Heavy Menstrual Bleeding (HMB) - Primary Care

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Please see pathway for primary care management and identification of red flags. The following text applies to non-red flag patients

Investigation of treatment depends on whether an enlarged uterus is found on examination

Uterus not enlarged

- Perform FBC, smear if overdue
- Treatment should be pharmacological in the first instance in the following order:

1. Levonorgestrel-releasing intrauterine system – provided long-term (at least 12 months) use is anticipated

2. Tranexamic acid (consider simultaneous use with levonorgestrel-releasing intrauterine system), non-steroidal anti-inflammatory drugs (which can be used long term), or combined oral contraceptives

3. Norethisterone from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens

- If bleeding is very heavy ('flooding'), consider stopping it abruptly by giving tranexamic acid/oral norethisterone. Inform the woman that a withdrawal bleed will occur two to four days after stopping treatment.
- NB: the use of norethisterone for this indication outside of the standard licensed dose is outside of its marketing authorisation (product licence) in the UK.
- If hormonal treatments are not acceptable to the woman, then either tranexamic acid or NSAIDs can be used.As pain may be due to the passage of clots tranexamic acid can be used in combination.
- Monitor and review effectiveness, move to second or third line treatment in accordance with pathway if necessary, consider adding in NSAID and/or tranexamic acid or COC
- If symptoms don't improve after above treatments refer for USS
- Refer if abnormality on USS as appropriate.
- Consider referral to gynaecology if:

    - heavy bleeding persists despite adequate trials of pharmaceutical treatment
    - the woman wishes to consider surgery
    - the woman has iron deficiency anaemia that has failed to respond to treatment

Enlarged uterus

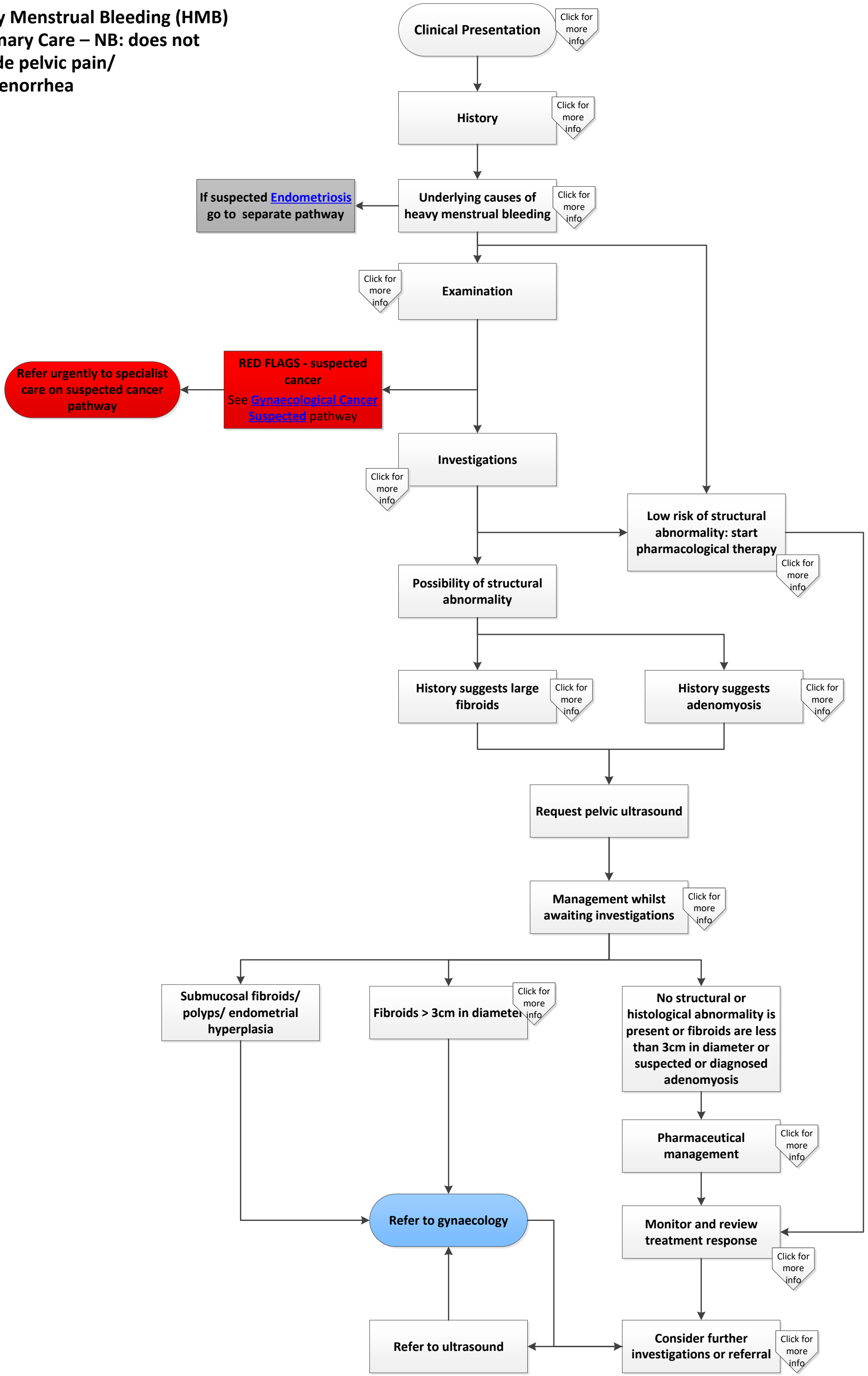
- Investigations:
    - FBC and smear as above
    - USS if uterus palpable abdominally or VE reveals pelvic mass of uncertain origin
- Whilst waiting for investigations tranexamic acid or NSAIDs can be tried
- If USS normal manage as per non-enlarged uterus
- If red flag on USS refer urgently/2WW pathway as appropriate
- In the case of fibroids >3cm, consider referring to secondary care when:
    - fibroids are palpable abdominally
    - intra-cavity fibroids are present
    - uterine length as measured by ultrasound or hysteroscopy is greater than 12cm
- In the case of fibroids <3cm (and are not causing distortion of the interuterine cavity), consider trial of pharmacological therapy in the first instance, as per non-enlarged uterus.
- Refer to a specialist if symptoms persist as per non-enlarged uterus as above

