Investigation and Management of Heavy Menstrual Bleeding Guideline

Key Document code:	WAHT-TP-027	
Key Documents Owner:	Mr Jonathan Chester	Locum Consultant Obstetrician and Gynaecologist
Approved by:	Gynaecology Quality Governance Committee	
Date of Approval:	14th December 2021	
Date of review: **This is the most current version and should be used until a revised document is in place**	20th February 2025	

Key Amendments

Date	Amendment	Approved by
13th August 2021	New document approved	Gynaecology Governance Committee
29th December 2023	Document extended for 6 months whilst under review	Alex Blackwell
20th August 2024	Document extended for 6 months whilst under review	Alex Blackwell

Introduction

Heavy menstrual bleeding (menorrhagia) is a common condition affecting around 1 in 5 women. Untreated it can have a huge impact upon a woman's quality of life, leading to embarrassment, stress and worry, time off work and social isolation. Heavy bleeding can cause anaemia, leading to physical impairment. A wide range of medical and surgical treatments are available, which when used appropriately can make a big difference to women.

1. Identification and Assessment of Heavy Menstrual Bleeding

1.1. Heavy menstrual bleeding (HMB) is a subjective condition, which is self reported. There is no objective measure of blood loss.

1.2. Women who report HMB should have their concerns taken seriously.

1.3. Women should have a thorough and appropriate history taken.

1.4. Women should be asked about:

- Severity of their bleeding
- Regularity of their cycle
- Dysmenorrhoea
- Intermenstrual or post-coital bleeding
- Related symptoms
- Their plans for their family

- Failed or non-tolerated treatments

1.5. When taking a history, the clinician should consider the common causes of HMB to try and guide their investigation and treatment. These include:

- Polyps
- Adenomyosis
- Leiomyomas (fibroids)
- Malignancy
- Coagulopathies
- Ovulatory dysfunction
- Iatrogenic
- Endometrial causes
- No cause.

1.6. Women should be asked for their goals/aims for treatment and these should be central to the discussion

1.7. Women with a history of HMB, seen in secondary care should undergo a complete physical examination.

2. Investigations

2.1. Blood tests

2.1.1. A full blood count should be carried out in all women with HMB.

2.1.2. If a woman has regular HMB without other symptoms then treatment can be initiated without further investigation. This can be done in primary care. (NICE 2018)

2.1.3. Coagulation screens should only be carried out where symptoms suggest coagulopathies – either bleeding since menarche or a personal/family history suggestive of coagulopathies (NICE 2018)

2.1.4. Other routine blood tests are not routinely required unless the history indicates otherwise.

2.2. Biopsy

2.2.1. Pipelle biopsy should be carried out for all women over the age of 40 or those refractory to treatment.

2.2.2. This should be done in the outpatient setting where possible.

2.2.3. Biopsy is not routinely required in those less than 40, but should be considered where there are risks factors for endometrial hyperplasia or cancer (e.g. high BMI, smoker, presence of diabetes) and bleeding is refractory or severe.

2.3. Hysteroscopy

2.3.1. Where endometrial pathology or polyps are suspected the woman should be referred for outpatient hysteroscopy.

2.3.2. Where outpatient hysteroscopy is unacceptable or unsuccessful, hysteroscopy under general anaesthetic or pelvic ultrasound should be considered.(NICE 2018)

2.3.3. Biopsy at the time of hysteroscopy should be taken to rule out endometrial pathology. (NICE 2018)

2.3.4. Hysteroscopy should be offered to women with submucosal fibroids, but only if they are large (>3cm) or there is no improvement with hormonal treatment options.

2.4. Ultrasound

2.4.1. Ultrasound scan should be performed where the following conditions are suspected:

2.4.1.1. Fibroids

2.4.1.2. Adenomyosis

2.4.1.3. Endometriosis

2.4.2. Ultrasound imaging should preferably be transvaginal.

3. Management of HMB

3.1. General principles

3.1.1. Management options should be clearly discussed with women, and this discussion should be appropriately documented.

3.1.2. Management options discussed should take into account suspected pathology, women's preferences, women's plans for future pregnancy and a woman's age.

3.1.3. Discussion should be individualised, with benefits and risks of each treatment option discussed.

3.1.4. In the absence of a polyp, women should be offered medical management as the first line treatment.

3.1.5. Surgical options should be used where medical options are unsuccessful or not acceptable.

3.2. Medical options

3.2.1. Medical treatment should be started as soon as is possible.

3.2.2. The following treatments should be considered:

3.2.2.1. Tranexamic acid and/or NSAIDs

3.2.2.1.1. *These provide a good non-contraceptive option if the woman does not wish to use hormonal treatment options.*

3.2.2.1.2. *Treatment can be initiated whilst investigation or referral is ongoing.*

3.2.2.1.3. *The addition of NSAIDs can be helpful for co-existing dysmenorrhoea.*

3.2.2.1.4. *These may take up to three cycles to be effective.*

3.2.2.1.5. *Can be continued for as long as is beneficial to the patient.*

3.2.2.2. Combined oral contraceptive pill

3.2.2.3. Progesterone only contraception – including mini-pill, depot Provera, Implanon.

3.2.2.4. Levonorgestrel intrauterine system

3.2.2.4.1. *This should be considered as a first line treatment (NICE 2018)*

3.2.2.4.2. *Women should be advised about the contraceptive benefits of an intrauterine system.*

3.2.2.4.3. *Women should be advised that at least 12 months treatment is needed for the full effect to be ascertained.*

