

Treatment of Heavy Postmenopausal Bleeding With Comorbidities in Septuagenarian, Octogenarian and Nonagenarian (Case Series)

Mamuna Qayyum, Abdul Bari, Nomira Waheed, Saba Zaman, Javeria Naeem, Osama Ali

Department of Obs & Gynae, Rahbar Medical & Dental College/Punjab Rangers Teaching Hospital/Cavalry Hospital, Lahore Pakistan

ABSTRACT

Few postmenopausal patients with a history of postmenopausal bleeding with comorbidities and unfit for general anaesthesia. These could not be treated with conservative treatments and developed moderate to severe anaemia. Diagnosis and curettage were required to treat the patients. Therefore, a saddle block was applied for D&C and polypectomy. According to histopathological reports, the optimal outcome was succeeded with a multidisciplinary team and post-operation patient care. Patients had follow-up visits after being discharged from the hospital, and the bleeding stopped. In this case series, we present three cases of treatment of heavy postmenopausal bleeding with comorbidities in septuagenarian, octogenarian and nonagenarian.

Keywords: Hemiplegia, Postmenopause, Polyps, Anesthesia.

How to Cite This Article: Qayyum M, Bari A, Waheed N, Zaman S, Naeem J, Ali O. Treatment of Heavy Postmenopausal Bleeding With Comorbidities in Septuagenarian, Octogenarian and Nonagenarian (Case Series). *Pak Armed Forces Med J* 2024; 74(1): 248-250. DOI: <https://doi.org/10.51253/pafmj.v74i1.10683>

This is an Open Access article distributed under the terms of the Creative Commons Attribution License (<https://creativecommons.org/licenses/by-nc/4.0/>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

INTRODUCTION

Bleeding after menopause is not normal, especially after the age of Septuagenarian (seventy years), Octogenarian (eighty years) and nonagenarian (ninety years). There are several benign causes, such as vaginal or endometrial atrophy, endometrial hyperplasia, uterine polyp, infection or inflammation of the cervix and uterus. About 10% of women have cervical or endometrial cancer.¹ Postmenopausal bleeding is abnormal. One reason is that the tissue of the vagina and vulva got thinner. It can be due to hormone changes.² In such cases, associated comorbidities are present for a long duration, such as hypertension, diabetes mellitus, cardiac diseases, CVA and hypothyroidism.³ These affect the heart, brain, kidneys, reproductive system, and the body's overall metabolism. These may require TVS, Endometrial biopsy, Sono-hysteroscopy, hysteroscopy, and D&C. Surgery is required for diagnosis and treatment.⁴ Due to these comorbidities, these patients were not fit for general anaesthesia. In these cases, saddle block was applied.⁵ In this case series, we present three cases of treatment of heavy postmenopausal bleeding with comorbidities in septuagenarian, octogenarian and nonagenarian.

CASE-1

A patient of 86 years (octogenarian), G6P6A0, has

had menopause for 30 years. She presented with heavy postmenopausal bleeding for the last year. She had hypothyroidism with hypertension and CVA 15 years ago. She was a wheelchair user and taking Tab Aspirin 150 mg with anti-hypertensive and tab thyroxin. She has a history of weight loss for one year and urinary incontinence for 3-4 months. Her USG of the pelvis revealed an endometrial thickness of 5.8 mm. A soft tissue thickening echogenic area bulges in the endometrial canal up to the cervix. It may represent an endometrial polyp. USG showed findings of pelvic congestion. Her laboratory reports showed pan-cytopenia with blood group O negative. Her peripheral smear shows hypochromic microcytic anaemia with macrocytes. No immature cells were seen, and WBC with PH are normal. Her renal function revealed raised serum urea and creatinine. After applying the saddle block, her D&C and polypectomy were performed. All endometrial tissue was sent for histopathology. The histopathology report revealed a benign polyp and a normal postmenopausal endometrial layer.

CASE-2

A patient of 74 years (septuagenarian) had HMB for the last 9-10 months. She was P6A2, all SVDs. She was diabetic and hypertensive for the last 18 years, taking anti-diabetic (HbA1C 6.8) and hypertensive. She had a bilateral renal cyst. She has bi-loculated right ovarian 5.14 cm seen on USG. CA 125 is 7.66 (normal <35). Her pre-anaesthesia workup revealed Hb 9.5 g/dl, Platelet 314, and a normal coagulation profile.

Correspondence: Dr Mamuna Qayyum, Department of Obs & Gynae, Rahbar Medical & Dental College/PRTH Lahore Pakistan
Received: 31 Jul 2023, revision received: 02 Nov 2023; accepted: 24 Nov 2023

Urea, creatinine and uric acid raised. Her echocardiography diagnosed mild dilated cardiomyopathy. Her LFTs and thyroid profile are normal. With a multidisciplinary team, and was done under saddle block. The vagina and uterus were postmenopausal. About 30 ml thick pus mixed with blood came out when uterine sound was passed. It was sent for culture and sensitivity. D & C was carried out and sent for histopathology. Anti-biotics were given according to the histopathological report.

