HEAVY MENSTRUAL BLEEDING

Patient information to assist informed consent

Heavy menstrual bleeding (HMB) is a common condition. Also called heavy periods or menorrhagia, HMB affects one in five women in Australia and New Zealand.

Although HMB is usually defined as a total menstrual blood loss of more than 80 millilitres during every period, this can be difficult to measure.

Therefore, the diagnosis is made on the basis of other signs, such as:

- an unusual increase in menstrual blood loss
- menstrual blood loss (excluding spotting) that lasts longer than seven days
- frequent flooding or menstrual loss not contained by pads or tampons
- increase in the number of times you have to change pads or tampons (more than every four hours, or more than once during the night)
- passing of blood clots that are wider than three centimetres (a bit more than one inch); small stringy clots are common and normal
- iron deficiency of the blood (anaemia) caused by HMB which can cause you to feel tired, weak or short of breath.

As your experience may vary from the points listed above, talk to your doctor so you can better understand HMB.

CAUSES OF HEAVY MENSTRUAL BLEEDING

Dysfunctional uterine bleeding

If no abnormality of the uterus is found, then the condition is called "dysfunctional uterine bleeding". More than half of women with HMB have dysfunctional uterine bleeding. It is most likely related to a problem with blood levels of female hormones that control menstruation, principally oestrogen and progesterone. During the menstrual cycle, levels of these hormones change constantly.

Although doctors know that hormonal changes can cause HMB, it is difficult to identify those changes in a woman and to know why they are causing problems. This is because:

- to accurately track hormone levels, blood samples would have to be taken daily (or more frequently), and the findings would not always be informative.
- it is difficult to measure the effects of hormones within the uterus where they interact in a complex environment of tissues, blood vessels and blood factors responsible for coagulation.

Fibroids

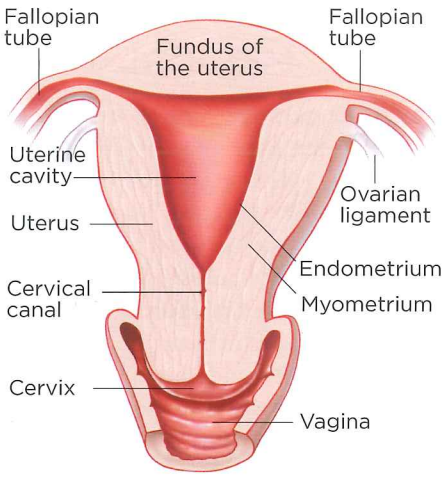
These are benign (non-cancerous) growths of the muscle and connective-tissue cells in the wall of the uterus. They are found in up to one in three women. Although fibroids are often found in women with HMB, most women with fibroids do not have HMB. In particular, small fibroids usually do not cause problems.

Endometrial polyps

These benign growths occur on the lining of the uterus. They may also lead to spotting between or after periods.

Endometrial hyperplasia

This is a thickening of the lining of the uterus (endometrium) that leads to heavier bleeding.



Anatomy of the uterus and cervix

Adenomyosis

This is an enlargement of the uterus caused by growth of the endometrium into the wall of the uterus.

Although the above conditions may cause, or be linked to, HMB, it is possible that HMB may occur in the absence of physical abnormalities of the uterus.

Uncommon causes of HMB

- Thyroid imbalance
- Contraceptive intra-uterine devices (IUDs) and some forms of hormonal contraception, such as the Pill
- Some liver or kidney conditions
- Blood clotting disorders, including medication taken to treat or prevent blood clots elsewhere in the body
- Endometrial cancer is a rare cancer that can cause heavy periods. However, it is more likely to cause bleeding between periods, blood-stained vaginal discharge, or post-menopausal bleeding.

IMPORTANT: FILL IN ALL DETAILS ON THE STICKER BELOW

Dear Doctor: When you discuss this pamphlet with your patient, remove this sticker, and put it on the patient's medical history or card. This will remind you and the patient that this pamphlet has been provided. Some doctors ask their patients to sign the sticker to confirm receipt of the pamphlet.

