15f. Asrugdara (Abnormal Uterine Bleeding)

Unit 15(f): Āsrugdāra — Abnormal Uterine Bleeding (AUB)

Learning goals

By the end of this chapter, you should be able to:

- define **Āsrugdāra** and correlate it with modern **AUB**;
- classify AUB using **PALM–COEIN** and recognise age-specific patterns (adolescent, reproductive, perimenopause, postmenopause);
- take a focused history and perform examination for heavy, prolonged, frequent, or irregular bleeding;
- plan **acute** and **chronic** management (Ayurveda + modern), including endometrial protection and anaemia care;
- write high-scoring answers with structured algorithms and documentation.

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1) Concept & definitions

1.1 Ayurvedic frame: *Āsrugdāra*

"*Āsruk*" = blood; "*dāra*" = excessive/continuous flow. **Āsrugdāra** denotes **excessive, frequent, or prolonged uterine bleeding** due to vitiation of **Doṣa** (predominantly **Pitta–Rakta**) with **Apāna-vāta** dysrhythmia and **Ārtavavaha Srotas** disturbance.

Classical anchor (quote this):

> **"अर्तवस्य विसर्गश्च काले येन प्रवर्तते।**
> **तद्वहानि स्रोतो ज्ञेयं गर्भाशयसमाश्रयं॥**
> **तस्य मूलं रक्तवहिन्यः स्युः गर्भाशयः स चोच्यते॥"**
> — *Caraka Saṃhitā*, **Vimānasthāna 5/8**
> *(Ārtavavaha Srotas carry timely discharge of ārtava; their mūla is **Garbhaśaya** and **Raktavāhinī**.)*

> **सुश्रुतसंहिता, उत्तरतन्त्र 38 (योनिव्यापत्प्रतिषेधाध्याय): पित्तोत्थ "रुधिराक्षरा"**
> वातला चेति वातोत्थाः, **पित्तोत्था रुधिरक्षरा** ।
> वामिनी स्रंसिनी चापि पुत्रघ्नी पित्तला च या ॥७॥

> **सुश्रुतसंहिता, उत्तरतन्त्र 38: योनिव्यापत्तियों का संक्षेप (सूची-प्रसंग)**
> विंशतिर्व्यापदो योनेर्निर्दिष्टा रोगसङ्ग्रहे ।
> मिथ्याचारेण याः स्त्रीणां प्रदुष्टेनार्थवेन च ॥५॥

> **तथा च रक्तप्रदरं चतुर्विधमुदाहृतम्।**
> **वातपित्तकफैरत्र त्रिधा चतुर्थः सन्निपाततः॥** (अ.सं. संदर्भ श्लोक 176 के रूप में उद्धृत)

> **विंशतिर्योनिरोगाः** स्युर्वातात्पित्तात्कफादपि।
> सन्निपाताच्च रक्ताच्च लोहितक्षयतस्तथा॥ (अ.सं. संदर्भ श्लोक 177)

नोट: सुश्रुत में "**रुधिराक्षरा**" (योनि से रक्तस्राव) पित्तोत्थ योनिव्यापद के रूप में वर्णित है—आधुनिक विवेचन में यही

असृग्दर/रक्तप्रदर के नैदानिक व्याख्यान से मेल खाती है। शार्ङ्गधरसंहिता में रक्तप्रदर का **वात/पित्त/कफ/सन्निपात** चतुर्विध भेद स्पष्ट दिया गया है।

Inference (exam line): In Āsrugdāra, **Srotodusṭi** at Garbhaśaya–Raktavāhinī alters **kāla** (timing) and **pramāṇa** (quantity) of bleeding.

1.2 Modern correlation: AUB

Abnormal Uterine Bleeding (non-pregnant, reproductive age) = deviation in **regularity, frequency, duration, or volume** of menses. Common patient-facing patterns:

- **Heavy menstrual bleeding (HMB)**: excessive volume (flooding/clots/anaemia).
- **Prolonged bleeding**: >8 days.
- **Frequent bleeding**: cycle interval <21 days.
- **Irregular bleeding**: unpredictable cycles/IMB.

Always **exclude pregnancy** first in reproductive age.

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2) Etiology & classification

2.1 Modern: PALM–COEIN (write this table!)

Structural (PALM)	Definition	Non-structural (COEIN)	Definition
Polyp	Endometrial/cervical polyp	**C**oagulopathy	e.g., von Willebrand disease
Adenomyosis	Ectopic endometrium in myometrium	**O**vulatory dysfunction	Anovulation/irregular ovulation
Leiomyoma	Fibroids (submucous = HMB)	**E**ndometrial	Primary disorders of endometrial haemostasis
Malignancy/Hyperplasia	Endometrial/cervical CA, atypia	**I**atrogenic	Hormones, anticoagulants, IUCD (copper)
		Not yet classified	Rare/unclear

Age nuances

- **Adolescent**: anovulation; consider **coagulopathy** (since menarche).
- **Reproductive**: PALM–COEIN full spectrum; **PCOS** common (O).
- **Perimenopause**: anovulation + structural (polyps/fibroids).
- **Postmenopause (PMB)**: **malignancy until proved otherwise**.

