

“Recent Advances in Management of Menorrhagia”

Miss Anjali Kothari

Consultant Obstetrician & Gynaecologist

The Hillingdon Hospital NHS Trust

Anjali.Kothari@thh.nhs.uk

Heavy menstrual bleeding

- Defined as excessive menstrual blood loss affecting quality of life:
 - physical
 - emotional
 - social
 - Material
- Can occur alone or in combination with other symptoms



Heavy menstrual bleeding, NICE clinical guideline 44

Background and Context

- Heavy Menstrual Bleeding
 - Fourth most common reason for referral to gynaecology outpatient clinics
 - Has a significant effect on women's quality of life
- Management options changed over past 20 years
 - Medical therapies
 - Mirena IUS System
 - Endometrial Ablation
 - Hysterectomy (60% of HMB in 1990)

HMB

- Investigations and management in primary care
- Education, information and choice for women
- Hormonal and non-hormonal pharmaceutical treatments
- Referral to secondary care
- Surgical management
- New therapies

Risk factors for HMB

- Gynaecological conditions such as:
 - uterine fibroids
 - adenomyosis or endometriosis
 - endometrial cancer
 - unopposed oestrogen use
- Increase in age
- Sociocultural factors

Investigations

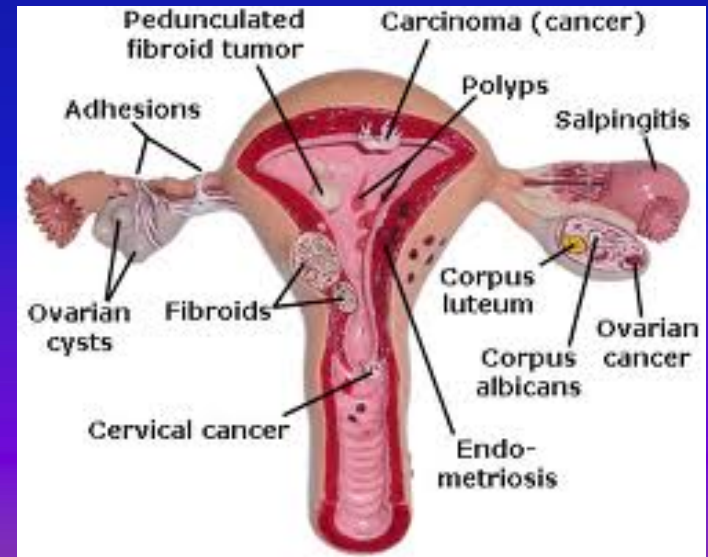
- FBC
- Coagulation (If HMB since menarche or family Hx of coagulation disorder)
- Thyroid function test (only if symptoms or signs of thyroid disease)

- Do not routinely test
 - ferritin and female hormones

History and Investigations

- Suspect structural or histological abnormality
- **IMB, PCB**
- **Pelvic pain**
- **Pressure symptoms**

