HEAVY MENSTRUAL BLEEDING (HMB)

Heavy menstrual bleeding (HMB) is responsible for a large proportion of primary care presentations and gynaecological referrals and is a significant cause of morbidity for many women. HMB affects 10-30% of women throughout their lifetime and up to half of perimenopausal women. HMB (*aka. menorrhagia*) is classically defined as menstrual loss > 80mls per month, but most guidelines now recommend that practitioners be guided by the woman's perception of the blood loss. If the woman feels that her heavy periods are interfering with her quality of life, then she should be offered treatment.

Common causes include dysfunctional uterine bleeding (often anovulatory) and benign uterine pathology (fibroids, polyps). There are many medical and surgical treatment options available, the large majority of which are available for use in primary care. The most appropriate first-line treatment will be dependent on individual patient factors such as:

- Need for contraception/ conception
- Willingness to use hormonal preparations
- Previously tried therapies
- Co-morbidities

Decisions regarding treatment are generally made on the basis of a complete patient history including the nature of the bleeding, associated symptoms, past medical history, medications, allergies and social history. For example, a young woman may prefer to use the COC as a first-line therapy, where as the combination of tranexamic acid plus mefenamic acid may be offered to a woman who finds hormonal therapies unacceptable.

Please find below an outline of the available medical treatment options[a] available for use in primary care.

Therapy	Prescriber information	Notes
IUD (progesterone-releasing) ***	**MIRENA***** (Levonorgestrol-releasing IUD) Releases 20mcg progesterone/24hrs Requires replacement every 5 yrs.	• ↓ *MBL by 71-96%,* full benefit may not be seen for 6 months. • Most effective non-surgical treatment for HMB. • 85% patient satisfaction at one year, but erratic bleeding patterns common in the first 6 months. • If pain or HMB in first 6 months, can use NSAIDs (E.g. mefenamic acid) simultaneously.
Antifibrinolytic[b]	**TRANEXAMIC ACID** (500mg tabs) **1g TDS/QID** From onset of menstruation, for up to 4 days.	• ↓ *MBL by 29-58%.* • SE: Indigestion, diarrhoea, headaches. • Large-scale studies show no increased risk of VTE
NSAID[b]	**MEFENAMIC ACID** (250mg tabs) **500mg TDS** Begin 24-48 hours before menstruation, use during menstruation.	• Reduces dysmenorrhoea • ↓ *MBL by 29-49%* • SE: Indigestion, diarrhoea (common); Peptic ulcers, worsening of asthma if sensitive (rare).
COC	Various options	• ↓ *MBL by 43%* • Also regulates cycle and reduces dysmenorrhoea • SE: Mood changes, headaches, nausea, fluid retention, breast tenderness (common); DVT, stroke, MI (rare).
Oral progesterone	**NORETHISTERONE 15mg daily** days 5 to 26 of cycle.	• ↓ *MBL by up to 83%* in the long term. • Note that oral progestins used only in the luteal phase are NOT effective at reducing MBL. Must be used day 5-26.

MBL: mean blood loss; SE: Side effects; VTE: Venous thromboembolism; NSAID: Non-steroidal anti-inflammatory drug; COC: Combined oral contraceptive pill