2.2 Ayurvedic mapping (viva-friendly)

- **Pitta–Rakta prakopa** → hot, bright-red, profuse early bleeding.
- **Apāna-vāta viṣama gati** → irregular/frequent onset with cramps.
- **Kapha kṣaya** (loss of containment) → endometrial instability.
- **Ārtavavaha Srotodusṭi** at Garbhaśaya–Raktavāhinī → **kālavyatyāsa** (timing error) + **pramāṇa vṛddhi** (volume increase).

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3) Clinical presentation — what to elicit

3.1 Focused history

- **Cycle diary**: interval, duration, pad count/flooding, **clots** (PBAC if used).
- **Onset & course**: since menarche? postpartum? perimenopause?
- **Associated**: dysmenorrhoea, **intermenstrual/postcoital bleeding (PCB)**, vaginal discharge/fever (PID), pelvic pressure symptoms (fibroid), **infertility**.
- **Systemic**: easy bruising/epistaxis (coagulopathy), thyroid symptoms, weight change (PCOS), drugs (anticoagulants, HRT), IUCD type.
- **Obstetric/gynecologic**: procedures (D&C), abortions, Pap/HPV status.
- **Red flags**: PMB, PCB, rapid weight loss, severe anaemia symptoms.

3.2 Examination

- **General**: pallor, tachycardia, orthostatic BP; BMI, **acanthosis**, thyroid, galactorrhoea.
- **Breast/Thyroid**: endocrine clues.
- **Abdomen**: uterine enlargement/irregular mass (fibroid), tenderness (PID).
- **Per speculum (PS)**: cervical lesion/polyp, contact bleeding, discharge.
- **Per vaginam (PV)**: uterine size/position, mobility; **CMT** (PID); adnexal mass.

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4) Investigations (stepwise)

1. **Pregnancy test** (urine/serum β-hCG) in reproductive age.
2. **CBC** ± ferritin (anaemia); **blood group** if heavy bleed.
3. **TSH**, **prolactin**; add **FSH/LH/E2/AMH** when POI/PCOS suspected.
4. **Coagulopathy screen** (esp. adolescents or life-long HMB): PT/INR, aPTT, **vWD** panel.
5. **Transvaginal USG** (or trans-abdominal if needed): endometrial thickness, polyps, fibroids, adenomyosis, ovarian pathology.
6. **STI screen** if cervicitis/PID suspected.
7. **Endometrial sampling**:
    - **Indications:** age **≥45 y**, or <45 with **risk factors** (obesity, PCOS/anovulation, chronic AUB, failed medical therapy, PMB).
    - **PMB**: TVS **ET >4 mm** or persistent bleeding → biopsy.
8. **Hysteroscopy** for focal lesions (polyp/submucous fibroid), failed therapy, or discordant findings.

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5) Acute AUB: stabilise first, then stop the bleed

5.1 Triage & resuscitation

- Assess **hemodynamics**: pulse, BP, mental state, capillary refill.
- **IV access**, fluids; **cross-match** if needed.
- **Tranexamic acid** (if no contraindication), **NSAIDs** (if pain, not in bleeding diathesis).
- **Pregnancy ruled out?** If not, manage per obstetric algorithms.

5.2 Rapid medical control (non-pregnant)

- **High-dose combined OCPs** (e.g., EE + levonorgestrel multiple daily doses for first 24–48 h, then taper).
- Or **high-dose oral progestin** (e.g., medroxyprogesterone 20–30 mg/day in divided doses, then taper).
- **IV conjugated oestrogen** (for severe, unstable bleed—specialist setting).
- Add **iron** (oral/IV) and antiemetics as needed.

5.3 Procedural options (if medical fails/contraindicated)

- **Hysteroscopic polypectomy** / myomectomy (submucous fibroid).
- **D&C** (diagnostic/temporary control) – not definitive.
- **Balloon tamponade**, **uterine artery embolization** (UAE) in select cases.
- **Hysterectomy** for refractory cases with completed family and pathology.

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6) Chronic AUB: treat the cause, protect the endometrium

6.1 Non-hormonal

- **Tranexamic acid** (during menses) — reduces blood loss;
- **NSAIDs** (mefenamic/ibuprofen) — useful in ovulatory HMB with dysmenorrhoea.

