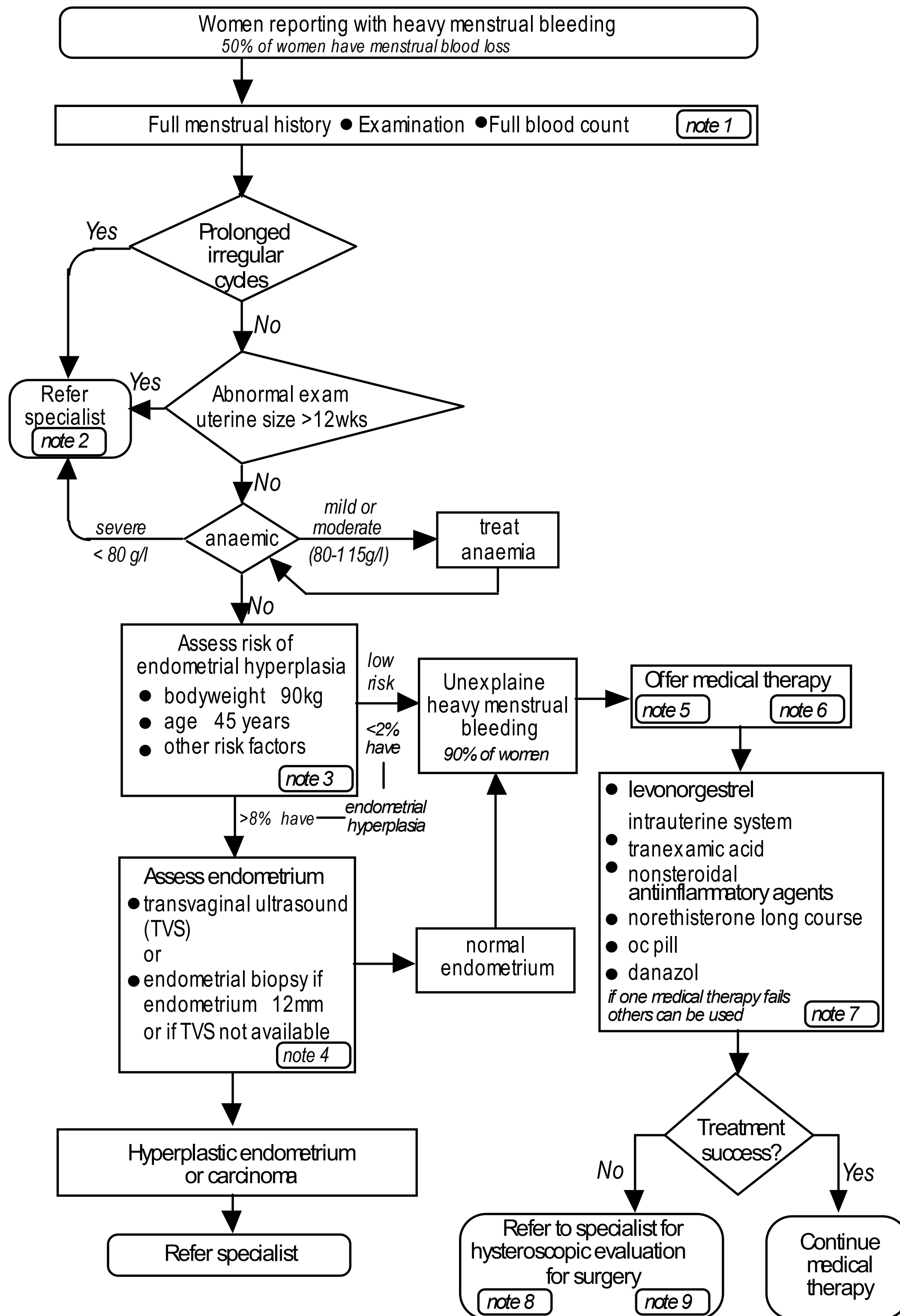
MAY 1998



note 1

- **In women <20 years old pelvic examination is unlikely to contribute to management of heavy bleeding (C) and the likelihood of pathology is small (C)**
- **Increased likelihood (70%) of heavy menstrual blood loss >80mls/cycle if Hb <120g/l (A)**
- **Consider pictorial blood loss assessment charts (appendix 6.5) for women with normal Hb (A)**

[Levels of Evidence *synopsis*]

note 2

- **The following women are recommended to see a specialist at the initial consultation because of increased likelihood of pathology*:**
  - Women with erratic menstrual cycles (regardless of loss) (B)
  - Women with an abnormal pelvic examination (confirmed by transvaginal ultrasound if possible) (C)
  - Perimenopausal women with less frequent cycles but normal blood loss do not require referral (C)
  - Women with severe anemia (C)

- **It is estimated that approximately 15% of all women with HMB will require specialist referral at the initial consultation**