CASE-3

A patient of 95 years old (nonagenarian) had postmenopausal bleeding for the last 3-4 months. She was P2 with SVD with one classical caesarean section. She was diabetic and hypertensive for the last 35 years. She has been a cardiac patient for the last 25 years. She was on insulin and HbA1C was 6.7. She was on anti-hypertensive and cardiac treatment as well. Her ultrasonography revealed an endometrial polyp. A vaginal examination revealed a small cervical polyp also. Her pre-anaesthesia workup was done. The anaesthetist examined the patient with all required investigation and decided on a saddle block. After applying the saddle block, her D&C and cervical polypectomy were done. Then, endometrial polypectomy is done, and all endometrial tissue is sent for histopathology. The histopathology report revealed benign polyps and a normal postmenopausal endometrial layer.

DISCUSSION

The international menopausal society and World Health Organization define menopause as the final menstrual period, a retrospective diagnosis when followed by 12 months of amenorrhea.⁶ It was also suggested that if, in menopause, endometrial thickness ≥ 11 mm, then further investigation is required.⁷ Most patients with comorbidities, especially after seventy years of age, are unfit for general anaesthesia, which is required to investigate further. In such cases, para cervical or saddle block can be used. Saddle block or caudal anaesthesia is the low spinal block used to anaesthetize the legs and thigh region's perineum, perianal, and medial side. It is used for obstetrical, urological, and anorectal surgeries. It is rapid onset, dense block, lower postoperative opioid requirement, early mobilization and less hospital stay. This technique provides analgesia for approximately 1-3 hours. It also provides an effective method of analgesia to avoid general anaesthesia with a low rate of adverse events.⁸ In patients with cardiopulmonary comorbidities, when receiving normal spinal, epidural

and subarachnoid block, coupled with circulatory overload, becomes complicated. The saddle block does not cause a sympathetic block, which results in cardio-circulatory problems. Although it is safe, simple and easy to perform, it has certain disadvantages. Complications are risk of infection, peripheral neuropathy, and cauda equina syndrome (numbness around the anus, back pain radiating down the leg, and loss of bowel or bladder control). There is always the risk of postoperative puncture headache.⁹ In all three cases, no complications developed.

It is concluded that mobilization with this technique is gratifying in postoperative periods. This method is worthy of use in this age group. It relieves the patients from presenting complaints and helps in diagnosis and follow-up. This method is safe and decreases mortality and morbidity.

Conflict of Interest: None.

Authors' Contribution

Following authors have made substantial contributions to the manuscript as under:

MQ & AB: Conception, data acquisition, drafting the manuscript, critical review, approval of the final version to be published.

NW & SZ: Data acquisition, data analysis, approval of the final version to be published.

JN & OA: Critical review, concept, drafting the manuscript, approval of the final version to be published.

Authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

REFERENCE

1. Cleveland Clinic. Post-menopausal Bleeding. Causes, Diagnosis and treatment. [Internet]. Available at: <https://my.clevelandclinic.org/health/diseases/21549>.
2. Newell S, Overton C. Postmenopausal bleeding should be referred urgently. *Practitioner* 2012; 256(1749): 13-5.
3. Harvard Medical School. Hypothyroidism-symptoms-and-signs-in-an-older-person. [Internet]. Available at: <https://www.health.harvard.edu/diseases-and-conditions/hypothyroidism-symptoms-and-signs-in-an-older-person> (Accessed on June 15, 2023).
4. Penson RT, Goodman A, Growdon WB, Borger DR, Lee SI, Oliva E. Case records of the Massachusetts General Hospital. Case 14-2013. A 70-year-old woman with vaginal bleeding. *N Engl J Med* 2013; 368(19): 1827-35. <https://doi:10.1056/NEJMcp1209276>.
5. American College of Obstetricians and Gynecologists. Perimenopausal Bleeding and Bleeding after Menopause. [Internet]. Available at: <https://www.acog.org/womens-health/faqs/perimenopausal-bleeding-and-bleeding-after-menopause>.

Treatment of Heavy Postmenopausal Bleeding

6. Baber RJ, Panay N, Fenton A; IMS Writing Group. 2016 IMS Recommendations on women's midlife health and menopause hormone therapy. *Climacteric* 2016; 19(2): 109-150. <https://doi.org/10.3109/13697137.2015.1129166>.
 7. Jokubkiene L, Sladkevicius P. Transvaginal ultrasound examination of the endometrium in postmenopausal women without vaginal bleeding. *Ultrasound Obstet Gynecol* 2016; 48(3): 390-396. <https://doi.org/10.1002/uog.15841>.
 8. Peterson KJ, Dyrud P, Johnson C, Blank JJ, Eastwood DC, Butterfield GE, et al. Saddle block anesthetic technique for benign outpatient anorectal surgery. *Surgery* 2022; 171(3): 615-620. <https://doi.org/10.1016/j.surg.2021.08.066>.
 9. Maryam A, Sajjad H. Saddle Anesthetic Block. Treasure Island (FL): StatPearls Publishing; 2023.
-