PRIMARY CARE
WOMEN'S HEALTH FORUM

TOP TIPS for management of women presenting with heavy menstrual bleeding (HMB) in primary care

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This resource has been produced by PCWHF consensus. Remember that these are guidelines and to please use your clinical judgement on a case-by-case basis.

1. Do not quantify, but ask how it affects her

HMB affects a woman's physical, psychological and social health and wellbeing. Any intervention for HMB should aim to improve the woman's quality of life rather than focusing on blood loss.[1]

HMB is a common concern but there remains a stigma and unappreciation of the impact on a woman's life, and it is under-reported to healthcare providers. One in five women suffers with HMB[1], 43% of women have taken time off work due to their heavy period, and 50% of affected women have never been to see a GP about their condition.[2]

So when a woman complains of heavy periods then it matters to her and it needs actioning.

It is the impact on her quality of life that matters; the amount of blood loss does not need to be quantified.

2. Clarify the bleeding pattern & pressure symptoms

It is essential to clarify the history of the woman's problem to decide on examination and investigation requirements. In addition to her complaint of heavy menstrual bleeding, it is important to determine the pattern of bleeding and whether there are any pressure symptoms suggestive of large fibroids or pain suggesting adenomyosis.

Note: women often complain of short cycle length rather than inter-menstrual bleeding (bleeding at a point of the cycle other than during the normal period) or erratic bleeding, which are symptoms of endometrial pathology.

3. Risk factors/When to worry

HMB is common and is usually a result of dysfunctional uterine bleeding but may be caused by endometrial hyperplasia and endometrial cancer. Risk factors include:

- Increasing age
- Obesity (BMI>35)

Plus any condition causing oestrogen excess/unopposed oestrogen including:

- Inadvertent use of oestrogen-only HRT
- Polycystic ovary syndrome with chronic anovulation
- Insulin resistance
- Tamoxifen use.

4. When to examine

Abdominal examination may reveal large fibroids and is usually expected by women when complaining of HMB. Speculum and pelvic examination should be considered if there are additional relevant symptoms of pelvic pressure, tenderness, or of post-coital bleeding, but may not be necessary if the symptom is of HMB only.

5. Basic laboratory investigations recommended

- Full blood count (FBC) for all
- Testing for coagulation disorders only if HMB since menarche or personal/FH of coagulation disorder
- Consider sexual health screening
- Cytology if due.

No indication for testing thyroid function, hormone levels, prolactin or ferritin without the presence of additional symptoms.

6. When to scan

Ultrasound (US) scans are overused, do not change management, and often lead to further unnecessary investigations. Consider what findings would be expected from an ultrasound scan to influence management.

If a scan is indicated, remember to request a trans-vaginal US scan in addition to a pelvic scan to allow improved imaging of endometrium and ovaries – and warn the woman to expect an 'internal' probe.

Consider:

- US scan if she has pressure symptoms, dyspareunia, or anything to suggest uterine enlargement
- US scan if unable to assess uterine size if obese or difficult examination
- Direct endometrial visualisation by hysteroscopy if she has persistent intermenstrual bleeding or endometrial risk factors
- No investigations required if none of above apply.

This guidance was compiled by the PCWHF and was correct at the time of going to press. The PCWHF will undertake annual reviews of this guidance to ensure it remains in line with best practice. The next review is due in August 2021. The guidance is for use by healthcare professionals only. The guidance has been compiled by a working group for The Primary Care Women's Health Forum and views expressed do not necessarily represent those of individuals or partners. Declaration of interests are available at www.abpi.org.uk/our-ethics/disclosure-uk/. For further information, please contact enquiries@pcwhf.co.uk

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7. When to hysteroscope/Refer

Refer for hysteroscopy or expert opinion if endometrial assessment required in women presenting with a history of persistent intermenstrual bleeding, fibroid or polyp suggested on US scan, endometrial risk factors, failed medical or surgical management.

List any identified risk factors on the referral letter to help the hospital team triage the referral directly into the hysteroscopy clinic if required and possible.

Hysteroscopy is usually performed in the outpatient setting with women awake. It is a short procedure which is usually tolerated very well. Local anaesthetic is used if required or requested. Most diagnostic hysteroscopes used allow endometrial samples to be taken directly from endometrial pathology or by a global suction using a pipelle.