*** It is beyond the scope of this guidance to provide recommendations for management in these instances**

[Levels of Evidence *synopsis*]

note 3

Risk of Endometrial Hyperplasia or Carcinoma in women with heavy menstrual bleeding:

all women	4.9%
<45yo and <90kg	2.3%
≥90kg	13%
≥45 years	8%

Other risk factors for endometrial hyperplasia: (B)

- Infertility + nulliparity
- exposure to unopposed endogenous or exogenous estrogen/tamoxifen
- family history of endometrial & colonic cancer

(C)

Endometrial hyperplasia with atypia may progress (if untreated) to endometrial carcinoma in 20-75% of cases over a 13 year period (B)

It is estimated that 20% of women with regular HMB will require endometrial assessment because of increased risk factors

[Levels of Evidence *synopsis*]

note 4

Assessment of the endometrium:

- **transvaginal ultrasound is recommended as first option for endometrial assessment but if not possible then an endometrial sample should be taken (A)**
- **if endometrial thickness on transvaginal ultrasound ≥12mm then an endometrial sample should be taken (A)**
- **consider specialist referral if abnormal transvaginal ultrasound suggestive of submucous fibroids (B)**
- **fifty percent of women ≥90kg, who have an endometrial thickness ≥12mm on TVS, have endometrial hyperplasia (A)**
- **less than 1% of women≥90kg, who have an endometrial thickness <12mm have endometrial hyperplasia (A)**
- **the number of endometrial samples needed to detect 1 case of endometrial hyperplasia overall is 23. In women ^{3}90kg the number needed to detect 1 case is 8 (B)**

[Levels of Evidence *synopsis*]

note 5

COMPARATIVE TABLE OF MEDICAL THERAPY FOR THE TREATMENT OF HEAVY MENSTRUAL BLEEDING

Drug	Mean reduction in blood loss (%)	Women benefiting -proportion with MBL <80ml/cycle (%)
Levonorgestrel IUS	94%	100%
Oral progesterone (days 5-25)*	87%	86%
Tranexamic acid	47%	56%
NSAIDs	29%	51%
OC pill	43%	50%
Danazol	50%	76%
Oral progesterone (luteal phase)	-4%	18%

* based on only one randomised controlled trial

[Levels of Evidence *synopsis*]

note 5

COMPARATIVE TABLE OF MEDICAL THERAPY FOR THE TREATMENT OF HEAVY MENSTRUAL BLEEDING		
Drug	Specific benefits	Adverse benefits
Levonorgestrel IUS	contraception no requirement to take tablets	menstrual cramps expulsion of system (5%) intermenstrual bleeding (27%)
Oral progesterone (days 5-25)*	cycle regularity	bloating, mood swings, PMS
Tranexamic acid	none	nausea diarrhoea
NSAIDs	relief of dysmenorrhoea and headaches	nausea diarrhoea headache
OC pill	contraception relief of dysmenorrhoea and PMS	nausea, breast tenderness headache
Danazol	none	weight gain, acne
Oral progesterone (luteal phase)	cycle regularity	hot flushes, bloating, mood swings, PMS

[Levels of Evidence *synopsis*]

note 6

The choice of medical therapy will be dependent on individual patient requirements

For example :

Does the patient require contraception ?

Consider: LNG-IUS
OC pill

Does the patient have painful menstruation ?

Consider: LNG IUS
NSAIDs
OC pill

Is the patient unable to tolerate hormone treatments ?

Consider: NSAIDs
Tranexamic A
LNG-IUS

Is the patient trying to conceive?

Consider: NSAIDs
Tranexamic A

- See decision analysis (Appendix 6.4)
- Some women who have completed their family may decline medical therapy and choose surgery as a first option

(A)

[Levels of Evidence *synopsis*]

note 7

MEDICAL THERAPY *	Ranking according to decision analysis** (A)
Levonorgestrel intra-uterine system	1
Tranexamic acid	2
Non steroidal antiinflammatory drugs	2
Oral contraceptive pill	3
Norethisterone (D5-25 15mg daily)	3
Danazol	4

* NB: more than one therapy can be considered

** based on efficacy, side effect profile and acceptability to women over 12 months (Lethaby et al, 1998)

(see appendix 6.5 for full description)

[Levels of Evidence synopsis]

note 8

If Medical Therapy Fails*:

- women who have no improvement in menstrual blood loss with medical therapy should have a TVS and be referred to a specialist for hysteroscopy as submucous fibroids may be present (B)

Surgical options (A)

Endometrial ablation	or Hysterectomy
• shorter operating time	• greater satisfaction
• fewer complications	• improved quality of life
• faster rates of recovery	• greater improvement symptoms
• less need for analgesia	• ease in taking replacement
• decreased cost of procedure	
• requirement for repeat	

(A)

No difference in mood states, mental health or sexual interest between ablation and hysterectomy (A)

[Levels of Evidence *synopsis*]

note 9

Surgical Options

- Endometrial destruction
  - laser
  - diathermy (heat)
  - balloon (heat)

- Hysterectomy
  - vaginal
  - abdominal
  - laparoscopic

[Levels of Evidence *synopsis*]