AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

GUIDE
for consumers

Heavy Menstrual Bleeding

Clinical Care Standard

What is the Heavy Menstrual Bleeding Clinical Care Standard?

The aim of the *Heavy Menstrual Bleeding Clinical Care Standard* is to ensure that women are offered the least invasive and most effective treatment appropriate to their clinical needs and preference, and are able to make an informed choice from a range of treatments suitable to their individual situation.

The *Heavy Menstrual Bleeding Clinical Care Standard* contains eight quality statements describing the care that you should expect to receive if you experience heavy menstrual bleeding.

This guide explains each quality statement and what it means for you.

For more information or to read the full clinical care standard visit: www.safetyandquality.gov.au/ccs.

What is heavy menstrual bleeding?

Heavy periods or heavy menstrual bleeding is a common health concern affecting around one in four women. It is defined as excessive menstrual blood loss which interferes with a woman's physical, social or emotional quality of life.

Symptoms of heavy menstrual bleeding may include bleeding through clothing, having to change pads or tampons every one or two hours including overnight, and being unable to leave the house on the heaviest days. Many women will also have other symptoms such as fatigue, anxiety and pelvic pain.

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1 Assessment and diagnosis

What the standard says

The initial assessment of a woman presenting with heavy menstrual bleeding includes a thorough history, assessment of impact on quality of life, a physical examination (where clinically appropriate), and exclusion of pregnancy, iron deficiency and anaemia. Further investigations are based on the initial assessment.

What this means for you

If you have heavy menstrual bleeding, your clinician will carry out a thorough assessment to help find the cause. They will ask questions to understand more about your bleeding, and how it affects your life, including your physical and emotional wellbeing, your mental health, and your ability to work, exercise and take part in social events. They will also ask about your past general health and any family medical problems. They may ask about your sexual health, previous pregnancies and births, current sexual activity, and whether you wish to become pregnant in the future.

With your consent, your clinician will carry out a physical examination. This may involve an internal examination where your clinician will use a tool called a speculum to help look at your vagina and cervix. They may also place one or two gloved fingers inside your vagina while pressing gently on the outside of your abdomen to be able to feel your pelvic organs, including your uterus. If you do not feel comfortable about having an internal examination, let your clinician know.

Your clinician will recommend a pregnancy test if there is any chance you are pregnant, and blood tests for iron deficiency (a lack of iron) and anaemia (a lack of red blood cells). Whether you need any other tests will depend on your individual assessment, but these may include other blood tests, a cervical screening test, internal swab tests for infection, or an ultrasound.

2 Informed choice and shared decision making

What the standard says

A woman with heavy menstrual bleeding is informed about her treatment options and their potential benefits and risks. She is supported to participate in shared decision making based on her preferences, priorities and clinical situation.

What this means for you

There are several ways to treat heavy menstrual bleeding and each woman has different needs and preferences.

Your clinician will discuss your condition with you and will ask questions to understand what is important to you. For example, they will ask questions about your goals for treatment, and whether you want to become pregnant in the future. They will explain the treatment options that are available to you and discuss the expected benefits and potential risks of each option. Together, you and your clinician should decide about the care that is best for you.

If you are not sure about understanding the information in English, you can ask for an interpreter.

You may also be given printed information or directed to useful electronic resources. Information should be provided in a format that suits you and that you can understand.

3 Initiating medical management

What the standard says

A woman presenting with heavy menstrual bleeding is offered medical management, taking into account evidence-based guidelines, her individual needs and preferences and any associated symptoms. Oral treatment is offered at first presentation when clinically appropriate, including when a woman is undergoing further investigation or waiting for other treatment.

