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Sheehan's syndrome-An Indian scenario

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Global Burden Disease (GBD) (1990) lists sequelae for postpartum haemorrhageas Sheehan's Syndrome and postpartum anemia. However in year 2000, onlypostpartumanemia was considered by GBD as afallout of postpartum haemorrhage.

However in developing countries, Sheehan's Syndrome is still visible and early recognition is important to prevent morbidity in young women. Serious Obstetric haemorrhageresults in panhypopitutarism or selective hormone deficiency. The probable etiology is an infarction of the enlarged pituitary gland of pregnancy.

Growth hormone and prolactin deficiency is seen in 90-100 % of cases and cortisol Gonadotrophin and thyroid stimulating hormones are decreased in 80-100 % of cases; sudden cortisol deficiency often results in circulatory collapse. Diabetes insipidus has also been reported. Anomalous presentations withhyper prolactinemia have also been found in Sheehan's after a literature review; although rare. Empty Sella sign on Magnetic resonance imaging is classically present in Sheehan's Syndrome. However a Microprolactinoma was observed in this institution.

Three cases have been of Sheehan's Syndrome were diagnosed in this hospital in last 3 years, while none in preceding 22 years. Early recognition of these cases was probably because of better knowledge of Gynecological Endocrinology in recent times. The treatment of Sheehan's Syndrome lies in the replacement of deficient hormones. Cyclic Estrogen and Progesterone is necessary to reverse genital atrophy and maintain bone mineral density. If fertility is desired, Ovulation induction is performed with Human Menopausal Gonadotrophins. Recombinant Follicle Stimulating hormone with varying doses of Luteinizing hormone can also be used.

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