ABNORMAL UTERINE BLEEDING

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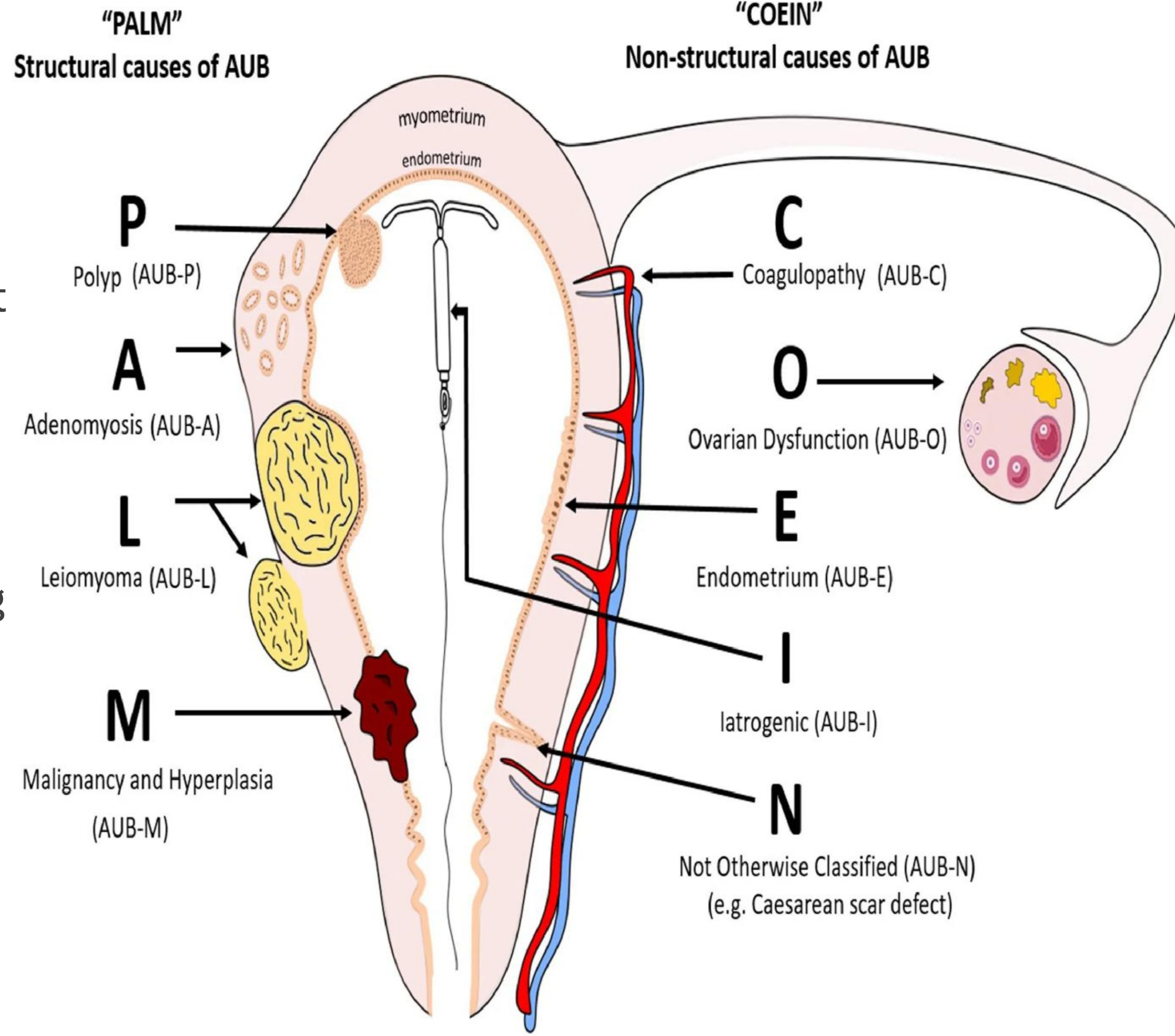
- Defn- heavy cyclical menstrual bleeding that interferes with the physical, emotional, social and QOL; can either be asymptomatic or symptomatic, e.g. syncope.