- Examination abnormal
- = Pelvic ultrasound



Investigations

- Ultrasound
- Endometrial biopsy
- Hysteroscopy

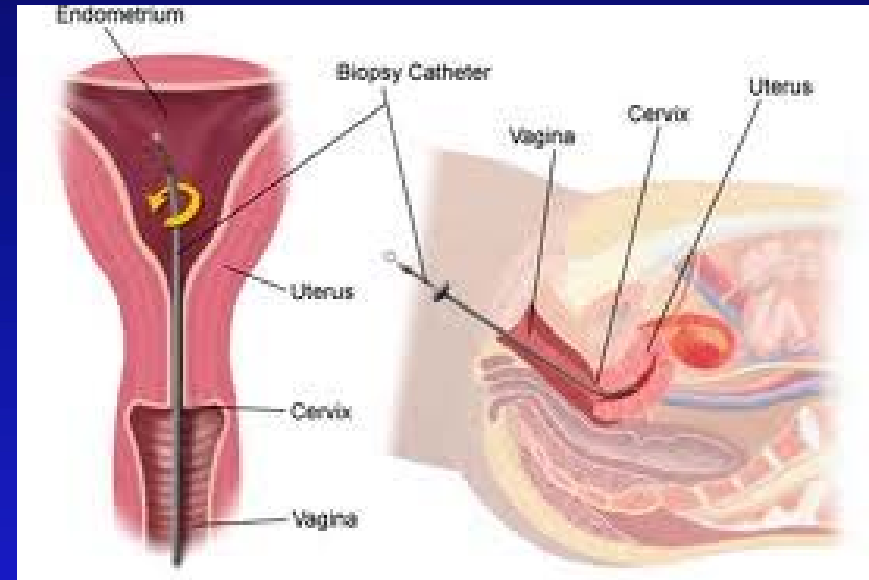
Role of Ultrasound



- To identify structural abnormalities

Endometrial Biopsy

- Indications:
 - Persistent IMB
 - medical treatment fails or is not effective in women aged 45 and older
 - Aim is to exclude endometrial cancer or atypical hyperplasia



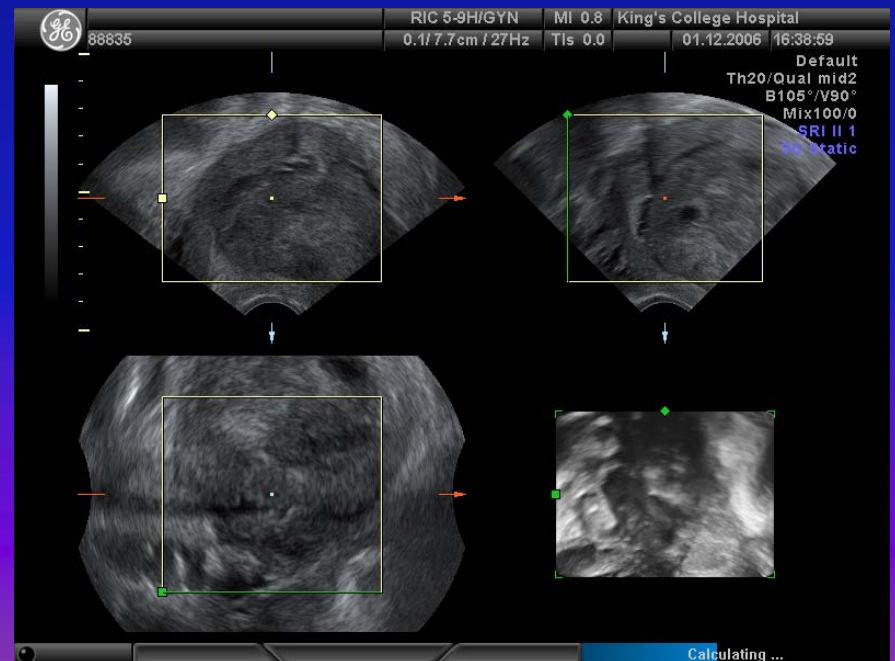
Hysteroscopy



- Indications
- USS – inconclusive/ suspicious/ possible pathology (fibroids/ polyps)
- Lost IUCD/ IUS
- Planning endometrial ablation

Second line investigations

- Saline infusion sonography
- MRI





"I THOUGHT IT MIGHT HELP YOU IF I LISTED MY SYMPTOMS."

Premenopausal AUB

- Intermenstrual bleeding – consider USS/ hysteroscopy for polyps, pedunculated fibroid
- Postcoital bleeding – check for chlamydia, smear test, ectropion
- Irregular bleeding – PCOS group
- Perimenarcheal girls

Pharmaceutical Treatment

- No structural or histological abnormality
(If no suggestion of this on history, can start Rx at initial visit without examination or investigation – except Mirena)
- Or fibroids <3cm not distorting the uterine cavity
- Can be used while investigations and definitive treatment being organised

Pharmaceutical treatment

- When either hormonal or non-hormonal treatments are acceptable consider in the following order:
 - levonorgestrel-releasing intrauterine system (12m atleast)
 - tranexamic acid or non-steroidal anti-inflammatory drugs or combined oral contraception
 - norethisterone (15mg daily from **D5-26**, not just luteal phase!) or injected long-acting progestogens