PEEL HERE

TREATMENT INFORMATION PAMPHLET

PROCEDURE: _____

PATIENT'S NAME: _____

DOCTOR'S NAME: _____

EDITION NUMBER: _____ DATE: D D / M M / Y Y Y Y

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DIAGNOSIS OF HMB

- An internal vaginal examination to feel the size of the uterus.
- A blood test for haemoglobin levels. If haemoglobin is low, further tests may be needed. Blood tests may be needed to look for a thyroid imbalance or a bleeding disorder.
- An ultrasound scan to examine the lining of the uterus in women who have a higher risk of endometrial hyperplasia or uterine cancer. Ultrasound can also detect uterine fibroids, ovarian cysts and other pelvic abnormalities. The ultrasound probe is usually placed into the vagina to obtain a better view of the uterus and ovaries. In some cases, the probe may be placed on the abdomen.
- Hysteroscopy is a procedure to look inside the uterus using a thin telescope. It is done as an outpatient or inpatient procedure. At the time of hysteroscopy, a sample of the cells that line the uterus can be taken for examination. Hysteroscopy may be recommended if an ultrasound has been performed and the results indicate an abnormality.

The patient education pamphlet "Hysteroscopy" provides further information and is available from your gynaecologist.

- A curette is an instrument used to remove endometrium in a procedure called dilatation and curettage (or D&C). This is a minor surgical procedure done under local or general anaesthesia.

Pieces of the endometrium are examined for abnormalities. If available, an ultrasound examination of the uterus may be done at the same time. Recent studies indicate that D&C does not appear to have any benefit in treating or curing HMB, so the procedure is less commonly performed.

The patient education pamphlet "Dilatation and Curettage – D&C" may be helpful.

If a piece of endometrium needs to be examined, your doctor may suggest an alternative called endometrial biopsy. This procedure to collect a small sample of tissue can be done quickly and easily in the doctor's surgery, especially for women who have delivered a baby through the birth canal.

- Vaginal swabs may be taken to check for pelvic infection.
- Laparoscopy may be required if a woman with HMB also has pelvic pain, infertility or a condition affecting the ovaries.

A diagnosis of HMB does not require a cervical screening test (which has replaced the Pap smear) or colposcopy.

MEDICAL TREATMENTS FOR HEAVY MENSTRUAL BLEEDING

Medication and surgery are available for the treatment of HMB. It is important that you understand the impact that surgical and medical treatments may have on your life. For example, a hysterectomy or medications that reduce fertility are not suitable if you are trying to become pregnant.

The severity and duration of HMB must also be taken into account. Other factors, such as family history, your response to medications, and your personal medical history (including pelvic pain or premenstrual syndrome) may influence your decision and your doctor's treatment recommendations.

Only you can determine how much the HMB is affecting you. While the choice of treatment is always yours, your doctor's role is to help you to understand your treatment options and whether they are suitable for you.

The following medications often have an effect during the first cycle they are used. There may be further improvement with subsequent cycles.

Hormonal treatments

Oral contraceptive pill: The Pill usually reduces menstrual blood loss by a little more than a third. It may bring relief to women with painful periods. However, side effects may include nausea, breast tenderness and headaches. It may not be suitable for women with risk factors for heart disease. The Pill is not recommended for women older than 35 who smoke.

Oral progesterone (progestogen): Oral progesterone reduces blood loss if it is taken for 21 out of 28 days from days five to 25 of a woman's cycle. It has the added advantage of producing regular cycles. However, side effects can include bloating, mood swings, pre-menstrual syndrome and irregular light bleeding.

Progestogen intrauterine device: Placed into the uterus via the cervix, this device steadily releases tiny amounts of progestogen. This keeps the endometrium thin and inactive rather than increasing in thickness during the build-up to ovulation. As the lining of the uterus does not increase, menstrual bleeding is reduced.

Nearly all women will experience a large reduction in their blood loss (on average, a 94% decrease in blood flow). The treatment usually takes several months to achieve the desired effect. It appears to be the most effective drug treatment of HMB. Added benefits are reliable contraception and no need to take tablets.

