

World Congress on

Gynecology, Obstetrics, Nursing & Healthcare

April 16-17, 2018 Dubai, UAE

When heavy menstrual bleeding is not the cause of the anemia

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Statement of the Problem: Heavy Menstrual Bleeding (HMB) is a prevalent condition affecting 20-30% of women of reproductive age and commonly presents to Emergency Departments (ED) and gynecology clinics. It may be in isolation or present in combination with other gynecological signs and symptoms, or symptoms associated with anemia. Occasionally, HMB is not the cause of the anemia and other pathologies need to be explored and considered.

Methodology & Theoretical Orientation: We report the case of a 22 year old nulliparous female presenting to the ED with a two years history of irregular HMB with hemoglobin of 38 g/L. Her past medical history included PCOS and a D2 total gastrectomy for a gastric adenocarcinoma in 2012. She was referred to gynecology for further investigation. Examination was unremarkable, there was mild-moderate PV bleeding, periods occurred once every three months. USS revealed PCOS with a normal endometrial thickness and no free fluid. PAP smears were all normal, STI screen and bHCG were negative. Observations were stable but she was symptomatic for anemia. Further investigation revealed microcytic anemia with a ferritin <2 ug/L and normal folate/B12. She received three units PRC's, an iron infusion and was admitted for observation. She was discharged two days later on regular iron supplements and GP follow up.

Result: Following investigation and thorough gynecological assessment it was concluded that the anemia was not secondary to her irregular HMB but rather due to her previous gastric surgery and inability to absorb iron. It is important to consider whether mal-absorption may be a cause, in particular in cases such as this where the history was of clinical significance. It is important to consider this in our clinical practice as numbers of gastrectomies being performed increases not only for gastric malignancies but for weight reduction therapy. Iron deficiency results from reduced dietary intake of iron rich foods following surgery, reduced gastric acid secretion resulting in decreased bio-availability of Iron and loss of intestinal absorption capacity.

Conclusion: It is important as gynecologists to consider when menorrhagia may not be the cause of anemia. When menorrhagia is the cause it can be treated with hormonal therapies such as COCP, IUD, uterine ablation or in severe cases hysterectomy. Other pathologies should also be considered, especially if there is a significant history of GI surgery. Iron-deficiency anemia has been found in 33-50% of patients following partial gastric resections and may develop years after initial surgery. Patients are recommended to have regular check-ups with their GP for iron, vitamin B-12 and folate deficiencies following surgery. Rising numbers of patients having these surgeries also pose some future challenges for clinicians as absorption of many medications may be impaired.

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