Non-hormonal treatment

- When hormonal treatment is not acceptable, for example if the woman wishes to conceive, consider using:
 - tranexamic acid
or
 - non-steroidal anti-inflammatory drugs (esp if dysmenorrhoea)
 - Stop if does not improve symptoms in 3 cycles
- do not use - danazol or etamsylate
- GnRH

LNG - IUS

- Levonorgestrel – releasing intrauterine system (Mirena)
- Contraceptive
- Advise of change in bleeding pattern – may last longer than 6m
- Persevere atleast 6m



Referral to Secondary Care

- Immediate referral offered if
 - Palpable abdominal fibroids
 - Intracavity fibroids
 - Bulky uterus – uterine length at USS or hysteroscopy >12cm?
- Failed medical treatment
- Integrated care pathway?

Education and information provision

- Information for patients ('Treatment and care for women with heavy periods') is available from www.nice.org.uk/CG044publicinfo



Surgical management

- **Endometrial ablation methods**

Use for HMB alone with uterus no bigger than 10-week pregnancy

- **Hysterectomy**

Endometrial Ablation

- Can be offered as initial treatment
 - Do not wish to conceive (Need effective contraception)
 - Uterus upto 10 week size or small fibroids (<3cm), no histological abnormality
 - All women should have access to 2nd generation endometrial ablation (NICE guidance)
-
- Success rate – 90%
 - Side effects – common – vaginal discharge, increased period pain or cramping
Less common – infection. Rare- perforation

Endometrial Ablation Methods



Endometrial ablation with radiofrequency energy

Freezing the endometrium with a special probe

Using heated fluid to destroy the endometrium

Bipolar Radiofrequency (Novasure)

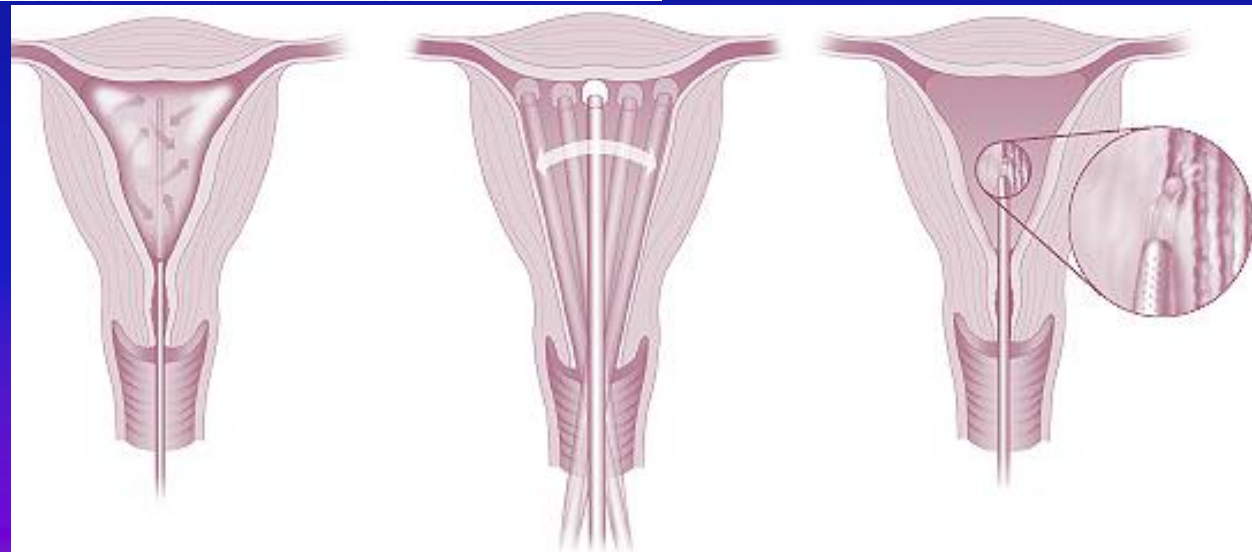
Cryotherapy (Her Option)

