Managing Heavy Menstrual Bleeding in Primary Care

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HOLOGIC® Campaign

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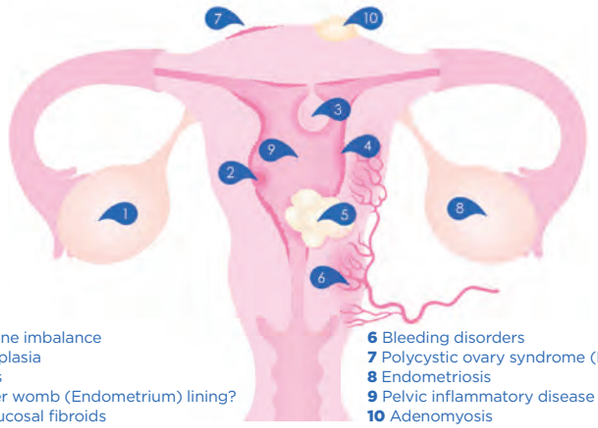
Background

Heavy Menstrual Bleeding (HMB) is the most common reason for women of reproductive age to be referred to a gynaecologist. NICE defines HMB as 'excessive menstrual blood loss which interferes with a woman's physical, social, emotional and/or material quality of life'. It can occur alone or in combination with other symptoms.[1] The psychological impact of HMB is often underestimated, but a recent survey of women with the condition found that 74% experienced anxiety due to HMB and 62% suffered with depression due to HMB.[2] Despite HMB affecting more than 1 in 5 women,[3] 62% do not realise that this is a treatable medical condition with a number of treatment options available.[2] This article will explore managing HMB in primary care.

Causes of HMB

There is no single cause of HMB, the diagram below identifies some of the most common causes of the condition.



1 Hormone imbalance
2 Hyperplasia
3 Polyps
4 Thicker womb (Endometrium) lining?
5 Submucosal fibroids
6 Bleeding disorders
7 Polycystic ovary syndrome (PCOS)
8 Endometriosis
9 Pelvic inflammatory disease (PID)
10 Adenomyosis

Diagnosis

History

The following questions can help determine if your patient has HMB

- What is the duration and frequency of her periods?
- Has there been a change in bleeding pattern?
- Is she using double protection e.g. tampon and pad and how often does she need to change period products?
- Does she pass clots and if so, how large are they?
- Is there a personal or a family history of excessive bleeding?
- Does she experience bleeding between periods?
- Does she have pelvic pain and/or pressure symptoms?
- What impact are her periods having on quality of life? Has she missed work or social activities?

Any related symptoms and other medical conditions should be documented. Medication (especially use of hormones) should be noted.

Examination

It is good practice to carry out an abdominal and pelvic examination, although first line pharmacological treatment (excluding Mirena IUS) can be considered without a pelvic examination in the absence of other related symptoms.[1]

Abdominal palpation should always precede vaginal examination. This could detect enlargement of the uterus due to fibroids, which would otherwise be missed.

A speculum examination to exclude cervical lesions (polyps/ulceration) is indicated. If due and appropriate, a cervical smear should be taken. A vaginal examination should be performed to assess the size of the uterus, with possible detection of uterine fibroids, or ovarian cysts.

Investigations

Haematology: a full blood count is recommended to check for anaemia. Coagulation tests should only be carried out if there is a personal or a family history of excessive bleeding.

Assessment of iron storage (serum iron or ferritin levels) is not indicated in the first instance. Thyroid function tests are only indicated in the presence of signs or symptoms of thyroid disease.

There is no value in assessing gonadotrophin levels in the majority of women, as this will not affect patient management.

Imaging/Hysteroscopy

The choice of first line investigation depends on the woman's history and examination findings and include either ultrasound, via the transvaginal route, or outpatient hysteroscopy particularly where uterine cavity abnormality or endometrial pathology are suspected. Ultrasound is helpful for assessing uterine fibroids and their position.

If intrauterine pathology eg. endometrial polyp or submucous fibroid is suspected, saline or contrast infusion (hystero-sonography) may enhance diagnosis.[4]

Endometrial sampling

Current NICE guidance does not recommend taking a blind endometrial biopsy. Sampling should be done at the time of an outpatient hysteroscopy.

A high index of suspicion is recommended for women with risk factors for endometrial hyperplasia and cancer. These include women with PCOS, nulliparous women, women taking tamoxifen and with co-morbidities including hypertension, diabetes and obesity.

Management

The choice of treatment depends on factors including aetiology, patient preference, suitability and fertility wishes.

Medical treatment

Pharmaceutical treatment should be considered where no histological abnormality is present.

Non Hormonal

Tranexamic acid has the benefit of only needing to be taken during menstrual bleeding, and not continually. The most effective dose is 1g,

four times daily for the first four days of bleeding.

Uncommon side effects are indigestion, diarrhoea and headaches.

Non-steroidal anti-inflammatory drugs (NSAIDs) eg. Mefenamic Acid 500mg tds, will reduce pain and bleeding. Common side effects include indigestion and diarrhoea.

Hormonal

The main hormones that are used are progestogens.