- Does not include pregnancy related bleeding , intermenstrual or PCB



Normal menstrual parameters

- Cycle frequency 24-38 days
- Duration of bleeding <8 day(mostly 4-6 days)
- Volume of blood loss 5-80ml per cycle
- Age at menarche- 10- 15 years

Risk factors

- Hx of chronic anovulation- PMOS(formerly PCOS)
- Exposure to unopposed eostrogen
- Tamoxifen exposure
- Hx of LYNCH syndrome(familial hx of endometrial and colon ca)
- Nulliparity
- Obesity- assocd to diabetes, HTN

History and exam

- Age
- LNMP
- Contraception
- Parity and desire for future fertility
- Freq and bleeding pattern
- Volume of bleeding
- Impact on QOL
- Dysmenorrhea
- CST status
- Cormobidities- DM, obesity, thyroid d’s, PMOS, bleeding disorders
- Current meds
- Symptoms of Fe def with/without anemia

Exam- abdominal and pelvic exam

HMB

- Losing more than 5– 6 tablespoons of blood (80mls)
- Passing clots that are larger than a 50 cent coin
- Bleeding so much that you have to change your pad/tampon every hour
- Having to get up most nights to change your pad/tampon
- Having to put a towel in your bed or use large maternity pads when you sleep
- Bleeding through clothing
- Have bleeding that lasts more than eight days (prolonged bleeding)

Investigations

- Pregnancy test
- FBE
- Fe studies
- Coag profile and vWD screening
- TSH
- CST
- Pelvic USS- ET thickness, uterine pathology- preferably TVS, on D5-10
- Hysteroscopy
- Endometrial sampling- pipelle/HDC

Investigations

- Endometrial biopsy considered if:
- ET- >12mm in premenopausal women
- Bleeding is unresponsive to medical treatment
- Presence of clinical R/F to Ca endometrium

MNGT

- **Non- hormonal treatment**

1. PO TXA (antifibrinolytic)1-1.5g TDS- QID, D3-5 of each cycle
2. NSAIDS(dec prostaglandins)- ibuprofen 200-400mg TDS, start just before or at onset of periods for 5/7 or MFA 500mg TDS

- **Hormonal treatment**

1. LNG- IUS- most effective+ contraception- upto 8 years
2. Combined hormonal contraception- pills or vaginal ring- extended(63/7 or 84/7- fewer bleeds) or continuous use(amenorrhea).

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3. Oral progestogens

- ✓ Regular/ovulatory cycles- for 21/7 or continuous

-medroxyprog 5-10mg, OD- TDS on D1-21 or norethisterone 5mg BD-TDS on D5-26

- ✓ Irregular/anovulatory cycle- cyclical or continuous

-medroxyprog 5-10mg OD for 12 days of each calender month or norethisterone 5mg OD/BD for 12 days of each calender month or micronized progesterone 200-300mg OD for 12 days of each calender month.

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4. Depot medroxyprogesterone- induces amenorrhea after a year in 50-70% using it for contraception.

- Alternative for LNG- IUS or vaginal ring.

Surgical treatment

- Hysteroscopic resection of polyps, SM fibroids
- Endometrial ablation
- Uterine artery embolization
- Myomectomy- lap or open
- Hysterectomy

Acute Severe Heavy Uterine Bleeding

- Exclude pregnancy
- Investigate for coagulation disorders in adolescents
- In adults investigate for underlying cause once stabilised.

1. **Oral progestogens-** risk of withdrawal once therapy is stopped

- ✓ Medroxyprog 10mg Q4-8hrly till bleeding stops OR
- ✓ Norethisterone 5-10mg Q4-8hry till bleeding stops

2. **COCs**- high dose oestrogen, EE 35- 50mcg Q6hrly till bleeding stops.