6.2 Hormonal (choose per goal & eligibility)

- **Levonorgestrel-IUS (LNG-IUS)** — first-line for HMB; strong reduction in blood loss; contraception bonus.
- **Combined OCPs** — regulate cycles, reduce volume, helpful in dysmenorrhoea and acne.
- **Cyclic/continuous progestins** — for anovulatory AUB and endometrial protection (e.g., MPA 10 mg × 10–14 d/month).
- **DMPA** — can induce amenorrhoea (counsel on irregular spotting initially).
- **Perimenopause** — consider **LNG-IUS** or **continuous progestin**; weigh risks/benefits of HT.

6.3 Targeted structural therapy

- **Polyps → Hysteroscopic polypectomy**.
- **Submucous fibroids → Hysteroscopic myomectomy**; intramural/subserous → myomectomy or **UAE** based on symptoms/fertility.
- **Adenomyosis → LNG-IUS**, NSAIDs; refractory → hysterectomy after counselling.
- **Endometrial hyperplasia** → progestin therapy vs hysterectomy depending on atypia and fertility wishes.

6.4 Iron and anaemia care

- **Oral iron** (elemental 60–100 mg/day) with vitamin C; treat for 3 months after Hb normalisation.
- **IV iron** for intolerance/very low Hb or peri-operative optimisation; diet counselling (iron-rich foods).

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7) Ayurvedic *cikitsā-sūtra* (integrative)

Aim: pacify **Pitta–Rakta**, normalise **Apāna-vāta gati**, stabilise endometrium (*kapha sthairyata*), clear **Ārtavavaha Srotas**, and rebuild **Rasa–Rakta**, while ruling out emergencies.

7.1 Pathya–apathya

- **Avoid (Pitta-provoking):** very **uṣṇa**, **amla**, **lavaṇa**, **katu** foods; alcohol; late nights; intense heat exposure.
- **Favour (śītala–madhura-tikta):** *śāli* rice, green gram, pomegranate, coriander-cumin water, bottle gourd, buttermilk (diluted), ghṛta in moderation; stress-reduction, adequate sleep.

7.2 Doṣa-wise supports (post-screening, no pregnancy)

- **Pitta–Rakta pradhāna (early/“hot” profuse bleed):**
  - *Śatāvarī, Amalaki, Gudūcī, Mustā, Yaṣṭimadhu*;
  - *Aśokāriṣṭa*, *Lodhra cūrṇa*, *Nāgakeśara* combinations;

  - **Mṛdu virecana** (gentle purgation) when indicated; local **yoni-piçu** with *Aśoka/Lodhra-siddha* taila in non-infective states.
- **Apāna-vāta viṣama gati (irregular/frequent with cramps):**
  - **Snehana-svedana**, **vāta-anulomana** (warm water, ghṛta), *Daśamūla kvātha*;
  - **Basti** in supervised settings (mātrā/anuvāsana with *tila taila* → nirūha with *Daśamūla*) once acute bleed controlled.
- **Kapha kṣaya (endometrial fragility):** combine **Pitta-śamana** with endometrial **rasāyana** (e.g., *Śatāvarī ghṛta*); avoid excessive **lekhana**.

Contra-points: Uttarabasti is **not** for active heavy bleeding/PID/pregnancy; consider only when stable, non-infective, and per institutional asepsis.

7.3 Integration with modern care

- Combine **Ayurvedic Pitta-śamana/Rakta-prasadana** with **LNG-IUS/COCP/cyclic progestin** for lasting control and **endometrial protection**.
- Add **iron** and diet therapy for **Rasa–Rakta** replenishment.
- Structural lesions → **hysteroscopic correction**; Ayurveda supports convalescence (agni–rasāyana).

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8) Special situations

- **Adolescents:** most AUB is **anovulatory**; check **vWD** if since menarche/bleeds elsewhere. Use high-dose **COCP/progestin** for acute control; long-term: COCP/LNG-IUS; strong emphasis on counselling and iron.
- **Perimenopause:** erratic anovulation + polyps/fibroids common; **endometrial sampling** has **low threshold**.
- **Postmenopausal bleeding (PMB): malignancy until proved otherwise**; TVS (**ET threshold ~4 mm**), biopsy/diagnostic hysteroscopy—**do not** rely on medical therapy before evaluation.
- **Anticoagulants/Copper IUCD:** iatrogenic AUB; consider dose review/switch or LNG-IUS.

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9) Documentation templates (copy-ready)

Focused OPD note

- *CC:* Heavy, prolonged menses × 6 months with clots and fatigue.
- *HOPI:* Cycles 28–35 d, bleeding 9–10 d; no PCB; no fever.
- *Exam:* Pallor++; BMI 26; thyroid N; abdomen soft; PS—cervix healthy; PV—uterus bulky, mobile.
- *Plan:* UPT negative; CBC/ferritin/TSH/prolactin; TVS. Start tranexamic acid during menses + oral iron; discuss LNG-IUS after USG.
- *Provisional:* **AUB-L (fibroid?) vs AUB-O**.