Referral letter should include the following:

- Nature of the bleeding,
- Associated symptoms, such as intermenstrual bleeding, post-coital bleeding, pelvic pain, pressure symptoms, bladder and bowel symptoms
- Impact on quality of life
- Conservative management trialled so far
- Current contraception
- Smear History: regular, irregular, including date and result of last smear

- Details of previous colposcopy, any treatments such as LLETZ/cold coagulation/laser
- Relevant past medical/surgical/obstetric history (including haematological/ coagulation disorders)
- Current regular medication
- Pelvic/ abdominal examination findings
- Speculum findings (e.g. normal, ectropion, cervicitis, cervical polyp)
- Investigation results

Heavy Menstrual Bleeding (HMB) – Primary Care – NB: does not include pelvic pain/ dysmenorrhea



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Clinical Presentation

Defined as excessive menstrual blood loss which interferes with a woman's physical, emotional, social, and/or material quality of life (QoL). Difficulties exist in defining 'normal' menstrual blood loss. Clinicians should take into account the range and natural variability in menstrual cycles and blood loss when diagnosing HMB. Interventions should focus on improving symptoms and QoL. In 40-60% of cases, no underlying cause is found. Patients may complain of passing large clots, feeling light headed, other symptoms of anaemia, quality of life impact. Measuring menstrual blood loss either directly or indirectly is not routinely recommended for HMB.

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History

This should cover the nature of the bleeding, details of menstrual cycle (e.g. association with intermenstrual bleeding or pain), related symptoms that might suggest structural or histological abnormality, impact on quality of life and other factors that may determine treatment options (such as the presence of comorbidities).

Predisposing factors for endometrial neoplasia:

- Obesity
- PCOS
- Unopposed oestrogen
- Age over 45
- Nulliparity
- Late menopause
- Tamoxifen
- Family history of breast, colon, endometrial cancer. These factors are particularly important if HMB of rapid onset or associated with IMB or prolonged bleeding. If endometrial neoplasia suspected patients should be referred on 2WW pathway.

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Underlying causes of heavy menstrual bleeding

These include:

- Uterine and ovarian pathologies, such as:
  - fibroids
  - endometriosis (see below and separate pathway)
  - adenomyosis
  - polyps
  - endometrial hyperplasia
  - endometrial cancer
  - polycystic ovary syndrome
- Systemic diseases, such as coagulation disorders, hypothyroidism, liver or kidney disease
- Iatrogenic causes, such as anticoagulant treatment, chemotherapy, intrauterine contraceptive device
- A structural abnormality is suggested by associated symptoms, such as intermenstrual or prolonged menstrual bleeding, pelvic pain, pressure symptoms

NB: reasons to suspect endometriosis (if suspected see separate pathway):

- Chronic pelvic pain
- Painful Periods (Dysmenorrhoea) with or without heavy menstrual bleeding
- Deep dyspareunia
- Dyschezia (pain on opening the bowels during and/or just preceding a menstrual period)
- Proctalgia fugax (A severe shooting pain in the ano-rectum that is most noticed at the time of opening bowels)
- Cyclical bladder or bowel symptoms
- Subfertility associated with the above symptoms

Examination:
Abdominal masses
Tender nodularity in the vaginal fornices

- Visible vaginal endometriosis

In HMB without other related symptoms consider pharmacological treatment without carrying out a physical examination (unless the treatment chosen is levonorgestrel-releasing intrauterine system).

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Examination

A physical examination should be performed if the history suggests the presence of structural or histological abnormality.

