Styplon in the Management of Gynaecological Bleeding Disorders

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Uterine bleedings are quite common in obstetric practice. Excessive menstrual flow or undue prolongation of the period of bleeding is known as menorrhagia. The patient is free from bleeding during the intermenstrual periods. Pure menorrhagia is an important symptom of many well defined conditions and should not be confused with the conditions giving rise to irregular bleeding. Metrorrhagia is a condition in which bleeding occurs between the periods. Both of these refer to the period of life in women when menstruation normally occurs.

Our conception of the causes of excessive menstrual loss have undergone considerable changes since the discovery of the ovarian hormones and their activators, the pituitary gonadotrophins. Ovarian dysfunction, due to one factor or another may be an important and a dominant cause. Ovarian dysfunction of endocrine origin may perhaps be responsible in cases of menorrhagia due to fibroids, subinvolution and chronic metritis. Endometritis is a much rarer condition than what it was believed to be.

Menorrhagia may be of endocrine origin as in puberty due to hypofunction of the anterior pituitary body and consequent failure of ovulation and lack of corpus luteum. In menorrhagia of mature women without obvious lesions of the generative or other systems, there may be cystic ovaries, absence of corpora lutea and changes in the endometrium. Pre-climacteric bleeding may be due to increasing failure of the ovarian functions and want of balance between the oestrin and progesterin.

In epimenorrhoea the menstrual cycle is shortened to 21 days instead of 28 and in hypomenorrhoea it is prolonged from normal of 28 days to 36 or 40 or more days.

Causes in the generative system such as endometritis, fibroids, retroversion and flexion of the uterus subinvolutions and various infectious diseases and causes in the blood, hypertension and diseases of the circulatory system may be responsible. The nervous system alone is not a cause of lasting menorrhagia but a single profuse period may result from the disturbance of nerve mechanism.

Metrorrhagia may result from benign or malignant growths of the uterus and inflammatory lesions or be due to hypertension or blood changes.

Dysfunctional uterine bleeding is often met with in gynaecological practice. This symptom is quite troublesome and annoying to the patient and sometimes difficult to relieve. There are many known cause of bleeding per vaginum. These have to be borne in mind and to be carefully eliminated.

The present study was carried out on 57 cases of various ages with the duration of bleeding between 2-4 months. Menstrual history, duration and the quantity of the flow were carefully determined. Obstetric history was elicited. In every case the clinical findings such as the condition of the cervix, uterus and the findings on speculum examination were noted. The diagnosis was confirmed by curettage biopsy findings in these cases. Routine blood count was done in all cases. The response to treatment was judged by its effect on the flow and duration of the periods and the recurrence.
There were 37 patients of dysfunctional uterine bleeding; eight were 30-40 years and four between 40-50 years. Twenty four cases showed slight to moderate enlargement of the uterus. The cervix was normal in most of the cases. Nothing significant was noted by speculum examination. Anaemia was a common finding in most of the cases.

Bleeding per vaginum lasted for 3 days but was very profuse in some cases. The complaints were predominantly those of bleeding and general weakness. In some cases the amount of blood loss was moderate but the duration was prolonged considerably.

The response to the drug was gauged from (a) diminished flow or arrest of bleeding (b) reduction in the number of diapers required (c) reduction in the number of days the bleeding lasted. If there was definite and immediate reduction in the flow and if the improvement was maintained in subsequent periods without further medication the response was considered very good. If the flow was less during the period but further maintenance doses of Styplon were necessary during subsequent bleeding episodes, it was considered good, and if there was no appreciable reduction in the flow it was considered poor.

The aim of treatment was to reduce the blood flow and give relief to these patients from this symptom. In all these cases Styplon tablets were started during the bleeding episode and were continued till the first day of the subsequent period. Two tablets were administered three times a day. Cases of dysfunctional uterine bleeding were observed for four subsequent periods. Cases with definite organic lesions were observed only for one period to see if the drug had any action on controlling bleeding till surgery is possible.

Styplon is an indigenous drug containing Chandrakala, Amla, Nagkesar, Somalata, Punarnava salts, Moolee salts, Praval bhasma, Lajward bhasma, etc. which are useful in controlling bleeding. Chandrakala is a powerful styptic and aids the process of coagulation and improves the tone of the blood vessels. Praval bhasma and Lajward bhasma supply ionisable calcium, Phyllanthus emblica supplies vitamin C which is very useful in maintaining the integrity of the capillary endothelium and the intercellular ground substance. Ruta graveolens contains Rutin. Lajwanti is styptic in action.

The following table shows the results as observed:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Very good</th>
<th>Good</th>
<th>Poor</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysfunctional uterine bleeding</td>
<td>12</td>
<td>19</td>
<td>6</td>
<td>37</td>
</tr>
<tr>
<td>Menorrhagia (with definite organic causes)</td>
<td>—</td>
<td>6</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Polymenorrhoea</td>
<td>—</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Metrorrhagia</td>
<td>—</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Metropathia haemorrhagica</td>
<td>—</td>
<td>—</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>29</td>
<td>16</td>
<td>57</td>
</tr>
</tbody>
</table>
Out of the thirty seven cases of dysfunctional uterine bleeding twelve showed excellent response as the amount of flow and its duration were both reduced to normal. All the subsequent periods were normal on follow-up without any further medication. Nineteen cases showed good response; the flow was diminished and the duration was reduced, but the subsequent period in these cases was not normal. These patients were again put on Styplon only during the subsequent bleeding episode. Bleeding was controlled satisfactorily during each episode but the complaint recurred when Styplon was completely stopped. Six cases showed poor response as neither the flow nor the duration of bleeding was diminished. Six out of the nine cases of menorrhagia showed a definite reduction of the amount with definite organic lesion of blood passed. Though the drug was not capable of removing the organic cause it was useful in controlling the bleeding as a palliative measure.

Half the cases of polymenorrhoea showed good response. The single case of Metropathia haemorrhagica did not show any response.

There were three cases of uterine fibroid; one of salpingo-oophoritis, one of cervical erosion, one of cystic ovaries and one of cervical carcinoma. Bleeding was controlled temporarily in these cases but they required surgical intervention or other treatment for relief.

**SUMMARY**

Fifty seven cases of uterine bleeding due to various causes were treated with Styplon tablets. Of 37 cases of dysfunctional uterine bleeding, 12 showed very good results, 19 good results and 6 did not respond. Out of 9 cases of menorrhagia 6 responded; out of 6 cases of Polymenorrhoea 3 responded; out of 4 cases of metrorrhagia, one responded. One case of metropathia haemorrhagica did not respond.

Styplon is very useful in controlling dysfunctional uterine bleeding and is useful as a palliative measure to control bleeding even in cases which require surgical correction.