The most effective route of administration is via an intrauterine system, which deposits the progestogen where it is needed, in the endometrial cavity. A levonorgestrel intrauterine system (LNG IUS) with 52 mg Levonorgestrel results in an average 85% reduction in bleeding, with some women becoming amenorrhoeic.

Possible hormonal side effects include unscheduled bleeding and abdominal/pelvic pain. These are generally minor and transient.

A progestogen can also be given orally, and NICE guidance recommends the use of cyclical oral progestogens (either Norethisterone or Provera) or use of progestogen only contraceptive pills. High dose systemic progestogens (e.g. norethisterone 5 mg t.d.s; medoxyprogesterone acetate 5-10 mg t.d.s) can be administered to arrest acute episodes of bleeding (single 10-14 day course).

Use of combined oral contraception (COC) is another treatment option for HMB, especially in women also requiring contraception.

GnRH analogues may be considered in secondary care for refractory bleeding despite use of recommended NICE medical treatments and / or in the presence of significant uterine fibroids. Addback hormone replacement therapy (HRT) should be considered.

Other

Oral or intravenous iron infusion or blood transfusion can be considered according to the severity of the anaemia and associated symptoms.

Surgical treatment

Endometrial ablation is a minimally invasive, quick technique with the most commonly used method delivering bipolar radiofrequency to ablate the endometrium (NovaSure®) For the majority of women, bleeding stops following treatment. The procedure is well tolerated in an ambulatory setting.

Post-ablation women must be advised to avoid pregnancy with the need to use effective contraception if required.

Treatment of structural abnormalities

Polyps, some submucosal fibroids, intrauterine adhesions and septae can be removed hysteroscopically using a normal saline solution distension medium and a morcellator (Truclear or MyoSure®).[5] The majority of cases using these minimally invasive techniques can be performed quickly and easily in an ambulatory setting with only a small number of women requiring a general anaesthetic.

Uterine artery embolisation

Uterine artery embolisation (UAE) is an effective method of treating symptomatic fibroids. It involves the placement of an angiographic catheter through the femoral or radial artery into the uterine arteries. Embolic particles are injected through the uterine artery, blocking blood flow at the arteriolar level. This produces ischaemic injury to the fibroids, causing necrosis and shrinkage, whilst allowing the surrounding normal myometrium to recover.[6]

Myomectomy

Intramural fibroids are usually removed by hysterectomy, open or laparoscopic dependent on their size. In cases where the patient wishes to preserve her fertility, a laparoscopic or open myomectomy is offered, the route dependent primarily on the size and location of the fibroids. Women undergoing this procedure need to be counselled about the rare possibility of hysterectomy if there is uncontrollable haemorrhage.

Hysterectomy

If other treatment options fail or are contraindicated, then hysterectomy may be indicated. Potential routes include a vaginal hysterectomy, laparoscopically assisted vaginal hysterectomy, total laparoscopic hysterectomy or an open hysterectomy. The route of choice depends on the suitability of the patient and experience of the surgeon.

Summary

HMB is a common, but time limited condition. Many women experience HMB during the perimenopause, and treatment is often required, but once menopause is reached, menstruation ceases. Many women don't realise that HMB is a treatable medical condition with several medical and surgical treatment options available. These include non-hormonal, hormonal and minimally invasive surgical options with hysterectomy being a last resort. Awareness should be raised to encourage women to ask for help. The Wear White Again website: www.wearwhiteagain.co.uk is a useful resource for patients and healthcare professionals looking for more information and/or support on HMB.

Heavy Menstrual Bleeding management during the COVID pandemic[7]

- Initial management should be by remote communication.
- History taking should assess the severity of the symptoms, the possibility of anaemia and the likely cause.
- To reduce the need for face to face interaction, consider the use of oral medications initially in preference to intrauterine hormonal devices.
- If patients are asymptomatic of anaemia or have possible mild anaemia NICE recommended medical treatment should be prescribed after exclusion of contraindications.
- Women should be referred as an **emergency** to secondary care for further management if there are symptoms of severe anaemia or haemodynamic compromise.
- Women should be seen in secondary care **within 30 days** if their symptoms are resistant to NICE recommended oral treatments and are considered unmanageable by the woman or are associated with significant risk factors for endometrial disease (atypical hyperplasia or cancer) e.g. morbid obesity (BMI >/= 40), obesity (BMI >/= 35) in women over 40 years of age, Lynch syndrome or are associated with significant anaemia.
- Women can be seen in secondary care **beyond 30 days** if ongoing HMB that has been resistant to NICE recommended oral treatments is considered manageable by the woman and significant anaemia is not suspected.
- If access to hysteroscopy is limited, then a blind endometrial biopsy should be taken to exclude endometrial cancer and endometrial hyperplasia.
- Endometrial hyperplasia and cancer should be managed according to local protocols and national guidance.

Wear White Again is a Hologic campaign. www.wearwhiteagain.co.uk

__Paula Briggs__ had attended advisory boards, received honoraria and been supported to attend conferences for Gedeon Richter, Bayer and Hologic. __Lucy Coyne__ has received honoraria from Gedeon Richter.

References

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