What this means for you

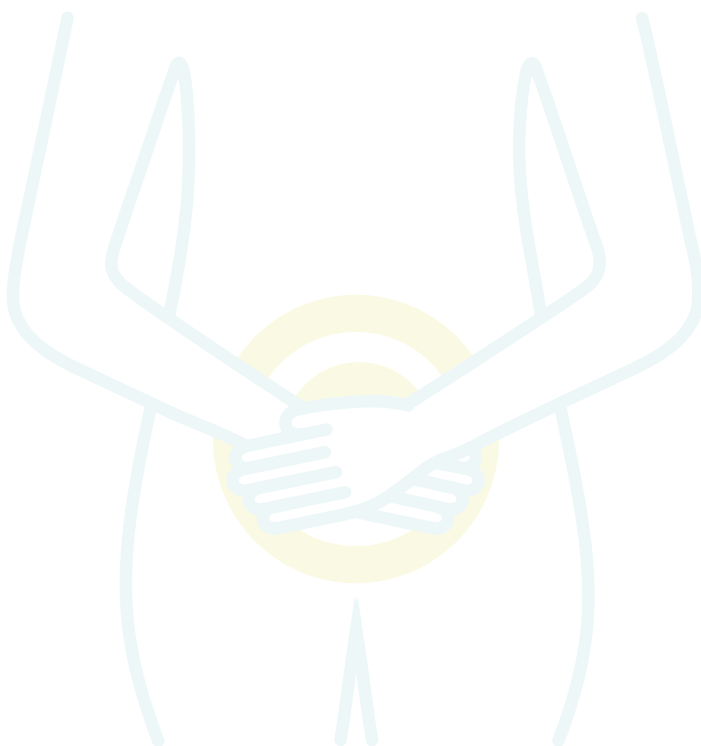
Your clinician will usually suggest medicine as the first treatment option to relieve your heavy menstrual bleeding. Which medicine is suitable for you will depend on several factors, including your preferences, the cause of your bleeding, whether you need contraception and any other health conditions you may have. Depending on your situation, options may include:

- Tranexamic acid which comes as a tablet that you take during your period. It helps your blood to clot and can reduce menstrual blood loss. It does not provide contraception.
- Anti-inflammatory medicines including ibuprofen, mefenamic acid and naproxen, which come as tablets or capsules and are taken during your period. They can reduce inflammation, pain and blood loss. Some anti-inflammatories are available without a prescription. Anti-inflammatories do not provide contraception.
- A combined oral contraceptive pill which contains synthetic hormones similar to the natural hormones oestrogen and progesterone. These thin the lining of the uterus and can reduce your period flow. The active hormones in the combined oral contraceptive pill may be taken for 21–24 days of a 28-day menstrual cycle but can also be taken continuously, which can avoid your period altogether. As its name suggests, this option also provides contraception.

- Other hormonal treatments that contain progestogen, which is similar to the natural hormone, progesterone. These may be in tablet form (oral progestogens) or given as an injection every three months (depot medroxyprogesterone). Some of these treatments also provide contraception.
- A hormone-releasing intrauterine device (IUD) which is a small plastic device that is placed inside your uterus and continuously releases a small amount of progestogen. This thins the lining of the uterus and is very effective at reducing bleeding. This device also provides contraception. (See Quality statement 5 – **Intrauterine hormonal devices**.)

Your clinician will explain your treatment options, their expected benefits and possible side effects, and ask about your preferences. If the first medicine you try is not satisfactory, you can return to your clinician to discuss other options.

If you need further tests to investigate your bleeding, such as a blood test or an ultrasound, or if you need to see a different doctor for your preferred treatment, your clinician will offer you medicine that you can start straight away to provide relief while you wait for other appointments. Later, you may decide on a different treatment.



4 Quality ultrasound

What the standard says

When a woman requires an ultrasound to investigate the cause of her heavy menstrual bleeding, she is offered a pelvic (preferably transvaginal) ultrasound, which assesses all pelvic structures, including the uterus and endometrium, and is ideally performed in days 5–10 of her menstrual cycle.

What this means for you

You may have an ultrasound of your pelvic area to look for some common causes of heavy menstrual bleeding, such as polyps or fibroids, and to check the size and shape of your uterus. There are two ways of doing the ultrasound and they are often done together:

- **Transvaginal ultrasound**, where the ultrasound operator places a narrow ultrasound probe in your vagina – this is the preferred way because it provides a better picture of the uterus and pelvic structures
- **Transabdominal ultrasound**, where the ultrasound probe is placed on the outside of your lower abdomen, while you have a full bladder – this way does not show the uterus and pelvic structures as well as the transvaginal scan because the probe is not as close to the reproductive organs.

For some women, a transvaginal ultrasound may not be appropriate, for example, for women who have not been sexually active, those who have been sexually assaulted in the past, those who have experienced birth trauma, or those who decline for cultural reasons. If you do not want to have a transvaginal ultrasound for any reason, discuss this with your clinician when they are organising your referral.