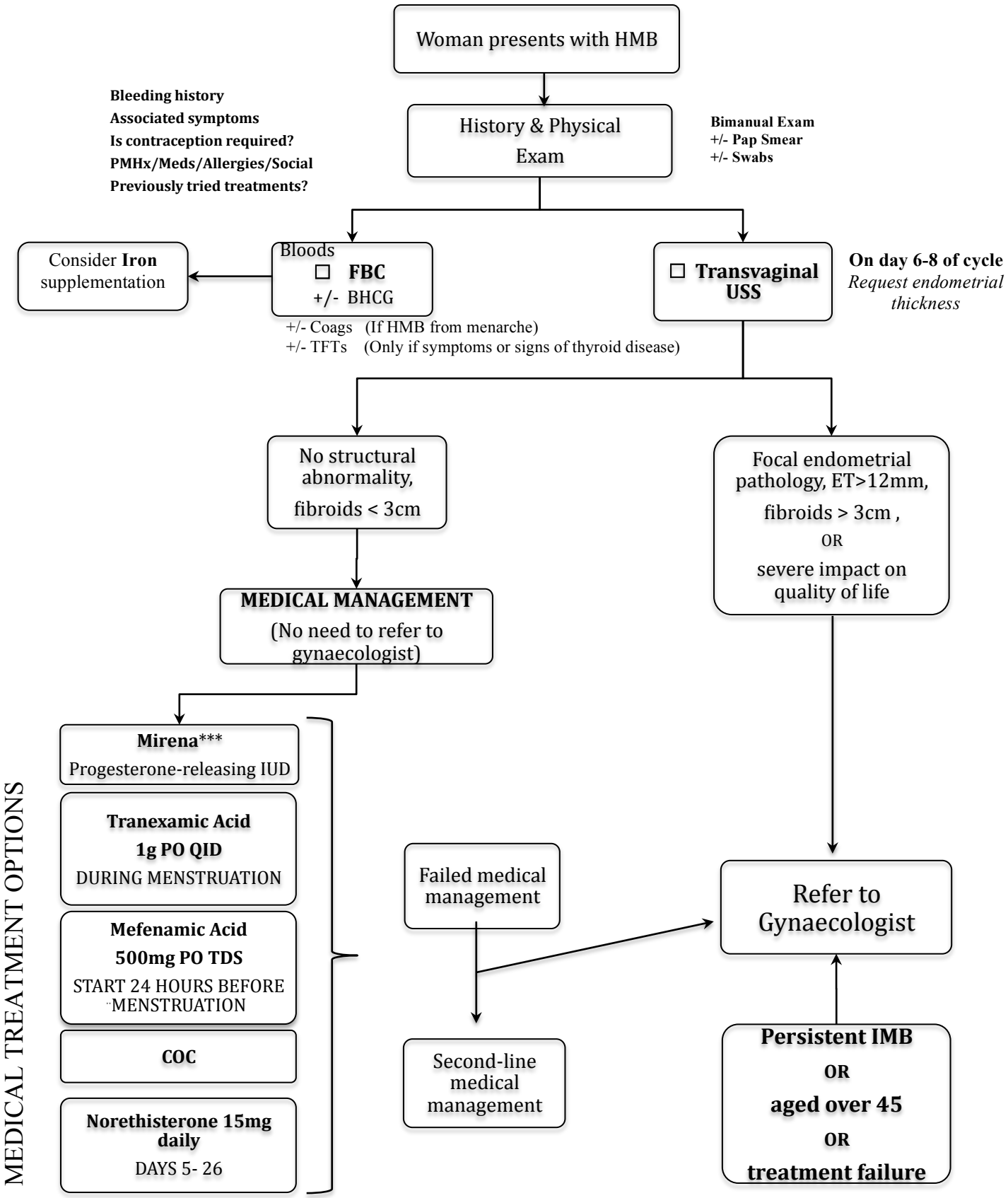
[a] Please review the contraindications to each of the above medications prior to prescribing.

[b] *Note that tranexamic acid and mefenamic acid are often used together to treat HMB*. NSAIDs and/or tranexamic acid should be stopped if it does not improve symptoms within 3 menstrual cycles.

More information may be found at the following sites:

- NICE guidelines (UK): http://guidance.nice.org.uk/CG44
- Australian Doctor: http://www.australiandoctor.com.au/htt/pdf/AD_031_038_MAR06_09.pdf

MANAGEMENT OF HEAVY MENSTRUAL BLEEDING IN PRIMARY CARE



HMB: Heavy menstrual bleeding; ET: Endometrial thickness.
Please note that the investigations marked with a " □ " must be attached to any referrals for them to be accepted.

***Note: There are **GPs on the Gold Coast that are accredited to insert Mirena** IUDs. Referring your patient to a GP for insertion of their Mirena may significantly reduce their waiting period. A list of these qualified GPs can be found at the FPQ website http://www.fpq.com.au/pdf/IUDDoctorDatabaseWebsite.pdf.