A common side effect is irregular light bleeding in the initial months of therapy. It can cause menstrual cramps and, rarely, the device may be expelled. The device is typically effective for about five years.

Danazol: Danazol may reduce menstrual blood loss by about two-thirds and may cause some women to stop menstruating. Possible side effects include weight gain, acne, hirsutism (male-patterned hairiness), hair loss, and voice changes. Other treatments are usually tried first. Danazol is a banned drug for women in competitive sports.

Non-hormonal treatments

Non-steroidal anti-inflammatory drugs (NSAIDs): NSAIDs are medications that reduce heavy bleeding. On average, NSAIDs reduce menstrual blood loss by about one-third. They also have the advantage of relieving painful periods and menstrual headaches. However, some women experience:

- stomach upsets, nausea and diarrhoea
- headaches instead of relief from headache.

The benefits and side effects of NSAIDs vary from woman to woman.

Tranexamic acid: Tranexamic acid may reduce menstrual blood loss by about half. Tranexamic acid affects clotting mechanisms in the lining of the uterus. Tablets are taken only on the days that the woman has heavy bleeding. Nausea and diarrhoea are uncommon side effects.

Iron supplements for anaemia: A woman with HMB can develop anaemia, which is a low concentration of red blood cells or not enough haemoglobin in red blood cells. Anaemia can cause shortness of breath, tiredness and heart palpitations. Anaemia is usually treated with tablets containing iron. This does not treat the cause of HMB. Constipation can be a side effect of iron supplements.

SURGICAL TREATMENTS FOR HEAVY MENSTRUAL BLEEDING

Endometrial ablation during hysteroscopy

This is the surgical removal or destruction of the lining of the uterus using a hysteroscope, an instrument that is inserted into the cavity of the uterus through the vagina and cervix. (See the patient education pamphlet "Hysteroscopy".)

The procedure is performed under general or local anaesthesia. Women are usually able to go home the same day. Its effectiveness is high. About 85 of every 100 patients report a significant improvement, and about 40 of these 100 women will have no periods. However, an improvement may not be long lasting for some women.

Endometrial ablation is not suitable for women with severely painful periods or chronic pelvic pain. The rate of major complications is between one and two in every 1,000 procedures.

Women planning to get pregnant in the future should not have endometrial ablation because the remaining endometrium may not be able to support a pregnancy; however, the procedure is not a contraceptive technique.

A newer technique uses low-intensity microwaves to heat and remove the endometrium. A probe is placed into the uterus through the vagina and moved throughout the uterus. Still being evaluated but becoming used more widely, this procedure is done under a local or general anaesthetic and takes several minutes.

Myomectomy

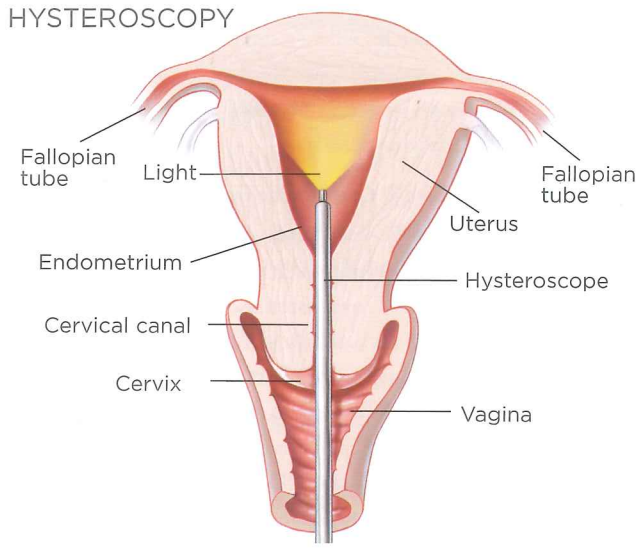
This is surgical removal of fibroids while retaining the uterus. Its precise effectiveness in reducing HMB has been a matter of debate.