Circulating hot water (Hydro ThermAblator)

Heated balloon (Thermachoice)

Microwave energy (MEA)

Resectoscope



Heated balloon that destroys the endometrium

Endometrial ablation with microwave energy

Electrosurgery with a roller-ball-tipped resectoscope

Endometrial Ablation

- 1st generation – resection or ablation
 - specialised training
 - under vision,
 - hysteroscopic myomectomy
- 2nd generation – Number of modern devices
 - simpler
 - blind
 - as effective
 - side effects similar, mostly mild
 - can be done under LA
 - usually upto 10 weeks size

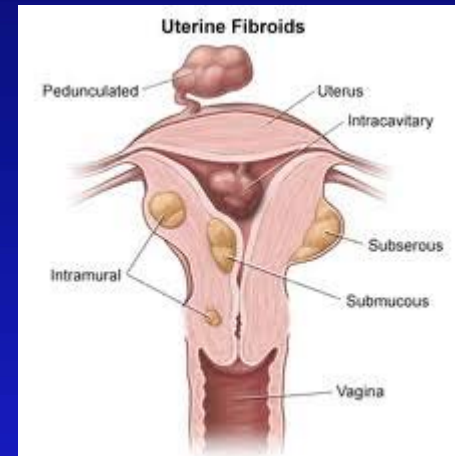
Novasure



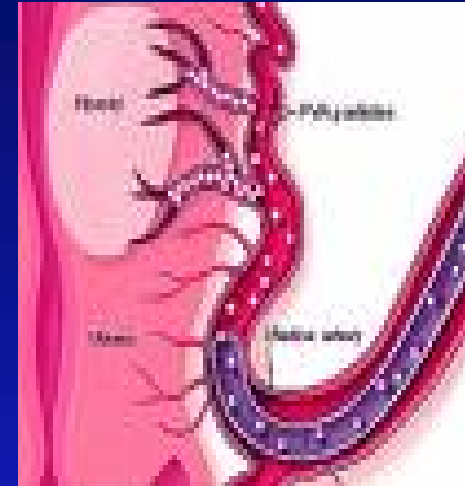
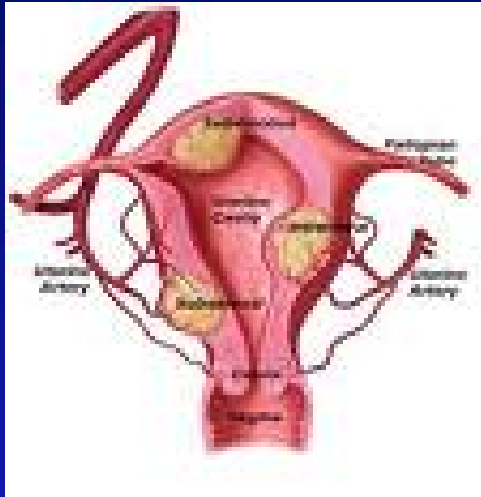
- Success rates and complications similar to other devices

Fibroids and HMB

- May also have dysmenorrhoea and pressure symptoms
- First – line treatment can be
 - Myomectomy (preserve fertility)
 - Uterine artery embolisation (UAE)
 - Hysterectomy



Uterine Artery Embolisation



- For those who wish to retain uterus and avoid surgery
- Side effects – Common – persistent vaginal discharge, post embolisation syndrome (Pain, nausea, vomiting and fever)
Less common – need for additional surgery, Premature ovarian failure
Rare – haemorrhage, tissue necrosis, septicemia