It is also possible to progress to treatment procedures in the outpatient setting when required to insert LNG-IUS, perform morcellation of endometrial polyps and small fibroids or endometrial ablation.

8. Treat on that day/Don't let the woman leave your room without

- Treat with tranexamic acid +/- analgesia at first visit, including while waiting for further investigations or referral.
- Tranexamic acid is well tolerated but requires a 1-1.5g tds dose to be effective.
- Myth buster: Tranexamic acid does not increase thrombotic risk or cause peptic ulceration.

9. Pathway of management – remember you can't go back following an irreversible procedure

Treatments depend on investigation findings, imminent fertility requirements, risk assessment and informed patient choice.

A useful resource is the NICE-endorsed 'Shared decision making aid for heavy menstrual bleeding'. Heavy periods: what are my options?[3]

For HMB where no abnormal pathology is found or considered likely, NICE recommends the use of levonorgestrel-releasing intrauterine system (LNG-IUS) as first line treatment. This can be offered in primary care where possible.

LNG-IUS

PROS:

- 80-90% reduction in bleeding at 12 months[1]
- Contraceptive & can be used as part of HRT if needed
- Reversible
- Licensed for use for HMB
- Long lasting
- Protection against endometrial hyperplasia (off – license).

CONS:

- Minor procedure for insertion
- Unpredictable bleeding – usually improves with time
- Hormonal side effects – but these usually subside after a few months
- Insertion risks; perforation, infection.

ALTERNATIVE MEDICAL OPTIONS INCLUDE:

- Hormonal; combined hormonal contraception, long-cycle progestogens (consider use of medroxyprogesterone acetate rather than norethisterone because of thrombotic potential of NET).
- Non-hormonal: tranexamic acid, any NSAID.

10. NovaSure® endometrial ablation

NICE recommends second-generation endometrial ablation techniques. NovaSure® delivers radio-frequency energy to ablate the endometrium and reduce or stop endometrial regrowth. Further information about the procedure for clinicians and patients is available on the Wear White Again website. https://www.wearwhiteagain.co.uk

OPTION IF:

- LNG-IUS not acceptable or effective
- Patient choice
- Family complete.

PROS:

- Minimally invasive surgery, easy to perform in the outpatient setting with women awake using local anaesthetic and analgesia
- No pre-treatment required
- Can be performed at any time of the menstrual cycle including during menstruation
- Procedure takes an average 60-90 secs with 15 minutes set up time
- Option for general anaesthetic day case procedure if requested
- Good outcome with 97% not requiring further surgical treatment within 5 years[4]
- Well tolerated with women returning to daily activities within 24 hours.

CONS:

- Risks of procedure include uterine perforation and post-procedure infection
- Permanent procedure that cannot be reversed
- Reliable contraception still required after ablation & IUCD difficult/impossible to fit unless included as part of the procedure
- Combined HRT preparations required for menopausal symptoms
- If unsuccessful, more invasive interventions required.

11. Hysterectomy

Hysterectomy for treatment of HMB should not be offered as a first line and was included in the list of inappropriate interventions produced by the Evidence-Based Intervention Programme published by NHS England[5]. The primary goals of the Evidence-Based Interventions programme are to avoid needless harm to patients and free up scarce professional time for performing other interventions.

HYSTERECTOMY

PROS:

- Amenorrhoea guaranteed
- High satisfaction rates.

CONS:

- Major surgery with associated risks
- Requires general anaesthetic
- Post-operative infection/DVT
- Can cause premature menopause
- 4-8 weeks post-op recovery time and delayed return to activities of daily living
- Long term possible pelvic pain, continence problems, sexual problems, psychological impact
- Death: mortality rate 0.4-1.1/1000.[6]

REFERENCES

1 nice.org.uk/guidance/ng88

2 Data on file: MISC-05658-GBR-EN Rev 001

3 http://www.wisdom.wales.nhs.uk/sitesplus/documents/1183/HMB_Shared_Decision_Making_Aid_Updated_version_Mar-2020.pdf

4 J Reprod Med 2007 Jun:52(6);467-72

5 https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

6 BJOG Vol 111 Issue 7, Juky 2004 688-694