3.2.2.4.4. *Women should be advised that there is the need to persevere for a minimum of six cycles,*

3.2.3. Where large fibroids are present (>3cm) *Ulipristal acetate* (UPA) can be considered for intermittent treatment, where: (NICE 2018/MHRA 2020)

3.2.3.1. Symptoms are severe AND

3.2.3.2. Surgery or uterine artery embolization are not suitable**,** declined or failed.

3.2.4. UPA should not be used routinely for management of fibroids prior to surgery. (MHRA 2020)

3.2.5. Women should be appropriately counselled about the risks of severe liver injury with UPA and the symptoms to look out for. (NICE 2018/MHRA 2020)

3.2.6. Liver function should be checked prior to initiation, monthly for the first two courses and once before each new treatment course. (NICE 2018/MHRA 2020)

3.2.7. UPA is contraindicated in those with a history of liver dysfunction.

3.2.8. UPA should be stopped immediately if signs of liver impairment are seen.

3.2.9. UPA 5mg can be given for up to four courses. (NICE 2018/MHRA 2020)

3.3. Surgical Options

3.3.1. Where medical options have failed, or are not acceptable then surgical options should be considered.

3.3.2. These should include:

3.3.2.1. Second generation endometrial ablation

3.3.2.1.1. This should only be offered where a women's family is complete.

3.3.2.1.2. Major structural abnormality, large fibroids (>3cm) or a large uterine cavity (>10cm) are contraindications to endometrial ablation

3.3.2.1.3. This should be performed under local anaesthetic in the outpatient setting where possible.

3.3.2.1.4. Hysteroscopy and biopsy should be performed prior endometrial ablation.

3.3.2.1.5. Where the endometrial appearance is normal, histological confirmation of normal endometrium is not required prior to ablation.

3.3.2.1.6. Women should be informed that endometrial ablation is not a contraceptive method and women should be offered appropriate contraception.

3.3.2.2. Uterine artery embolization

3.3.2.2.1. This method should be offered to women with large fibroids, who wish to preserve their fertility.

3.3.2.3. Hysterectomy

3.3.2.3.1. Hysterectomy should only be considered for HMB alone where: (CCG guidance)

3.3.2.3.1.1. A 6 month trial of the Mirena coil has failed or is medically inappropriate.

3.3.2.3.1.2. At least two other medical treatments have failed or are medically inappropriate.

3.3.2.3.1.3. Endometrial ablation has failed or is medically inappropriate.

3.3.2.3.1.4. Myomectomy has been considered where appropriate.

3.3.2.3.1.5. All operative risks have been optimised.

3.3.2.3.2. When discussing hysterectomy with a woman – all appropriate routes (vaginal, laparoscopic, open) should be discussed.

3.3.2.3.3. Subtotal and total hysterectomy should be discussed if a women is having an open procedure.

3.3.2.3.4. Oophrectomy should be discussed with women, dependent upon their age and any other risks factors.

Monitoring Tool

This should include realistic goals, timeframes and measurable outcomes.

How will monitoring be carried out?

Who will monitor compliance with the guideline?

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.
	Proportion of women with inadequate/insufficient Pipelle biopsy results requiring hysteroscopy.	Retrospective evaluation of cases where Pipelle was carried out.	Yearly	Ambulatory gynaecology lead	Gynaecology Governance	Yearly.

References

- 1. American College of Obstetrics and Gynaecology. Abnormal Uterine Bleeding (AUB) New Standardized Terminology, Definitions, Classification. ACOG. 2014.
- 2. National Institute of Clinical Excellence. Heavy menstrual bleeding: assessment and management: NG88. NICE. 14 March 2018
- 3. Munro M, Critchley H, Broder M et al. FIGO classification system (PALM-COEIN) for causes of abnormal uterine bleeding in nongravid women of reproductive age. IJOG. 2011 (13) 3-13
- 4. Lethaby A, Hussain M, RIsworth J et al. Progesterone or progestogen-releasing intrauterine systems for heavy menstrual bleeding. Cochrane Database Syst Rev. 2015. 30:4.
- 5. Gupta J. Systematic review of meta analysis: Vaginal hysterectomy is the best minimal access method for hysterectomy. Evid Based Med. Published online: Oct 2015.

Supporting Document 1 - Equality Impact Assessment Tool

.

Appendix- 1 Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	X	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Mrs Pratibha Arya**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Mr J. Chester	**Locum Cons O&G**	**j.chester@nhs.net**
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Heavy menstrual bleeding guideline**
What is the aim, purpose and/or intended outcomes of this Activity?	Provide clear guidance for management of patients with heavy menstrual bleeding.

Who will be affected by the development & implementation of this activity?	X X ❑ ❑	Service User Patient Carers Visitors	X ❑ ❑ ❑	Staff Communities Other _____
Is this:	XReview of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	NICE Guidance NG88 – Heavy menstrual bleeding.			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Document circulated to ambulatory care consultants Document presented at Gynaecology Governance meeting.			
Summary of relevant findings				

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		X		
Disability		X		
Gender Reassignment		X		
Marriage & Civil Partnerships		X		
Pregnancy & Maternity		X		
Race including Traveling		X		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Communities				
Religion & Belief		X		
Sex		N/A		Only relevant to females.
Sexual Orientation		X		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		X		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		X		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				

When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Mr J. Chester
Date signed	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	
2.	Does the implementation of this document require additional revenue	
3.	Does the implementation of this document require additional manpower	
4.	Does the implementation of this document release any manpower costs through a change in practice	
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.