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Case Report on Abnormal Uterine Bleeding With Severe Anemia

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Abstract:

Introduction: Adolescents are prone to abnormal uterine bleeding. The most common cause of AUB in this age range is immaturity of the hypothalamus pituitary ovarian axis.[2] As detailed in this chapter, several characteristics of underlying hereditary or acquired blood disorders increase the "anticipated" hormonal imbalance at this age, increasing the morbidity of the underlying condition. Despite the fact that blood problems can cause AUB, uterine structural and/or endocrine abnormalities are frequently missed when a blood disorder is present.[5]Haematologists and gynaecologists, as well as adolescent medicine specialists, must work together to treat a complex cause. **Main symptoms and/or important clinical findings:** A 42 year old female was admitted in AVBRH in gynaec ward Sawangi Meghe Wardha with chief complaint of abnormal uterine bleeding since 2 month, abdominal pain since 1 week, weakness. **The main diagnoses, therapeutic interventions, and outcomes:** After physical examination and investigation, this case was diagnosed having abnormal uterine bleeding since 2 month, abdominal pain since 1 week, weakness. Also she was provided calcium supplement and iron supplement. Present case was stable but blood investigation revealed sign of anemia. **Nursing perspective:** Fluid replacement i.e. DNS and RL, monitoring of vital signs per hourly. **Conclusion:** Dysfunctional bleeding is most common during the start and end of a woman's reproductive years, with 20% of instances occurring in adolescents and more than 50% in women over 45. The majority of abnormal uterine bleeding is of the dysfunctional type, however this diagnosis is only made after all other reasons have been ruled out. The most common cause of dysfunctional uterine haemorrhage is "uninterrupted" oestrogen levels, which cause uterine mucosa expansion.

Keywords: Abnormal Uterine Bleeding, Anaemia, Goitre

Introduction:

The most common cause of anaemia in perimenopausal women has been identified as heavy heavy menstrual bleeding.[1] Menstrual abnormalities contribute for 5% to 10% of the women who arrive with iron deficiency anaemia in the perimenopausal age category (IDA). In poorer nations like India, where dietary Iron deficiency is relatively widespread in perimenopausal age group women, menorrhagia is an aggravating factor that leads to severe anaemia.[2-4] Anemia correlates to an increase in morbidity and death in this age group. Cases that necessitate surgical intervention.[5] Anemia raises the chances of needing a blood transfusion, having a pre-operative problem, and having a delayed postoperative recovery. As a result, anaemia must be treated as soon as feasible before surgery in these patients. Because anaemia must be treated rapidly before the next bout of bleeding, oral iron is usually not indicated in these patients. As a result, blood transfusion or parenteral iron preparation is the primary

treatment for these patients. Blood transfusion, on the other hand, comes with its own set of dangers that should be avoided at all costs.[6-7] The widespread use of commercially available iron preparations, such as iron sucrose and iron dextran, is limited by their potentially fatal adverse effects and the need for many doses.[8] FCM (ferric carboxymaltose), a novel iron complex with a ferric hydroxide core stabilized by a carbohydrate shell, allows for the controlled delivery of iron to target tissues, with up to 1000 mg of iron delivered in under 15 minutes.[9]

Patient information:

Patient specific information: A 42 years Old female was admitted in AVBRH on date 31/05/2021 with chief complaint of abnormal uterine bleeding since 2 month, abdominal pain since 1 week, weakness. After physical examination and investigation, doctor diagnosed this case as abnormal intrauterine bleeding with anaemia.

Primary concerns and symptoms of the patient: Present case visited AVBR hospital at OBGY OPD on date 31/05/2021 with chief complaint of Heavy menstrual bleeding, Tingling sensation and fainting since last night. Her haemoglobin level was low i.e. 7gm% at the time of reporting.

Medical, family, and psycho-social history: Present case had no history of any medical problems. She belonged to joined family and her husband had medical history of Hypertension. She was mentally stable, conscious and oriented to date, time and place. She had maintained good relationship with doctors and nurses as well as other patients also.

Relevant past intervention with outcomes: Present case had bad obstetric history (abortion). The patient was admitted in civil hospital Yavatmal with chief complaint of abnormal uterine bleeding, pain in abdomen and excessive clot since 8 days. That time patient general condition was poor so patient was referred to AVBRH Sawangi Wardha for further management.