Structural abnormality is suggested by:

- Intermenstrual bleeding
- Pelvic pain
- Pressure symptoms
- Lower abdominal distension

Examination should also be carried out before:

- Levonorgestrel-releasing intrauterine system fitting
- Investigations for structural or histological abnormalities

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Start pharmacological therapy when there is low risk of structural abnormality

In HMB without other related symptoms consider pharmacological treatment without carrying out a physical examination (unless the treatment chosen is levonorgestrel-releasing intrauterine system).

Non-hormonal treatment options:

- Tranexamic acid
- NSAIDs (non-steroidal anti-inflammatory drugs)

Hormonal treatment options:

- Levonorgestrel-releasing intrauterine system − provided long-term (at least 12 months) use is anticipated
- Combined hormonal contraception
- Cyclical oral progestogens

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Investigations

Laboratory:

- Take a full blood count in all women with heavy menstrual bleeding
- Coagulation is only indicated when women have had HMB since their periods started and have a personal or family history suggesting a coagulation disorder
- Thyroid function is only indicated when other symptoms of disease exist

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The history and examination suggest structured abnormality:

- Large fibroids are more likely if
  - An abdominally palpable uterus
  - A history or examination suggests a pelvic mass

  or
  - When examination is inconclusive or difficult, for example in women who are obese
- Submucosal fibroids, polyps or endometrial hyperplasia are more likely if:
  - Persistent irregular bleeding i.e. no pattern to bleeding, not irregular cycle
  - Infrequent heavy bleeding +/- prolonged bleeding in women who are obese or have polycystic ovary syndrome often associated with IMB
  - Tamoxifen use
  - Failure of treatment for HMB

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The history and examination is suggestive adenomyosis because they have:

- Significant dysmenorrhoea (period pain) or
- A bulky, tender uterus on examination

If a woman declines transvaginal ultrasound or it is not suitable for her, consider transabdominal ultrasound or MRI, explaining the limitations of these techniques

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Management whilst awaiting investigations

If pharmaceutical treatment is required while investigations and definitive treatment are being organised, either tranexamic acid or non-steroidal anti-inflammatory drugs (NSAIDs) should be considered. Advise women these treatments are for symptomatic relief and will not affect the underlying cause.

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Pharmaceutical management

First line:

1. Levonorgestrel-releasing intrauterine system − provided long-term (at least 12 months) use is anticipated

If a woman with HMB declines an LNG-IUS or it is not suitable, consider the following pharmacological treatments:

Non-hormonal:

- Tranexamic acid
- NSAIDs (non-steroidal anti-inflammatory drugs)

Hormonal:

- Combined hormonal contraception
- Cyclical oral progestogens

If bleeding is very heavy ('flooding'), consider stopping it abruptly by giving tranexamic acid/oral norethisterone. Inform the woman that a withdrawal bleed will occur two to four days after stopping treatment.

NB: the use of norethisterone for this indication outside of the standard licensed dose is outside of its marketing authorisation (product licence) in the UK.

If hormonal treatments are not acceptable to the woman, then either tranexamic acid and/or NSAIDs can be used.

As pain may be due to the passage of clots tranexamic acid can be used in combination.

NB: Pain may be due to passage of clots and helped by tranexamic acid and/or NSAIDs

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Monitor and review treatment response

If initial treatment is ineffective (and treatment was complied with):

- Consider a second pharmaceutical treatment rather than immediate referral to surgery
- Consider adding on an additional drug, e.g. a non-steroidal anti-inflammatory drug which can be combined with tranexamic acid; or a combined oral contraceptive

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Consider further investigations or referral

If treatment is unsuccessful, the woman declines pharmacological treatment, or symptoms are severe, consider referral for:

- Investigations to diagnose the cause of HMB if no previous investigation
- The woman has iron deficiency anemia which has failed to respond to treatment, and other causes have been excluded.
- Specialist opinion regarding surgical options:
  - second-generation endometrial ablation
  - uterine artery embolisation
  - hysterectomy
  - Hysteroscopic removal of submucosal fibroids
- NB: referral is particularly recommended in women aged 45 and older with treatment failure or ineffective treatment

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For women with fibroids of 3 cm or more in diameter:

Consider specialist referral for additional investigations and consideration of treatment options.
If pharmacological treatment is needed while the woman is awaiting treatment or referral appointment, offer tranexamic acid and/or an NSAID.

Secondary care treatment will depend on the size, location, and number of fibroids as well as the severity of symptoms. Treatment options include:

1.Non-hormonal treatment: NSAIDs (off-label use) or tranexamic acid.
2.Hormonal treatment: LNG-IUS (off-label use for some brands), CHC, or cyclical oral progestogens. Ulipristal acetate (may be considered for some premenopausal women in line with advice issued by the Medicines and Healthcare products Regulatory Agency (MHRA).
3.Uterine artery embolization.
4.Surgical treatment: myomectomy, hysterectomy, or second-generation endometrial ablation.