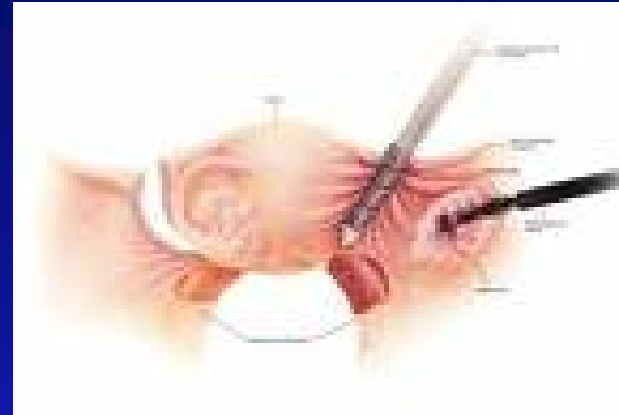
Hysterectomy

- Not first line.
- Consider if
 - Other Rx options failed, C/I or declined
 - Wish for amenorrhoea
 - Woman requests (fully informed)
 - Woman no longer wishes to retain uterus and fertility
- Complications should be discussed

Hysterectomy

- Total laparoscopic hysterectomy
 - Laparoscopic assisted vaginal hysterectomy
 - Vaginal
 - Abdominal
-
- Depends on uterine size, descent, mobility, fibroids, previous surgery

Laparoscopic hysterectomy



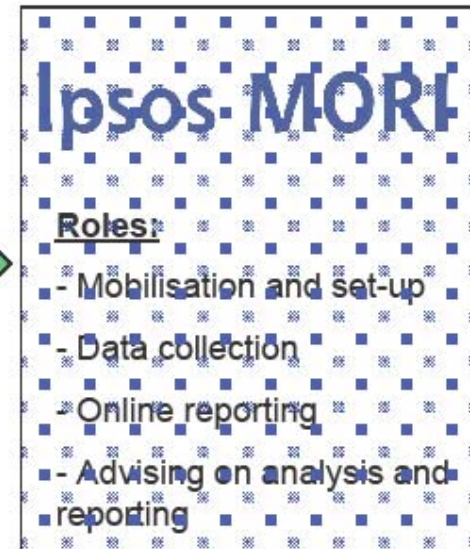
- Shorter stay
- Quicker recovery
- Less scarring!

Hillingdon Hospital

• Procedures	• <u>2009/10</u>	<u>2010/11</u>
• Novasure endometrial ablation	• 40 (64%)	36 (67%)
• Vaginal Hysterectomy	• 1	1
• LAVH	• 3	1
• Abdominal Hysterectomy	• 18	16

National Heavy Menstrual Bleeding (HMB) Audit

Audit Structure and Roles



Costs and savings

Recommendations with significant resource impact	Annual cost £millions
full blood count investigations	0.9
transvaginal ultrasound investigations	10.4
endometrial biopsy for suspected endometrial cancer	-0.9
pharmaceutical treatments levonorgestrel-releasing intrauterine system	-0.6
substitution of hysterectomy with endometrial ablation	-1.2
Total net cost of implementing the HMB guideline	8.7

Early Pregnancy Unit

Hillingdon Hospital



Early Pregnancy Unit (EPAU)

- <18 weeks pregnant
- Mon – Fri 8:30 – 4:30 pm
- USS – 13:30 – 4:30 pm (Weekend am – emergency scans)
- Follow up patients and blood tests am
- Specialist nurse, HCA and doctor (Reg/SHO)
- Consultant – Wed pm and Fri am

Referral

- Direct referral via GP and A&E
- Telephone (01895279440) or fax (01895 279189)
- Patient contacted with appointment
- Referral criteria – positive pregnancy test
 - pain or bleeding
 - previous ectopic pregnancy
(uss at 6 weeks)

Management

- Miscarriages – Expectant
 - Medical (Misoprostol – 800; 400, 400 **at home**)
 - Surgical (ERPC)
- Ectopic pregnancy – Medical (**out patient** Methotrexate)
 - Surgical (Laparoscopy >90%/
Laparotomy – rare)
 - Expectant (uncommon)

Management

- Pregnancy of unknown location (need to exclude ectopic pregnancy)
 - Early IUP
 - Ectopic pregnancy
 - Miscarriage – complete/ incomplete

Followed up with blood tests and scans

Thank You

Questions?