NHS
Vale of York
Clinical Commissioning Group

Referral Support Service

Gynaecology

GY11
Heavy Menstrual Bleeding (Menorrhagia and Polymenorrhagia)

Definitions

Menorrhagia: Excessive menstrual blood loss which interferes with the woman's physical, emotional, social and material quality of life and which can occur alone or in combination with other symptoms.
Polymenorrhagia: Frequent heavy bleeding, with shortening of menstrual cycle (eg < K- 5/21) for more than 3 cycles.

Most cases are due to *Dysfunctional uterine bleeding* (DUB), however, this is a diagnosis of exclusion.

Exclude Red Flag Symptoms

- Postmenopausal Bleeding (PMB) i.e. bleeding >12 months after last period over age 55
- Persistent Intermenstrual bleeding (IMB): if >45 or other risk factors for endometrial cancer (eg obesity, PCOS unopposed oestrogen**, tamoxifen**)
- Treatment failure in women aged 45 years or over
- Significant anaemia- Hb< 8- consider admission for transfusion/ urgent referral
- Suspicious USS features

General Points
History:
- Sudden change in bleeding pattern?
- Recent childbirth?
- Recent change in contraception?
- Family history/ onset of HMB from puberty- consider von Willebrand Disease.

Examination:
- Consider infection (especially if under 25 or change in partner)
- Abdominal examination/ Pelvic examination (is there pain, is there an enlarged uterus?)

Investigations:
- Bloods: FBC, TFTs.(check for vWF if onset of HBM from puberty)
- Consider USS if enlarged uterus or new change in bleeding pattern.
- Refer for hysteroscopy if any suspected polyps or thickened endometrium on USS.

How to Reduce Sudden/New onset Heavy Bleeding
Exclude pregnancy first, then consider:
1. Cyclical oral progestogens *: either noreristhisterone 5mg (one tab) 2-3 times a day for 10-21d/ cycle OR medroxyprogesterone (Provera)10mg two- three times a day*
    - **Norerithisterone** *may not be suitable for all patients (as theoretically 10-20 mg of norethisterone/day equates to an equivalent of 20-30 micrograms of ethinylestradiol*

daily and hence may carry the same VTE risks as combined oral contraceptives). The risks vs. benefits should be considered in patients depending on their underlying risk factors for thrombosis

- **Medroxyprogesterone 10mg** *is an alternative to those patients with high risk of VTE but it should be noted that it is not specifically licensed for treatment of menorrhagia.*

2. **Tranexamic acid 500mg-1g tds** reduces blood loss by up to 50%.

How to delay Periods (holiday planning):

- **If using COCP:** can omit pill free interval (guidance usually in the manufacturers leaflet)
- **No contraception:** (exclude pregnancy and thrombosis risk): **Provera (MPA) 10mg bd** or **Norethisterone 5mg tds, starting 3-4d prior to expected start of period**.

(nb! Norethisterone is an androgenic progesterone and has a slightly higher risk of endometrial hyperplasia and thrombosis, MPA is advised first line choice of progesterone).

Management of Menorrhagia

If under age 45, with no additional risk factors for endometrial hyperplasia:

- **Mirena IUS** is first line for woman with normal sized uterus on examination. A trial of at least 6m is advised.
  - Mirena can be used for fibroids upto 3cm in size (or uterus <14/40 size).
  - Cautions: previous PID, uterine anomalies on USS. See UK MEC
- Hormonal therapy Options:
  - **Combined hormonal contraceptives** - may reduce menstrual loss and regulate cycle. First line choice is **Rigevidon®** (ethinylestradiol 30micrograms and levonorgestrel 150micrograms).
  - Please refer to York/Scarborough net formulary for approved alternatives.
  - Please refer to UKMEC or SPC or BNF or for exclusion criteria
  - Oral Progesterones: **either Norethisterone or Medroxyprogesterone Acetate.**
    - used for 10- 21d, with a 7d break may reduce prolonged, heavy periods for a 3m trial.
  - The **progestogen only pill eg. desogestrel** and **Nexplanon®** may also help particularly if amenorrhoea is achieved.
  - Injected progesterone eg. **Depo Provera®**
- **Non-hormonal therapy:**
  - **Tranexamic Acid** and NSAIDs
- Oral Progesterones: **Provera(MPA) or Norethisterone** (as above).

Management of Fibroids over 3cm or distorting endometrial cavity:

- Under shared care guidance, **GnRHa** may be used to help shrink fibroids (usually considered pre-operatively).
- **Ulipristal** is a new medication licensed for reducing fibroid size- Not currently commissioned.

If above measures have failed- please advise patient of third line treatment options:

- Endometrial ablation

- Fibroid embolisation
- Hysterectomy – Please click here to view the full Hysterectomy Commissioning Statement.
- Recommend the patient decision aid tool: click here

Patient information leaflets/PDAs

Patient Decision Aid: https://medical.azureedge.net/decision-aid/heavy-periods.pdf
PILS: https://patient.info/health/periods-and-period-problems/heavy-periods-menorrhagia

References

- NICE Guideline (August 2016) Heavy Menstrual Bleeding
- https://cks.nice.org.uk/menorrhagia#!scenario
- *Fam Plann Reprod Health Care* 2012;**38**:148–149. doi:10.1136/jfprhc-2012-100345; Safer prescribing of therapeutic norethisterone for women at risk of venous thromboembolism