Assessment and management of heavy menstrual bleeding

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NICE published a new guideline on the assessment and management of heavy menstrual bleeding (NG88) in March, in response to new developments in diagnosis and treatment. This article provides a brief summary of the guidance.

Since NICE published its earlier guideline on the diagnosis and management of heavy menstrual bleeding (CG44) in 2007, improvements in diagnostic imaging have increased the detection of adenomyosis, and the use of surgery has declined with the increasing popularity of the levonorgestrel-releasing intrauterine system (LNG-IUS). These developments have prompted a revision and update of many of the recommendations made a decade ago.

The new guideline (NG88) is divided into five parts: the impact of heavy menstrual bleeding on women; history, physical examination and laboratory tests; investigations; information for women; and management. The first two are brief and little altered from the original document. Clinicians should “recognise that heavy menstrual bleeding has a major impact on a woman’s quality of life, and ensure that any intervention aims to improve this rather than focusing on blood loss”. The process of documenting symptoms, impact on quality of life and nature of the bleeding should now also include assessing how co-morbidities and previous treatments might affect current options.

Investigations
A physical examination is recommended before all investigations and before fitting an LNG-IUS. Lab tests should include a full blood count in parallel with treatment and, for women who have had heavy bleeding since the onset of their periods or a family history suggesting a bleeding disorder (such as von Willebrand disease), testing for a coagulation disorder. Women should be given information explaining heavy menstrual bleeding and the pros and cons of the various treatments and surgery, including their effect on bleeding patterns and fertility, psychological impact and complications.

Drug treatment is an option before carrying out investigations for women...
who are at low risk of fibroids, uterine cavity abnormality, histological abnormality or adenomyosis, bearing in mind the risk of cancer. The choice between hysteroscopy or ultrasound as the first-line investigation depends on the history and examination. Suspected submucosal fibroids, polyps or endometrial pathology are indications for hysteroscopy, offered on a ‘see and treat’ outpatient basis with appropriate counselling. Women who prefer general or regional anaesthesia may be offered inpatient treatment. Biopsy should be considered for women at high risk of having endometrial pathology. Pelvic ultrasound is an alternative for women who decline hysteroscopy and for those with pelvic mass or when examination is difficult. Women with suspected adenomyosis should be offered transvaginal ultrasound.

Management
The choice of how to manage heavy menstrual bleeding should take into account the woman’s preferences, co-morbidities, the presence of fibroids, polyps, endometrial pathology or adenomyosis, and symptoms such as pressure and pain. The treatment of first choice for women with no identified pathology, fibroids ≤3cm in diameter or suspected or diagnosed adenomyosis is an LNG-IUS (though not all are licensed for this indication). If this is not suitable, the non-hormonal options are tranexamic acid and (though unlicensed) NSAIDs; hormonal alternatives are combined oral contraceptives and cyclic oral progestogens (some not licensed). If drug treatment is not successful or unsuitable, hysterectomy and second-generation endometrial ablation are further options.

Referral for additional investigation should be considered for women with fibroids ≥3cm. Tranexamic acid or NSAIDs may be offered until this step is completed, after which the options for drug treatment are similar to those for other women, though potentially less effective in those with larger fibroids. The guideline excludes mention of ulipristal acetate (Esmya) in this setting pending the outcome of a safety review by the European Medicines Agency (EMA) to minimise the risk of rare but serious liver injury. Since publication of the NICE guidance, the EMA’s Pharmacovigilance Risk Assessment Committee (PRAC) has recommended that Esmya must not be used in women with known liver problems and that regular liver function tests should be performed before, during and after stopping treatment. Other treatment options are uterine artery embolisation and (possibly with pretreatment with a gonadotrophin-releasing hormone analogue if uterine fibroids are causing an enlarged or distorted uterus) myomectomy and hysterectomy. The route and method of hysterectomy should be chosen in discussion with the woman; the ovaries should be removed only on the expressed wish and consent of the individual after weighing up the risks and benefits. Dilatation and curettage should not be offered as a treatment option (this was also the case in 2007).

Gaps in knowledge
NICE acknowledges there are some gaps in the evidence supporting its recommendations. It says it is unclear which are the best options for diagnosis and management – initial testing with hysteroscopy, testing with pelvic ultrasound or (as is common practice) empiric drug treatment. Also, it’s not certain which of the recommended options for drug treatment is most effective: the LNG-IUS is popular but not suitable for all women. Combined oral contraceptives have many contraindications and though progestogens have fewer contraindications they also have less supporting evidence. Finally, the long-term outcomes of drug treatment for the 20–35% of women who have adenomyosis are not known.

There is also uncertainty about the effectiveness of surgical interventions. New endoscopic techniques have increased the safety and feasibility of hysteroscopic myomectomy and it should now be compared with uterine-sparing interventions such as drug treatment or more invasive surgery. The effectiveness of second-generation endometrial ablation in women with adenomyosis or uterine fibroids is unclear, meaning that some may be denied this option and offered a more invasive alternative, or it may be offered inappropriately and delay access to more effective alternatives. NICE suggests a cohort study would clarify its role.

Reference

Declaration of interests
None to declare.

Steve Chaplin is a medical writer specialising in therapeutics