Clinical findings: The patient was conscious and well oriented to date, time and place. Her body built was moderate and she had maintained good personal hygiene. Her haemoglobin was low i.e. 7gm, pulse rate was slightly increased. On breast examination, breast was normal. On abdomen inspection, steria gravidarum, linea nigra was present. Abdominal girth was 94 cm. On vaginal examination, discharge was seen (heavy bleeding), no any uterine prolapse was observed.

Timeline: Present case had bad obstetric history (abortion). The patient was admitted in civil hospital Yavatmal with chief complaint of abnormal uterine bleeding, pain in abdomen and excessive clot since 8 days. That time patient general condition was poor so patient was referred to AVBRH Sawangi Wardha for further management.

Diagnostic assessment: On the basis of patient history, physical examination, abdominal palpation and USG and other investigations the patient is having abnormal uterine bleeding and anemia.
Blood sugar was normal but Hemoglobin level was increased. Urea serum was slightly decreased. Total WBC count was increased.

No challenges experienced during diagnostic evaluation.
Prognosis: Blood investigations show that the present case is anemic, WBC level is increased.

Therapeutic intervention:

Present case took the medical management with Inj.cetax1 gm BD , inj. Metro 100 ml IV TDS, Inj. Amikacine 500 mg IV BD, Injection Pause 5 ml Twice a day, Injection Panprazole 40 mg BD, Syp.k-sol 10 ml in 1 glass of water BD, ORS powder in 1 litre water, Thrombophob ointment 2 times in daily,

Injection multi vitamin in 500 ml 5% D5, tab. Folic acid twice a day.

No changes were made in therapeutic intervention.

Nursing perspectives: IV fluid was provided to maintain the fluid and electrolyte. Monitored fatal heart rate and vital signs per hourly.

Discussion:

Present case was admitted in hospital with chief complaints was Heavy menstrual bleeding, Tingling sensation and fainting. After physical examination and investigation doctor diagnosed this case as Intrauterine bleeding with Anaemia. She took treatment of iron and calcium supplementary drug. Patient condition was stable, Hemoglobin was slightly normal i.e. 10gm %.

According to a review research, prolonged bleeding was the most prevalent bleeding pattern among nearly half of the women involved in the study (41.7 percent; n = 45). This finding was higher than an Indian study[10] with one-third (33.6%) of all the study participants presenting with prolonged bleeding. The Indian study followed 250 patients aged 25 to 65 years old for six months and used a retrospective study design. The variation in percentage of research participants could be explained by differences in study design, timeframe, and target population. More than eight days of bleeding was considered prolonged bleeding. It may have been simpler to count for more than 8 days than to measure other types of AUB, such as excessive bleeding.

Sometimes of leiomyomas in which the patient longings to save richness, and furthermore in instances of serious adenomyosis, another procedure that might be utilized is uterine blood vessel embolization (UAE), with the catheterization of the leiomyoma supporting courses by a vascular specialist and infusing Gelfoam (Pfizer, New York City, NY, US) or polypropylene dabs, subsequently stopping the blood stream of the myomas or the organ, and disposing of the myomas or lessening the adenomyosis. Also studies related to anaemia in females and children were reviewed[11-12]. Related studies on abnormal uterine bleeding were reported[13-15]. Wankhade et. al. studies on histopathological changes and transvaginal sonography findings in the endometrium of patients with abnormal uterine bleeding[16]. Daga et. al. conducted sonography evaluation of abnormal uterine bleeding in perimenopausal women with pathological correlation[17]. Gadge et. al. compared transvaginal sonography and hysteroscopy for the detection of endometrial lesions in women with abnormal uterine bleeding[18].

Conclusion:

Abnormal uterine bleeding caused by hormonal changes rather than injury, inflammation, pregnancy, or malignancy is known as functional bleeding. Dysfunctional bleeding is most common during the start and end of a woman's reproductive years, with 20% of instances occurring in adolescents and more than 50% in women over 45. Strange uterine draining is a typical issue in ladies of conceptive age that normally can be revised with a medical procedure or medicine. Medical procedure might have the option to address underlying reasons for unusual dying. In the event that there are no underlying causes, clinical treatment frequently can reestablish ordinary monthly cycles. Whatever

the reason for unusual uterine dying, the numerous medicines accessible today generally can resolve the issue. Patients ought to address their PCPs about which clinical or careful choices might be best for them.

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