It is best if you can book to have the scan done 5–10 days after the first day of your period. This is when the lining of the uterus is thinnest, and the reading will be most accurate. Talk to your clinician if timing the scan will be difficult for any reason – for example, because your periods are very irregular, or because you live in an area where it is not easy to access an ultrasound. Your clinician may offer you medicine that you can start straight away to provide relief while you wait for your appointment.

5 Intrauterine hormonal devices

What the standard says

When medical management options are being considered, a woman is offered a 52 mg levonorgestrel-releasing intrauterine device if clinically appropriate, as it is currently the most effective medical option for managing heavy menstrual bleeding.

What this means for you

If it is suitable for you, your clinician may suggest a 52 mg levonorgestrel-releasing intrauterine device (LNG-IUD). This is a hormonal treatment that is released from a small plastic device placed inside your uterus. It can be left in place for up to five years (and can be removed earlier if it is no longer a suitable option).

The LNG-IUD also acts as a contraceptive. It is usually recommended because it is the most effective medical treatment for treating heavy menstrual bleeding.

If it is suitable for you to consider, your clinician will explain how it works, and its benefits, risks and side effects to help you decide if you want to have it. They will explain that it may take three to six months or more to get the full benefit of the treatment.

The device needs to be placed in the uterus by a health professional who has been trained to insert intrauterine devices (IUDs). This means that if you choose the LNG-IUD, you may be referred to another clinician to have it inserted. Depending on the services available in your area, you may be referred to a general practice, a family planning clinic or another specialist service.

Your clinician may recommend that you have an ultrasound before the device is inserted. If you have to wait for an ultrasound or other appointment before the device can be inserted, your clinician may offer you medicine that you can start straight away to provide relief while you wait.

6 Specialist referral

What the standard says

A woman with heavy menstrual bleeding is referred for early specialist review when there is a suspicion of malignancy or other significant pathology based on clinical assessment or ultrasound. Referral is also offered to a woman who has not responded to medical management.

What this means for you

Heavy menstrual bleeding can often be managed in primary care, usually by a general practitioner (GP) or family planning doctor. However, you may be referred to another doctor if your ultrasound or other history suggests further assessment would be helpful. For example, the ultrasound might identify fibroids or polyps, which are common types of non-cancerous growths that may be contributing to your bleeding. While it is rare for heavy menstrual bleeding to be caused by cancer, your clinician may also want to order tests or other investigations to rule this out.

You might also be referred to a specialist if your bleeding is not improving with prescribed medical treatments. It may take time to get the full benefit of some treatment options. If you are concerned about your treatment at any time, go back to your primary care clinician and discuss your situation.

7 Uterine-preserving alternatives to hysterectomy

What the standard says

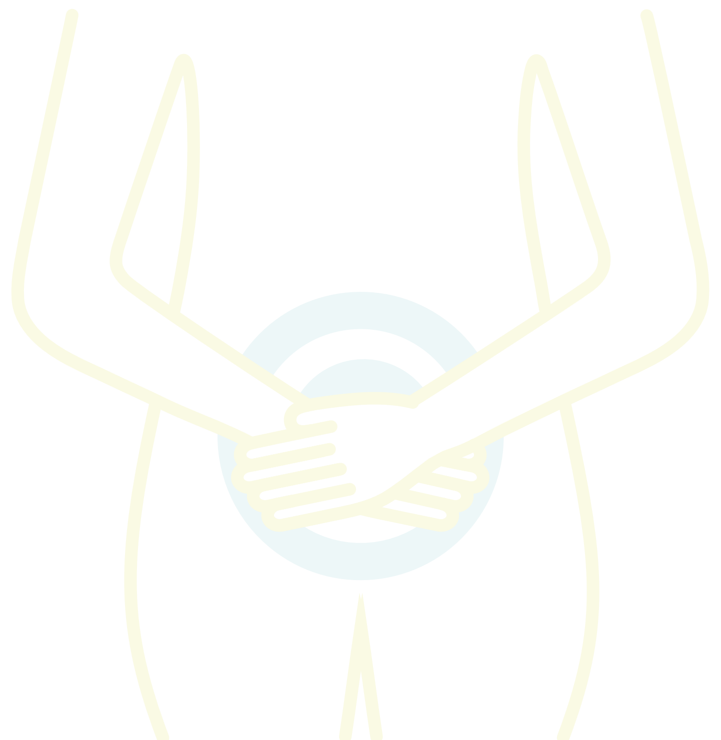
A woman who has heavy menstrual bleeding of benign causes and who is considering non-medical management is offered uterine-preserving procedures that may be suitable (such as endometrial ablation, uterine artery embolisation or surgical removal of local pathology). She is supported to make an informed decision and is referred appropriately.

