EDITORIAL

Inadequate Obstetric Care and Pituitary Disease in Young Women

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Sheehan's syndrome (SS) refers to varying grades of anterior pituitary hormone deficiency resulting from the infarction of the physiologically enlarged pituitary gland of pregnancy following peripartum or postpartum hemorrhage (PPH) and consequent circulatory failure. Known to gynecologists for more than a century as "superinvolution of uterus", this clinico-pathological entity came to bear Sheehan's name after he, in a series of classic papers, emphasized and clarified the relation of the clinical syndrome and the postpartum necrosis of the anterior pituitary. The clinical manifestations of hypopituitarism in patients surviving the period of postpartum shock are rapid and dramatic. Failure of lactation and mammary involution are the earliest signs. Fatigue, loss of vigor and hypotension are common findings during the puerperium followed by loss of public, axillary hair and other features common to hypopituitarism. Failure to establish diagnosis and institute replacement therapy promptly may have lethal consequences.

Because the risk of obstetric hemorrhage resulting in significant hypotension is much greater in developing countries, the majority of cases of SS occur in developing countries. The sheer number of women residing in these regions of the world make SS the commonest cause of hypopituitarism worldwide. In SS, variable patterns of pituitary hormone deficiency can be observed; GH and PRL deficiency are the most common abnormalities. In one series from our center, 98 % women had amenorrea/ oligomenorrea (suggesting gonadotroph failure), 94% had failure of lactation (suggesting lactotroph failure) (1). One of the first presentations of SS is failure of lactation. This is sine quo non of postpartum pituitary necrosis. However, failure of lactation may rarely be either due to isolated prolactin deficiency or prolactin resistance (2,3). The degree of hypopituitarism in SS is highly variable. Partial or complete spontaneous recovery does take place in some cases and subsequent pregnancy in these patients has been reported (4-6).

There was no clear data available on the incidence and prevalence of Sheehan's syndrome largely because it has become almost extinct in the developed world. Sheehan himself estimated in 1930s that for every 10,000 population there are about 2 severe cases of SS and 7 of lesser severity and, more importantly that many of these cases are unrecognized and/or misdiagnosed. Nearly seven decades later, the situation seems to be unchanged in the developing regions of the world like ours. We have been, for more than a decade, diagnosing SS in increasing number of women who are suspected to have SS by primary care doctors who have become sensitized to the condition over the years. These clinical observations prompted us to design a study to estimate the prevalence of SS in Kashmir valley of Indian subcontinent and understand its clinical spectrum. Two hundred seventy-nine (3.20%) of the 8,730 parous females aged 20-39 years and 124 (4.18%) of 2,970 parous females aged 40 years or older who were screened were suspected to

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have Sheehan's syndrome; 115 and 55 of these females in the two age groups were fully evaluated, and 98 and 51 of them, respectively, were proven to have Sheehan's syndrome. At these rates, the projected number of women with Sheehan's syndrome among a total population of parous females aged _20 years (12,32,827, as per census data) would be 38,691 in the Kashmir valley (7).

I conclude that SS is a widely prevalent problem in our part of the world. Because of its varied presentation and socioculturally based reluctance of our patients to volunteer reproductive dysfunction details, we must have a low threshold for suspecting this condition. Massive improvements in medical care in general and in obstetric care in particular are required to contain this problem of enormous medical and social costs.

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