menorrhagia is not identified. Abnormalities of platelet function, such as Von willebrands disease, appear to be more prevalent in women with menorrhagia than in the general population^{1,11}. There are no data suggesting that lower quality of life occurs more commonly in women with menorrhagia and Von willebrand's disease than in those with menorrhagia alone¹². The most common anatomic causes in menstrual disorders in premenopausal women are uterine polyps and submucous Fibroid¹³, although disturbance of prostaglandin synthesis or metabolism or local coagulation mechanism may be involved. Other local causes include leiomyoma, adenomyosis, endometriosis, endometrial polyps, intrauterine contraceptive devices, endometrial hyperplasia, endometrial adenocarcinoma, polycystic ovarian disease congenital anomalies of uterus and sometime myometrial hypertrophy and uterine vascular malformation^{12,13,14,15,16,18}. In rare cases menorrhagia can occur as a result of systemic disease which results in hepatic and renal impairment. Both hypo and hyperthyroidism can also cause heavy menstruation¹⁷. In most of the cases no cause can be found. In a retrospective study of 117 menorrhagia patients by **Syeda Batool Mazher** it was found that in more than half of the patients with menorrhagia, no obvious abnormality was detected on examination and routine investigations¹⁹.

A Full blood count is useful to determine hemoglobin level and can be used to monitor treatment with haematinics²⁰. An ultrasound scan of pelvis and abdomen is a useful tool in diagnosis and for describing masses suspected or actually found on physical examination especially in obese women where examination can be suboptimal²⁰. An endometrial biopsy should be taken if a woman is over 40 or under 40 with particular risk like tamoxifen use, unopposed estrogen or obesity²⁰.

METHODOLOGY

This case series study was conducted in Gynea unit of Naseer Teaching Hospital Peshawar over a period of one year from June 2006 to May 2007. All the patients were outdoor patients. Eighty patients with menorrhagia between 21-50 years of age were studied. Pre questioning was done in 10% of cases to make necessary changes in my questionnaire and final questionnaire was made. The purpose and benefits of the study were explained to all patients and they were assured that study is done purely for data publication and research purpose. Moreover they were also assured that their confidentiality will be maintained. Detailed questions including age, socioeconomic status, parity, amount, duration and pattern of bleeding, number of sanitary pads soaked, any associated gynecological problem like dysmenorrhea, infertility, symptoms suggestive of myxedema or bleeding disorder, hormonal treatment or history of intrauterine contraceptive device were recorded on a performa. Detailed abdominal and pelvic examination was performed and patient investigated accordingly. All the patients having menstrual blood loss of more than eight days or history of passage of clots or having hemaoglobin less than 10 gram per deciliter were included in the study and patients having puberty menorrhagia, less than 20 years of age, postmenopausal patients and patients on hormone replacement therapy were excluded.

RESULT

Over a period of one year, 80 cases of menorrhagia were seen. The common age group was above 40 years (63.75%). Twenty nine (36.25%) cases were in the age range between 21-40

years. Considering parity 30 patients had 1-5 parity, 25 had parity between 6-8, 25 patients had more than 8 parity (table 1). Regarding the casue of menorrhagia 38(47.5%) patients had fibroid uterus while 20 (25%) had adenomyosis. Endometrial polyp was found in (7.5 %) (table 3).All of them were anemic at the time of presentation. (Table 2)

Table: 01 Age And Parity Wise Distribution Of Sample n=80

S. No	Age Range	Frequency	Percentage
1	21-40	29	36.25%
2	>40 years	51	63.75%
S. No	Parity	Frequency	Percentage
1	1-5	30	37.5%
2	6-8	25	31-25%
3	More than 8	25	31-25%

Table: 02 Investigations Of Sample n=80

S. No	HB	Frequency	Percentage
1	<6gm%	1	1.25%
	6-8 gm%	45	56.25%
	>8-<10 gm%	34	42.75%
2	Ultrasound:		
	Transabdominal Transvaginal	63 17	70.75% 21.25

Table: 03 Causes of Menorrhagia in Sample n=80

S.No	Causes	Frequency (n=80)	Percentage
1	Fibroid uterus	38	47.5 %
2	Adenomyosis	20	25%
3	Endometrial polyp	6	7.5%
4	Endometrial hyperplasia	5	6.25%
5	Endometriosis	1	1.25
6	Ch. Endometritis	1	1.25%
7	IUCD induced	4	5%
8	Injectable Progestogens	5	6.25%

DISCUSSION

The causes of menorrhagia may often be recognized on careful history and examination alone, although the majority requires more thorough evaluation. Causes may be local, systemic and dysfunctional. In our study all patients with menorrhagia had some cause on examination and routine investigation which is against the result of a retrospective study of 117 menorrhagia patients by Mazhar²³ where in more than half of the cases no cause was found. In our study of 80 patients with menorrhagia the most common cause was leiomyoma which was commonest organic lesion of the uterus and was found in 47.5% of cases. This is comparable with the prospective study of

121 patients with menorrhagia by Shagufta Shaheen²¹ who reported it to be 47.10% Adenomyosis was found in approximately 20% of removed uterus and probably is of more clinical significance than is generally recognized. In a study adenomyosis was found to be diagnosed correctly before surgery in 10% of cases²². In our study it was found in 25% of removed uteri (on histopathology) while in study by Shagufta Shaheen it was found in 30.05%²¹.

Chronic endometritis has been known to follow pregnancy or abortion. It may be a result of intrauterine contraceptive device or accompanied by mucopurulent cervicitis and pelvic inflammatory disease²⁴. In a study conducted by Goldsten, 26(17%) women with menorrhagia had isolated endometritis²⁵. While in my study it was seen in 1.25% cases. Chronic endometriosiis was found in 1.25% cases which is compared to Mackenzie where its incidence was 0.8%²³.

Endometrial hyperplasia can be caused by exposure of endometrium to continuous estrogen unopposed by progesterone. The diagnosis of endometrial hyperplasia should be suspected in women with prolonged, frequent or irregular uterine bleeding. In particular abnormal uterine bleeding in perimenopausal women is the most common symptom of endometrial neoplasia, although such bleeding is usually 80% due to a benign condition²⁵. In my study the incidence of endometrial hyperplasia was 6.25% compared to study conducted by Fayaz S and Luqman where the incidences are 4.68% and 4% respectively^{26,27}.

CONCLUSION

Fibroid uterus and Adenomyosis are the most common causes of menorrhagia found mostly in multigravidas causing anemia leading to disruption and psychological problems for many women.

RECOMMENDATIONS

Increased awareness of the problem and precise diagnosis using transvaginal ultrasound, endometrial sampling is required for the detection of the cause which will allow more precise treatment of the individual case.

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