CHAPTER 11

Disorders of Uterine Bleeding

Dysfunctional Bleeding

Dysfunctional bleeding is defined as irregular bleeding (compatible with altered ovarian function) from the endometrium. The hormonal dysfunction is related to disturbances of follicular maturation, ovulation, and corpus luteum formation. The basic defect in most instances is in the pituitary-hypothalamic axis. It is frequently observed just after menarche (page 67), in the postpartum period, and in the premenopausal years.

Dysfunctional bleeding may appear as a disturbance in duration or amount of flow. The various types of abnormal uterine bleeding are shown in Fig. 82. Uterine bleeding as a result of organic lesions such as endometrial or cervical polyps, adenomyosis, and endometrial cancer by definition are not causes of dysfunctional bleeding.

Polymenorrhea is shortening of the cyclic intervals to less than 25 days, if the duration and amount of flow are normal. The reason for the polymenorrhea is a shortening of either the corpus luteum phase or the proliferative phase. Another possibility is a short monophasic cycle with early regression of the follicle. Diagnostic curettage in the premenstrual period reveals an incomplete secretory effect in 60% of cases and a proliferative endometrium in 20%. In the remaining 20%, a secretory endometrium develops before day 12 of the cycle.

Diagnosis is provided by the basal body temperature chart, which indicates the time of ovulation and suggests which of the phases of the cycle are normal and which are shortened (Fig. 83). The physical properties of the cervical mucus, pregnanediol excretion, vaginal cytology, and endometrial biopsy provide additional information.

Treatment is required in patients who are infertile or who are anemic because of the extent of blood loss. A patient with a 21-day cycle has four or five menstrual periods more per year than does a woman with a 28-day cycle.

A shortened follicular phase can be extended by the administration of estrogens during the first 5 days of the cycle or by clomiphene. A corpus luteum insufficiency can be corrected by premenstrual administration of progesterone, or sometimes by the injection of LH.
Ovulation in a monophasic cycle can often be induced by clomiphene. Delay in the menses without treating the cause can be achieved with estrogen-gestagen combinations contained in oral contraceptives.

**Oligomenorrhea.** This is prolongation of the menstrual cycle beyond 38 days. This irregularity is an expression of ovarian insufficiency and may be a precursor of amenorrhea. The abnormality may be primary or secondary. Oligomenorrhea is diagnosed only after at least six normal menstrual periods have occurred. Secondary oligomenorrhea is a common sign of the Stein-Leventhal syndrome. In approximately 70% of other cases, the follicular phase is delayed. Maturation of the follicle may be inadequate. The follicles reach the size of only 5 mm and then undergo atresia. Ovulation is delayed but the corpus luteum phase is of normal length in 50 to 70% of cases. It is shortened in 10 to 20% and absent in 10 to 30%.