- ✓ Advise on risk of withdrawal bleeding once OCP is stopped.
- ✓ VTE risk with high dose.
- ✓ Antiemetic recommended.

Acute Severe Heavy Uterine Bleeding

- TXA
- ✓ Clinic setting- PO 1-1.5g Q 6-8hrly till bleeding stops
- ✓ Hospital setting- IV 10mg/kg Q8hrly till bleeding stops

CLINIC REFERRALS AND APPOINTMENTS

- GP referrals received are monitored with a consultant review and triage of each referral for the allocation of appointments according to triage category and appointments sent to the consumer as per standard Specialist Consulting room processes.
- Patient with HMB are referred for early specialist review when there is a suspicion of malignancy or other significant pathology based on clinical assessment or ultrasound(CAT 1).
- Recommended that patients be referred if no response after 6 months of medical treatment.
- Correspondences to the GP after first appt, ongoing reviews and upon discharge.

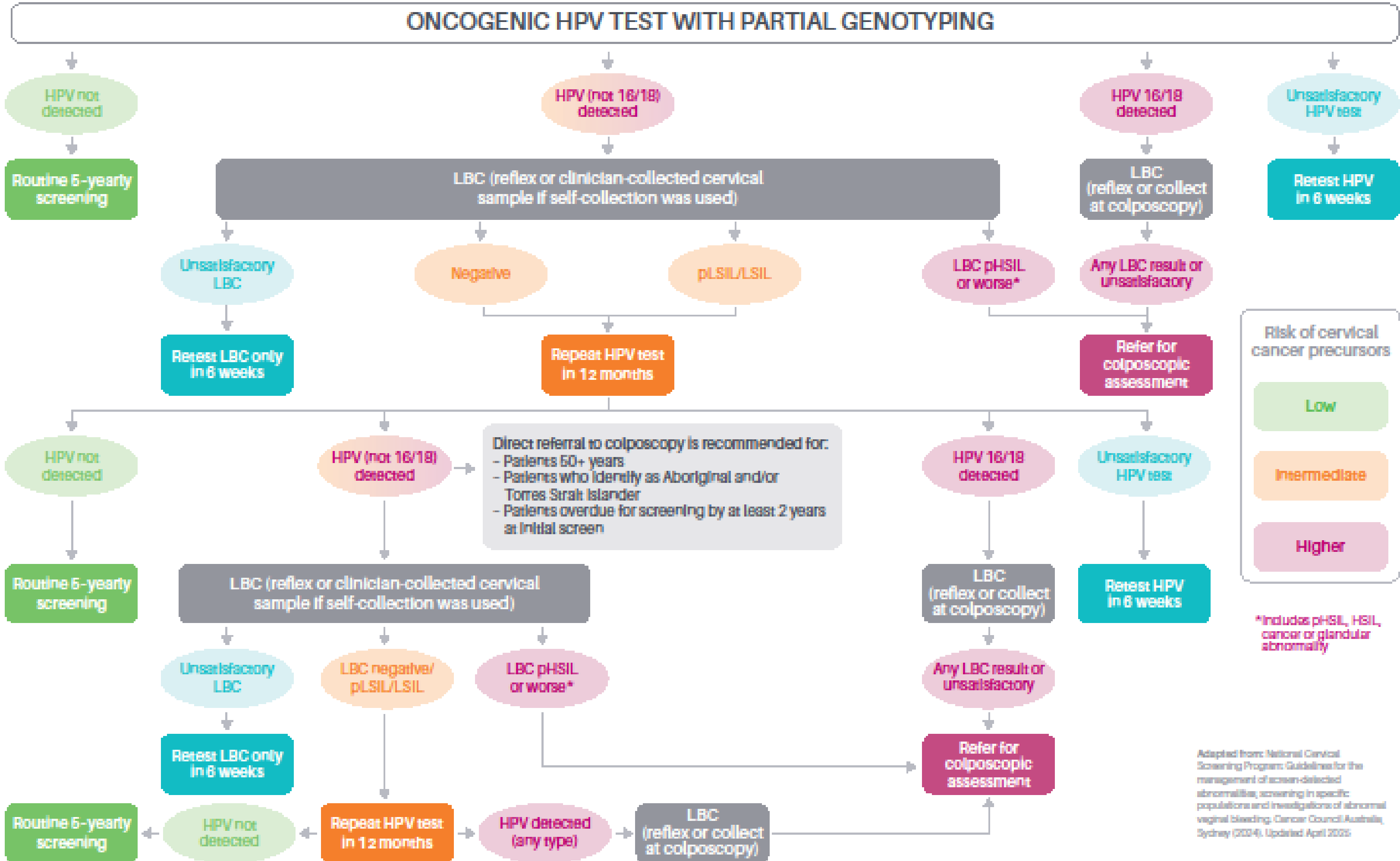
CST

- A preventative healthcare program aimed at reducing the rates of cervical cancer and death from cervical cancer in people with a cervix between the ages of 25 and 74 years old.
