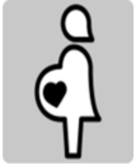
TYGERBERG HOSPITAL
Department of Obstetrics and Gynaecology: General Specialist Services
Protocol for management before referral to Specialist Services



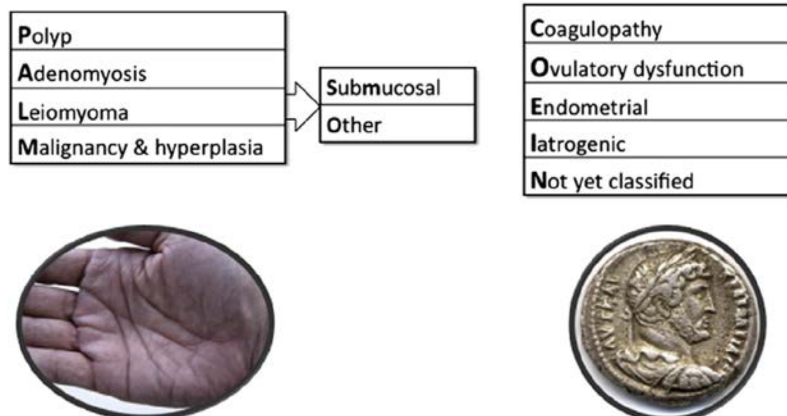
Management of Heavy Menstrual Bleeding/Abnormal Uterine Bleeding (compiled from EDL, NICE 2018 and FIGO 2011)

Clinical problem: bleeding from the uterus that is abnormal in volume, regularity, and/or timing, and has been present for the majority of the past 6 months.

GENERAL MEASURES

- All women over 40 years of age should have a transvaginal ultrasound and endometrial sampling for histology (or any age if at risk for endometrial hyperplasia/polyps as identified from history and/or examination)
- Actively exclude organic causes, e.g. fibroids, for abnormal uterine bleeding (PALM-COEIN).
- All women should receive a speculum examination to rule out cervical pathology. A cervical cytology smear should be performed if indicated according to the screening program. If the cervix appears abnormal, do a cervical biopsy as well.

Classification (FIGO) of causes



APPROACH:

Take a thorough history
Focus on:

- details of the menstrual cycle (menarche, normal cycle, LNMP, change in bleeding pattern)
- symptoms of pregnancy
- dysmenorrhoea
- dyspareunia
- medication including:

        - Hormonal contraception
        - HRT
        - Anticoagulation
    - bleeding tendencies (personal/family history)
    - endocrine causes (symptoms of thyroid dysfunction)
    - last normal cytology smear

Good clinical examination including:

- Signs of anaemia (conjunctival pallor, tachycardia)
- Petechiae
- Purpura
- BMI
- Breast
- Thyroid exam
- Abdominal exam for abdomino-pelvic mass
- Speculum exam (with Pap smear)
- Bimanual exam (only defer in patient who is virgo intacta)

Investigations:

- Urine Pregnancy test
- Cervical cytology smear (unless normal result in last year – see report/get telephonic report from laboratory)
- Ward Hb (FBC if Hb < 8g/dl)
- Clotting profile (if suspecting bleeding tendency, e.g. heavy bleeding since first menstruation)
- TSH (not FT4/FT3)- only when signs or symptoms of thyroid disease are present
- Prolactin (expensive test- only do when no other pathology is present, e.g. fibroids)
- Not needed- Estrogen, FSH, LH levels.
- Transvaginal ultrasound and endometrial sampling if 40 years of age or more

Treatment: Actively bleeding, unstable & requiring transfusion:

- Admit
- Stabilise
- Do blood investigations
- Start emergency blood
- Transfer Tygerberg Gynae Registrar on call

Medical treatment <u>when no organic cause is present or identified</u> (if any underlying causes or pathology is identified, refer to Tygerberg Gynaecology clinic for hysteroscopy/evaluation).

<u>Arrest of acute bleeding</u>
Progestin, e.g:

- Norethisterone, oral, 5 mg 4 hourly until bleeding stops up to a maximum 48 hours.

OR

- Tranexamic acid, oral, 1g 6 hourly on days 1–4 of the cycle.

After bleeding has stopped, continue with:

- Combined oral contraceptive, oral, 1 tablet 8 hourly for 7 days (if not contra-indicated).
- Follow with 1 tablet once daily for 3 months.

<u>For restoring cyclicity:</u>

For women in their reproductive years:

- Combined oral contraceptive, oral, 1 tablet daily for 6 months.

As alternative to combined oral contraceptives:
Progestin only:

- Medroxyprogesterone acetate, oral, 30 mg daily from day 5 to day 26 of the cycle. Use for 3–6 cycles.

OR

- Norethisterone, oral, 15 mg daily from day 5 to day 26 of the cycle.
  Use for 3–6 cycles.

OR
NSAID, oral: e.g.

- Ibuprofen, oral, 400 mg 8 hourly with meals.
  Begin trial of NSAID starting on 1st day of menses until menses cease.

OR

- Tranexamic acid, oral, 1 g 6 hourly on days 1–4 of the cycle.

<u>ADD</u>
For dysmenorrhoea and abnormal bleeding:

- Ibuprofen, oral, 400 mg 8 hourly for 2–3 days with meals, depending on severity of pain.

If medical or conservative management fails, refer to Tygerberg for evaluation for LNG-intra-uterine system.

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DATE EFFECTIVE	1 June 2018
REVIEW DATE	30 April 2019
EVIDENCE	Evidence basis for the above decision is available on request

Signed: GS Gebhardt
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