Acute AUB (casualty)

- *Status:* Pulse 112, BP 90/58; soaked 3 pads/h with clots.
- *Action:* IV line, fluids, cross-match; tranexamic acid; high-dose COCP protocol; arrange TVS; consent for escalation (D&C/hysteroscopy) if uncontrolled.

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10) High-yield revision (10 bullets)

1. **Āsrugdāra ≈ AUB**: altered **frequency, regularity, duration, or volume**.
2. Quote **Ca. Vi. 5/8** to ground Ārtavavaha Srotas (Garbhaśaya–Raktavāhinī) in answers.

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3. Classify with **PALM–COEIN**; think **age** (adolescent → O/C; PMB → evaluate for malignancy).
4. **Rule out pregnancy** first; stabilise if acutely bleeding.
5. **CBC + ferritin** for all HMB; **TSH/prolactin**, **coagulopathy** if history suggests.
6. **TVS** for structure; **biopsy** if ≥45 y or risk factors/persistent AUB.
7. **Acute control**: tranexamic/NSAIDs + high-dose **COCP/progestin**; IV estrogen in selected unstable cases; escalate to procedures if needed.
8. **Chronic control**: **LNG-IUS** (first-line HMB), COCP, cyclic progestin; treat structure (polypectomy/myomectomy).
9. Ensure **endometrial protection** in anovulation to prevent hyperplasia.
10. Integrate **Pitta-śamana/Rakta-prasadana** and **vāta-anulomana** with modern care; replenish **iron**.

Assessment

A) MCQs (one best answer)

1. The **mūla** of Ārtavavaha Srotas is:
   A. Yakṛt–Pliha B. Hṛdaya–Dhamanī C. **Garbhaśaya-Raktavāhinī** D. Basti–Vṛkka
2. The **first step** in evaluating reproductive-age AUB is:
   A. TVS B. Endometrial biopsy C. **Pregnancy test** D. Coagulation profile
3. In PALM–COEIN, **AUB-O** refers to:
   A. Adenomyosis B. **Ovulatory dysfunction** C. Ovarian tumour D. Oral-drug related
4. A 47-year-old with irregular heavy bleeding should have **endometrial sampling** because:
   A. Parity 2 B. **Age ≥45 y** C. BMI 22 D. No dysmenorrhoea
5. Best long-term option for **heavy menstrual bleeding** with completed family and no mass is:
   A. **LNG-IUS** B. Antibiotics C. Dexamethasone D. Copper IUCD
6. Adolescent with HMB since menarche: besides anovulation, consider:
   A. Thyroid malignancy B. **von Willebrand disease** C. Cervical cancer D. Endometriosis
7. For **acute** control of heavy non-pregnant AUB, an effective regimen is:
   A. Low-dose COCP once daily only B. **High-dose COCP or high-dose progestin, then taper** C. Oestrogen patch D. Only iron
8. PMB evaluation: TVS shows ET 7 mm. Next step:
   A. Reassure only B. **Endometrial biopsy/diagnostic hysteroscopy** C. Tranexamic acid only D. OCP
9. Copper IUCD user with heavier bleeds is an example of:
   A. AUB-E B. **AUB-I (iatrogenic)** C. AUB-N D. AUB-C
10. In anovulatory AUB, **endometrial protection** is best ensured by:
    A. Monthly antibiotics B. **Cyclic progestin/COCP or LNG-IUS** C. Vitamin C only D. Observation

Answer key: 1-C, 2-C, 3-B, 4-B, 5-A, 6-B, 7-B, 8-B, 9-B, 10-B.

B) Short Answer Questions (3–5 lines each)

1. Define **Āsrugdāra** and correlate it with the modern construct of **AUB**; add one line on *Srotodusṭi*.
2. Write the **PALM–COEIN** classification with one example for each category.
3. Outline **acute AUB management** in a haemodynamically unstable non-pregnant woman.
4. List **three indications** for **endometrial biopsy** in AUB.
5. Describe **Ayurvedic measures** for **Pitta-Rakta pradhāna** bleeding and how you integrate them with modern therapy.

C) Long Answer Questions

1. **Discuss Āsrugdāra/AUB** under: definition, classical basis (include Ca. Vi. 5/8), PALM–COEIN, history & examination, investigations (with biopsy indications), **acute** and **chronic** management (medical, procedural),

anaemia and endometrial protection, age-specific notes, and integrated Ayurvedic approach.

2. A 38-year-old P2L2 with HMB, Hb 8.4 g/dL, TVS suggestive of a 1.8-cm endometrial polyp. Write a **comprehensive plan**: stabilisation and iron, choice between **tranexamic/COCP** vs **hysteroscopic polypectomy**, and post-procedure maintenance (LNG-IUS vs cyclic progestin) with supportive **Pitta-śamana/Rakta-prasadana**.