- People with a cervix are invited to be screened every 5-years, or more frequently if results are abnormal, through testing for presence of Human Papilloma Virus (HPV).
- HPV is a common virus that can cause cervical cancer.
- This test can be clinician or self collected.

HPV

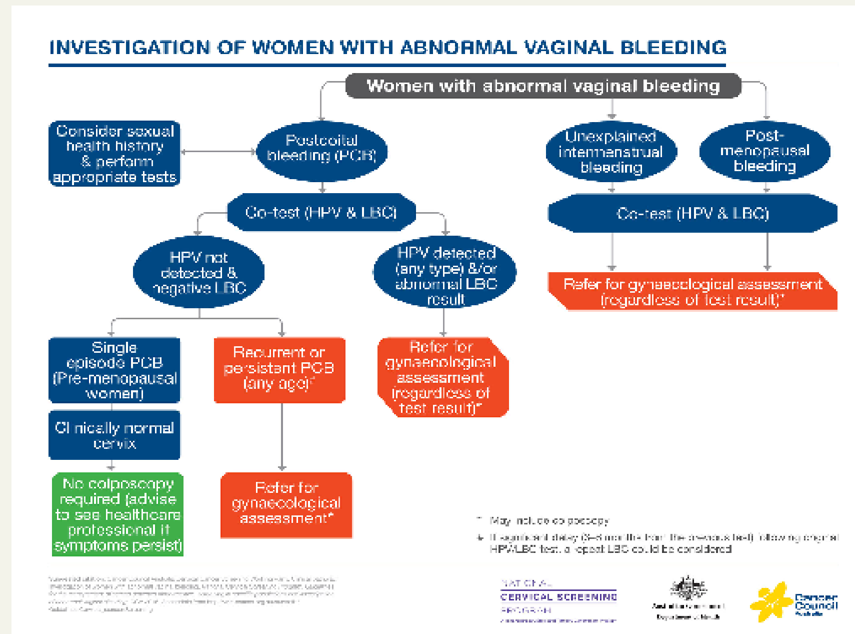
- More than 100 subtypes
- 40 infect the lower genital tract epithelium
- HPV 6 and 11 cause about 90% of the genital warts
- No association with cervical cancer but with 10% of LSIL
- 15 subtypes recognized as potentially oncogenic- 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68, 73, 82
- HPV 16 and 18 are believed to be responsible for approx. 70% of ca cx in Australia

Routine cervical screening (clinician- or self-collected)



MELBOURNE PATHOLOGY

Figure 4. Investigation of women with abnormal vaginal bleeding



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Reference

- RANZCOG guidelines on heavy menstrual bleeding
- GVH- HMB guidelines
- NCSP guidelines

THANK YOU

QUESTIONS??