

Research Article**Polycystic Ovarian Syndrome Diagnosis in a Patient Undergoing Treatment for Bipolar Affective Disorder at Mbale Regional Referral Hospital, Uganda: A Case Report**Achipa Doreen¹, Nteziyaremye Julius^{*1,2}¹Department of Obstetrics and Gynaecology, Faculty of Health Sciences, Busitema University, Uganda²Department of Obstetrics and Gynaecology, Mbale Regional Referral Hospital, Uganda

BACKGROUND: The association between bipolar affective disorder (BAD) and polycystic ovarian syndrome (PCOS) is elucidated in medical literature. However, what is inconclusive is whether one causes the other and /or the neuroleptics such as sodium valproate could cause PCOS as a side effect. However, to the best of our knowledge, there is a dearth of such case reports in our setting. We therefore report a case of this nature in our setting with the aim of further reemphasizing the likely comorbidity and the need for collaborative multidisciplinary approach during management of such patients. **CASE REPORT:** We present a case of 34 years old, parity 0+1, human immune virus seronegative, a known patient of bipolar affective disorder (BAD) for 18 years. She was initially started on chlorpromazine and carbamazepine that she used for 13 years and later switched to sodium valproate and sertraline daily due to side effects of chlorpromazine in 2014. She presented with 6 years history of abnormal uterine bleeding and dysmennorrhoea for 2 months. A diagnosis of PCOS was made based on history and confirmed by laboratory and radiological investigations. **CONCLUSIONS:** Physicians need be aware of the likely comorbidity or sequel and the need for multidisciplinary engagement.

Key words: Bipolar affective disorder; polycystic ovarian syndrome; sertraline; sodium Valproate; Mbale; Uganda.

INTRODUCTION

Polycystic ovary syndrome (PCOS) also known as Stein and Leventhal syndrome, is the most common endocrine disorder in reproductive aged women, with a prevalence estimated to be between 5% and 15%, depending on the diagnostic criteria one uses (DA., 2005; Lauritsen MP, 2014). It was first described by Stein and Leventhal as a syndrome of oligoamenorrhoea and polycystic ovaries, additional clinical signs such as hirsutism, acne, and obesity have continued to define the syndrome (Barbieri RL, 1983; Irving F. Stein, 1935).

Since the 1990 National Institutes of Health-sponsored conference on polycystic ovary syndrome (PCOS), it has become appreciated that PCOS is a syndrome rather than a single clinical entity and thus encompasses an array of signs and symptoms. The 2003 Rotterdam consensus workshop concluded that PCOS is a syndrome that may include menstrual irregularities, signs of androgen excess, and obesity. Moreover, according to the Rotterdam criteria, diagnosis of PCOS requires the presence of at least two of the following three findings:

hyperandrogenism, ovulatory dysfunction, and polycystic ovaries (Group, 2004). Therefore, clinically diagnosing a woman as having PCOS implies an increased risk for infertility, dysfunctional uterine bleeding, endometrial carcinoma, obesity, type 2 diabetes mellitus (DM), dyslipidaemia, hypertension, and possibly cardiovascular disease (CVD)- all that have wide implications both economically and socially (Ricardo Azziz, 2009).

The relationship between mental disorders and PCOS per se is not a straightforward one. Symptoms that are associated with the syndrome itself such as acne, hirsutism, scalp hair loss, menstrual disorders with infertility and obesity are normally distressing enough and have been associated with impaired quality of life.

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