What this means for you

If you are considering options other than medicines for your heavy menstrual bleeding, the first procedures to consider are those that will leave your uterus in place. The procedures that may be suitable for you will depend on the cause of your bleeding and other factors such as whether you want to be able to get pregnant in the future. Depending on your situation, suitable options may include:

- **Endometrial ablation** which is a common procedure that involves removing or destroying the lining of the uterus (the endometrium) using heat. A long, narrow instrument is put inside the uterus (through the vagina) to apply heat or cut out the uterus lining. After this procedure, it is not safe to get pregnant, so you must avoid any future pregnancy by using effective contraception.
- **Uterine artery embolisation** (UAE) which may be suitable for women with fibroids larger than 3 cm. UAE involves blocking off the blood flow to the fibroids so that the fibroids shrink in size and produce less bleeding. A small tube is placed in an artery near the groin or wrist to access the blood vessels to the uterus. The tube delivers particles to block the blood vessel and is removed after the procedure. You can be referred to an interventional radiologist to discuss UAE in more detail. If you wish to become pregnant in the future you should discuss the specific risks with your doctor.
- **Myomectomy** which is an operation to surgically remove fibroids from the uterus. It leaves the uterus intact and it may be suitable for women who are planning to have children. There are different types of myomectomy depending on how the surgeon accesses the uterus including abdominal (through a cut made in your lower abdomen), laparoscopic (through a keyhole incision) or hysteroscopic (through the vagina – see also **Hysteroscopic removal** below).
- **Hysteroscopic removal** which is a procedure to remove any growths such as polyps or fibroids that may be causing the heavy menstrual bleeding, or to remove the lining of the uterus. A thin, flexible instrument with a small camera (a hysteroscope) is inserted into the uterus through the vagina and specialised instruments are used through the hysteroscope to cut, burn or destroy the growths.

The suitability of these procedures will differ for each woman. Your clinician will discuss the benefits and risks with you, and other features such as recovery times, based on your individual situation. Some specialists may not conduct these procedures themselves, in which case they may instead refer you to another specialist for further assessment and treatment.



8 Hysterectomy

What the standard says

Hysterectomy to manage heavy menstrual bleeding is considered when other treatment options are ineffective or are unsuitable, or at the woman's request. A woman considering a hysterectomy is fully informed about the potential benefits and risks of the procedure before making a decision.

What this means for you

Hysterectomy (surgery to remove the uterus) stops heavy menstrual bleeding because it permanently stops your periods. Hysterectomy involves removing part or all of the uterus, often with the fallopian tubes. When it is considered clinically appropriate, the ovaries may also be removed.

Hysterectomy can be done in different ways, including abdominal (through a cut in the lower abdomen), laparoscopic (keyhole surgery performed through small cuts in your abdomen), or vaginal (surgery performed through your vagina). Hysterectomy is a major surgical operation, and it has a higher risk of complications than other treatments for heavy menstrual bleeding.

Hysterectomy will be discussed as an option to consider if alternative treatments are not suitable for your situation, if alternatives have not worked for you, or if it is your preference. Your doctor will explain what the surgery involves, the types of hysterectomy available to you, the expected benefits and the possible complications or unwanted effects. This is so you can make an informed choice about whether to go ahead with the procedure.

After a hysterectomy, you can no longer become pregnant. While complications are uncommon, there is a risk of infection, blood loss, damage to the ovaries, bowel or bladder, and other surgical complications. If your ovaries are removed, then you will experience early menopause. Different risks may apply according to your situation and the way the hysterectomy is done, and your doctor will discuss these with you.

Questions?

Find out more about the *Heavy Menstrual Bleeding Clinical Care Standard* and other resources. Scan the QR code or use the link safetyandquality.gov.au/hmb-ccs.

The Australian Commission on Safety and Quality in Health Care has produced this clinical care standard to support the delivery of appropriate care for a defined condition. The clinical care standard is based on the best evidence available at the time of development. Healthcare professionals are advised to use clinical discretion and consideration of the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian, when applying information contained within the clinical care standard. Consumers should use the information in the clinical care standard as a guide to inform discussions with their healthcare professional about the applicability of the clinical care standard to their individual condition.

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