Hysterectomy

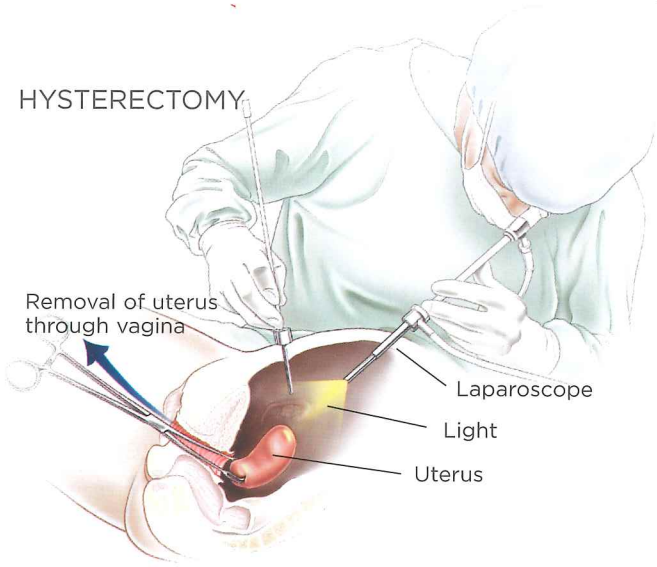
This is the removal of the uterus. The operation can be done in one of four ways:

- abdominal hysterectomy – removal of the uterus through a cut in the abdomen
- vaginal hysterectomy – removal of the uterus through the opening of the vagina
- laparoscopically assisted vaginal hysterectomy – removal of the uterus through the vagina with small cuts in the abdomen to assist the surgeon
- laparoscopic hysterectomy – removal of the uterus through small cuts in the abdomen.

The surgical method chosen depends on a range of issues, including the nature of the woman's problem and her medical history. Hysterectomy is a major surgical procedure, and up to four in 10 patients may have some type of operative or post-operative complication. However, only a small percentage of these women will have severe or long-lasting complications.



The hysteroscope is introduced through the cervical canal and into the uterus. No incision is necessary.



Laparoscopically assisted vaginal hysterectomy

A decision to have a hysterectomy needs to be carefully discussed. Some women may wish to seek a second opinion.

Although few women with HMB regret their decision to undergo hysterectomy, it is important that you have enough information about possible complications to fully weigh up the benefits and risks of any surgical procedure that may be recommended. For more information, see the patient education pamphlet "Hysterectomy", available from your gynaecologist.

TALK TO YOUR DOCTOR

This pamphlet is intended to provide you with general information that is based on evidence from research as well as expert opinion.

It is not a substitute for advice from your doctor and does not contain all known facts about HMB. This information will change with time, due to clinical research and new therapies.

If you are not sure about the risks, benefits and limitations of treatment, or related matters, ask your doctor.

Terms are used in this pamphlet that may require further explanation by your doctor. Read this pamphlet carefully, and save it for reference.

Write down questions you want to ask. Your doctor will be pleased to answer them. Use this pamphlet only in consultation with your doctor.

If you are uncertain about your doctor's advice, you may wish to seek the opinion of another doctor.

Consent form: If you decide to have surgical treatment, your doctor will ask you to sign a consent form. Before signing, read it carefully. If you have any questions about the form, the procedure or other related issues, ask your doctor.

Costs of treatment: Ask your doctor for an estimate that lists the likely costs. Due to unexpected tests or treatments, the final account may vary from the estimate. It is best to discuss costs before treatment, rather than afterwards.

FREQUENTLY ASKED QUESTIONS ABOUT HMB

Q: How common is HMB?

A: About one in five healthy women have excessive menstrual bleeding. The condition is treatable, with several effective treatment options being available.

Q: I have been sterilised. Could this be the cause of my HMB?

A: No. At one time, it was thought that female sterilisation may increase menstrual blood loss. It is now thought that stopping the Pill causes the change in menstrual blood loss. Women on the combined oral contraceptive pill tend to have light periods. When the Pill is discontinued after sterilisation, the periods return to the blood loss that would have been experienced without the benefit of hormonal control.

Q: Should I have tests to find the cause of my HMB?

