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Extreme Anemia (1.8g/Dl) Due to Chronic Abnormal Uterine Bleeding

Jakub Nożewski MD[1*], Maria Klopocka Prof[1], Klara Nicpon-Nozewska PhD[2], Jakub Konieczny MD[1]

[1]Faculty of Health Sciences, Nicolaus Copernicus University, Emergency Department, Torun, Poland
[2]Faculty of Health Science, Department and Clinic of Geriatrics, Nicolaus Copernicus University, Torun, Poland

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***Corresponding author:** Jakub Nozewski

Abstract **Case Report**

Anaemia is a pathological condition of multifactorial basis that affects about 25% of world population. It is defined as reduction of haemoglobin level. When sudden blood loss of 50% of blood leads to death, chronic longstanding nonsignificant bleeding without rapid decrease of haemoglobin level can be tolerated and compensated for a very long time. In this case report we present a 40-year-old fully conscious female with abdominal pain which was manifested with haemoglobin level of 1.8 g/dl.

Keywords: Pathological condition, Anemia, Uterine Bleeding.

INTRODUCTION

Anaemia is defined as a decrease in red blood cell mass [1]. Highest prevalence of anaemia is in preschool age children ~ 50%. Men are the group of the lowest prevalence ~12%. Population group with the greatest number of individuals affected is nonpregnant women – about half a billion worldwide [2].There are 3 main etiologic categories: blood loss, increased red blood cell destruction and decreased red blood cell production. The most common cause of anemia include iron, witamin B12 and folate deficiency, hemoglobinopathies, thalassemia and bleeding (acute or chronic). Chronic menorrhagia due to uterine leiomyomas or genital tract cancer is a common cause of anaemia in women of reproductive age. According to World Health Organisation (WHO), around 18 million women aged 30–55 suffer from excessive blood loss during the regular menstrual cycle. 10% of them will experience bleeding that leads to anaemia. Nearly 30% of all performed in the United States hysterectomies are due to heavy menstrual bleeding.

CASE REPORT

A 40-year-old woman was brought by an ambulance to the emergency department with abdominal pain, weakness and prolonged uterine bleeding for a few weeks. There were symptoms of hypovolemic shock due to bleeding and vomiting, heart rate was 107 per minute, blood pressure114/45mmHg, saturation 98%, respiration rate 16 per minute, body temperature 36.4 degrees Celsius. She had a history of alcohol dependence and irregular uterine bleeding without any diagnosis. Because of low social status, she neglects gynaecological care. She denied melaena or blood stool, coffee ground vomitus, drug abuse, renal disease or prosthetic valves. The examination showed pale-yellow skin, normal vesicular murmur over the lungs, forced foetal position on the right side due to abdominal pain. Abdominal examination shows tenderness in the hypogastric region with palpable thinning, without peritoneal signs. There was also significant lower extremity oedema. In per rectum examination there were no signs of pathology and a trace amount of light brown loose stool, without blood, mucous or clots. There was a trace of fresh blood over the labia. During the visit in the emergency department; three different tests were performed showing haemoglobin value of1.8 g/dL (blood test, table 1). The bedside ultrasound examination showed the enlarged heterogeneous uterus, no signs of metastasis, ascites or other pathology.

In Emergency Department, there were 4U of universal blood transfused; the patient was consulted by a gynaecologist. Because of chronic bleeding and extremely low Hg level she was qualified for uterine curettage after stabilization of the patient's general condition. She was transferred to the internal ward, she received blood transfusion: 9 U of packed RBC, 4 of FFP. Following stabilization of general condition, the patient was consulted gynecologically.

Endoscopy: two papillary lesions on the ectocervix, diameter up to about 7 cm, scant bloody discharge in the vagina. Per vaginam, the uterine body

is anteflexed, enlarged, 1.5 fists in size, movable, painless, appendages bilaterally without pathological resistance and soreness on palpation.

USG TV: the uterine body is anteflexed, enlarged, echogenically heterogeneous, AP 72mm, homogeneous endometrium is 3.8mm, compressed by fibroid. In the posterior wall, there is an intramural fibroid compressing the uterine cavity – a lesion of 63x60mm. The right ovary, 43x29mm, with two follicles 21 mm and 19 mm in diameter. The left ovary, 27x19mm, is normoechogenic. In the pouch of Douglas, there is a small amount of free fluid–a pocket up to 9mm in depth. Due to the high level of tumour markers: Ca12, HE 4, Ca 19-9, CEA, she was qualified for an urgent diagnosis. A bivalve speculum was inserted into the vagina and scanty bleeding from the uterus was found, and two papillary lesions on the vaginal portion of the cervix (on the anterior lip approx. 8mm in diameter, on the posterior lip approx. 3mm in diameter). The vaginal portion of the cervix was grasped with bullet forceps and pulled downwards. The length of the uterine cavity was checked with a uterine probe. The cervical canal was dilated to Hegar No. 6.5. Curettage of the cervical canaland then of the uterine cavity was performed. Specimens were collected from both lesions located on the ectocervix. Tissue material for histopathological examination was secured from each of the sites. 1g of Exacyli.v. was administered.

The patient was discharged in stable general condition with the recommendation to come with histopathology results. After 12 days, the patient returned to the Gynaecology Department with the diagnosis of adenocarcinoma endometrial is G2 - hysterectomy was performed. The patient was qualified for brachytherapy.

Table-1

Hematology		
Name	Value	Standard
WBC	13.78 G/l	3.9-10.2
RBC	1.33 T/l	4.0-5.0
HGB	1.8 g/dl	12-16
HCT	7.8 %	37-47
MCV	58.6 fl	80-99
MCH	13.5 pg	27.0-33.5
MCHC	23.1 g/dl	31-37
RDW	24.6%	11.5-14.5
PLT	336 G/l	130-400
%NEUT	83.8	36-68
%LYMPH	8.7	20-44
%MONO	7.3	3-12
%EOS	0.1	0.5-5.5
%BASO	0.1	0-1.75
#NEUT	11.55 G/l	1.5-7.7
#LYMPH	1.2 G/l	1.1-4.5
#MONO	1.01 G/l	0.1-1.00
#EOS	0.01 G/l	0.02-0.55
#BASO	0.01 G/l	0.01-0.20

DISCUSSION

This case show how a young organism with no co-morbid conditions can adapt to such a low hemoglobin (1.8g/dl) level due to chronic bleeding in a stable clinical condition. Women's addiction to alcohol, low social status and frequent alcohol overdose lead to neglecting all symptoms and avoiding medical help for several months.This case adds to other case reports of patient survival with a hemoglobin level of <2 g/dL [4-7].In this patient, the cause of the bleeding was heterogeneous: a fibroid and a neoplastic lesion. The patient was qualified for an urgent oncological surgery and brachytherapy.

European Union (EU) health policy seeks to give all people living in EU access to high quality health care. Although there is easily accessible high quality free medical care in Poland, 7% of women never ask there gynaecologist for cytological tests and 14% haven't been examined with ultrasound. 40% of polish woman doesn't see the need for regular examination, 27% visits gynaecologist in connection with pregnancy for the first time. The only hope can be better health campaigns aimed at raising public awareness and obligatory periodic examination [12].

CONCLUSION

The uniqueness of this case is associated with the lowest haemoglobin level reported in the literature in a patient with chronic genital bleeding. Clinicians in gynaecology departments and emergency departments should be vigilant and monitor haemoglobin level in every patient with chronic, even slight bleeding, in connection with the healthy body adaptability described in this case.

Conflicts of Interest

The authors declare that they have no conflicts of interest and nothing to disclose.

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