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Mini Review

Clinical Management of Gynecological Uterine Hemorrhages

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Abstract

In the clinical practice of the gynecologist, it is very common to face the dilemma of treating abnormal uterine bleeding, especially when the patient is overwhelmed by the repetition of such bleeding and opts for surgery, without waiting to seek other opinions or exhaust medical possibilities. In this article, it is sought in a simple way to guide the clinical management of abnormal uterine bleeding, not only applying what is established by FIGO, but also understanding the plasticity of the realities of the history of each patient, especially in premenopausal patients. There is a lot of information on the subject, so it will not delve into the same, but rather to achieve more factual results in our practice.

Keywords: *Uterine Hemorrhages; FIGO; PALM-COEIN*

Introduction

Gynecological uterine hemorrhages are the second reason for attending the office, after vaginal discharge. It represents a real urgency for the patient, due to the fear of its association with a probable cancer and the generalized and chronic weakness that it can cause.

These uterine bleeding, although FIGO, in 2012, reduced its main causes in the mnemonics or acronym such as PALM-COEIN, dividing them into organic and functional, most can be ruled out or oriented through epigenetic evaluative anamnesis, in addition to complementary laboratory studies, ultrasound and other special tests. In the end, the severity of the uterine hemorrhage derives from the characteristics of the bleeding in terms of its relationship with the menstrual cycle, volume, persistence in the cycle and if it is associated with menalgia, malodor and the presence of pelvic-abdominal masses [1,2].

Clinical gynecologists must understand that, within the pathophysiology, an alteration of the estrogenic response necessarily prevails, as well as a dyssynergy with the progestational desquamative response, either mild or severe.

Thus, we have leiomyomatosis, in which the altered and labile response to estrogenic stimulation is observed mainly in submucosal fibroids and also in adenomyosis and endometrial polyposis. This translates into stimulation of gene promoters that lead to endometrial proliferation and thickening, as well as in other situations to uterine bleeding due to hypotrophy or secondary endometrial atrophy. Undoubtedly there must be an alteration in the feedback of the hypothalamic, pituitary and gonad axis, as well as in the peripheral fat and adrenal gland, which maintains this controlled, but fragile, inflammatory allostasis process of the uterine hemorrhage situation of our patients [1].

Bearing this in mind, what to do in the event of uterine bleeding, based on the FIGO recommendations and the clinical practice of experts?

Mechanicist management of uterine hemorrhage

Understanding the pathophysiology of uterine bleeding, based on what is found in the clinical history, semiological evaluation, imaging studies and specific laboratory tests, the gynecologist must establish the guidelines that are correct in the most probable causes of bleeding and establish therapeutics. It sounds simple, but it is not always going to be, since most of these hemorrhages are multifactorial in origin and should be treated as such [1].

Although the uterus is a muscle that looks very simplistic, however, its structure is quite complex, because multiple physiological processes are based on it, including fertility, menstrual desquamation, contractile and functional dynamics during pregnancy and childbirth, such as her postpartum involution. Likewise, the muscle is highly sensitive to respond to fibroblastic and epidermal growth factors similar to insulin, which favor its increase in volume over time, and the uterus in its endometrial layer also manifests proliferative, secretory and desquamative changes during menarche. menopause for many cycles at the time of fertility [3].

Knowing the uterus by its own individual anatomy of each patient, through ultrasound, hysteroscopy and in special situations through minilaparoscopy, can give us an orientation of it. Without failing, of course, to assess the hormonal effect that it suffers throughout its monthly cycle.

In the general treatment of hemorrhage or uterine bleeding, we must specify that although there may be an organic cause, we must direct the treatment to counteract the hormonal stimulus on these structures, especially estrogen, by reducing its influence, whether of ovarian origin or that increases it, especially in anovulatory cases such as occurs in perimenopause and on the other hand if we seek to saturate progesterone receptors with their synthetic or natural derivatives, we can reduce bleeding by avoiding its thickening, dysplasia and perhaps atypia due to chronic inflammation.

The above is important to highlight, because even in the presence of leiomyomatosis, adenomyosis and polyposis, we do not necessarily have to go to surgery in the first instance for its solution, but we must modulate the probable hormonal imbalance, using various hormonal preparations such as contraceptives, progestogens and Gonadotropin releasing hormone agonists (GnRH).The already trite beneficial effect of hormonal implants based on levonorgestrel or etonogestrel stands out, by reducing uterine bleeding, reducing endometrial cell hypertrophy, reducing endometriotic extension and reducing pelvic pain.

In this sense, the clinician must evaluate the organic pathology within the patient's medical context, to determine if the medical treatment can really be tried, before thinking about a myomectomy or hysterectomy. His decision will depend on the deleterious effect on the patient's morbidity, especially anemia, cardiovascular decompensation and the need for blood transfusions. The size of the fibroids, their location and growth over time, the recurrence of polypectomies or the possibility of precancerous endometrial lesions should also be assessed [4].

In addition to the above, associated hormonal disorders such as hypothyroidism, cortisol alterations, hematological disorders, especially coagulation factor mutations and secondary thrombophilia's should be evaluated. Therefore, by correcting these alterations, uterine bleeding will surely decrease and the menstrual period will be regulated.

We must not forget to also evaluate infections by actinomycetes and anaerobes that can cause chronic endometritis with bleeding, especially in users of copper intrauterine devices and also retention of bone residues from previous undiagnosed abortions, as occurs in bone endometrial hyperplasia. In these cases, treatment with antibiotics that covers anaerobes and actinomycetes such as sultamicillin can be started, complemented with non-steroidal anti-inflammatory analgesics or NSAIDs to reduce inflammation and release of cytokines.

If, despite this, a weekly treatment schedule does not improve, the copper IUD should be withdrawn. The continuation of bleeding should warrant a hysteroscopic study and all that this implies, to better define the diagnosis and therapy [4].

Conclusion

The management of abnormal uterine bleeding must be thorough in determining the possible cause, but medical treatment should be attempted before resorting to surgery, especially hysterectomy, since the high prevalence and incidence of the surgical procedure is of concern, without exhausting therapeutics previously noted.

Abnormal uterine bleeding is a main cause of consultation for our patients, so we should not underestimate its seriousness, since it is common for them to perceive it as almost normal, without knowing that it can really affect their quality of life.

The gynecologist must provide the greatest assistance and offer all known treatment possibilities, always seeking to advance from the simplest to the most complex.

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