A: Tests are important to help find out the cause. A blood count may be needed because HMB can cause anaemia.

For women aged from their late teens through to their 30s (and when obvious problems have been excluded), further investigation may be necessary only if:

- the woman is at risk of endometrial hyperplasia or endometrial cancer
- the bleeding is irregular or it fails to respond to medication.

Q: What would be a reasonable initial treatment for a teenager or young woman with HMB?

A: The combined oral contraceptive pill is usually an effective first choice for a younger woman, particularly if she also needs contraception. Teenagers with HMB may be having "anovulatory cycles", meaning that an egg is not being released each month.

Progestogens taken in the second half of the cycle may be effective and are often favoured by parents with concerns about starting their young daughters on the contraceptive pill.

Tranexamic acid taken on the days when the bleeding is heavy can also be a good first choice. When pain accompanies the heavy blood loss, a non-steroidal anti-inflammatory drug (NSAID) may be appropriate.

Q: What if I am trying to get pregnant?

A: If you are trying to get pregnant, many of these therapies are not suitable. To plan treatment, it is important that you tell your doctor whether you intend to become pregnant. Your treatment can often be tailored to your needs.

Q: Are alternative therapies effective in treating HMB?

A: There are anecdotal reports of alternative therapies that have appeared to work for some women, but evidence in large or validated studies is lacking.

POSSIBLE COMPLICATIONS OF SURGICAL TREATMENT FOR HMB

As with all procedures, surgical treatment for HMB does have risks, despite the highest standards of practice. While your gynaecologist makes every attempt to minimise risks, complications can occur that may have permanent effects. It is not usual for a doctor to outline every possible side effect or rare complication of a procedure. However, it is important that you have enough information about possible complications to fully weigh up the benefits and risks of the procedure.

Any discussion of frequency of risks or benefits (for example, one patient in 100, or "rare" and so on) can only be estimates as the outcomes of clinical research can vary widely. Such outcomes can depend on many factors, such as the surgical methods, equipment, surgeons' experience and data collection, among others.

The gynaecologist cannot guarantee that your symptoms will improve following treatment. The following possible complications are listed to inform, not to alarm you. There may be other complications that are not listed.

General surgical risks

- A blood clot can develop in a deep vein of the thigh or leg (DVT), which can be life threatening if it moves to the heart or lungs. However, this is not common and can be treated.
- Risks of general anaesthesia.

Specific risks of hysteroscopy

- Trauma to the cervix during dilatation of the cervical canal.
- Perforation of the uterus with the hysteroscope or other surgical instrument. The gynaecologist may decide to postpone the hysteroscopy until the uterus has healed. A perforation usually heals quickly. Rarely, further surgery may be required.
- Cuts or puncture damage to nearby organs if perforation of the uterus has occurred. Laparoscopy or open surgery to repair the damage may be necessary.
- Postoperative infection, such as infection of the bladder (cystitis) or uterine lining (endometritis).
- Heat damage to nearby organs (such as the bladder, bowel or blood vessels) caused by electrical or laser instruments during cautery to stop bleeding, or during resection or ablation of tissue.
- Excessive bleeding. Treatment may include medication or, uncommonly, blood transfusion. In severe and rare cases, a hysterectomy may be needed if bleeding cannot be stopped.
- Fluid imbalance. Hysteroscopic surgery is sometimes performed with the uterus distended with fluid. A fluid imbalance may occur in the body, which in rare cases might be life threatening. Further treatment and observation in hospital for several days may be needed until the problem resolves.
- Gas embolism. If carbon dioxide gas is used to distend the uterus, a gas bubble may rarely enter the bloodstream. This can be life threatening but can usually be treated by the anaesthetist and surgeon.

The text of this pamphlet was partially derived from a project supported by a Victorian Department of Human Services Quality Improvement and Best Practice funding grant and from patient education supplied by gynaecologists in Australia and New Zealand.

YOUR DOCTOR

"Heavy Menstrual Bleeding" has been reviewed by obstetricians and gynaecologists in Australia and New Zealand

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