

Managing menorrhagia

Menorrhagia continues to be one of the most common reasons for referral to a gynaecologist and an increasing range of treatment options can make decision-making for both patient and doctor difficult. A simple stepwise approach to the management of the woman with menorrhagia will make decision making easier. These steps include:

- 1) Establishing the severity of the problem and its impact on the woman's life.
- 2) Assessing the need for further investigation and ruling out any pathology that may limit her treatment options.
- 3) Discussing her contraceptive needs and plans for children in the near or longer term.
- 4) Advising her of what you feel is the most appropriate treatment for her. This may include discussing the benefits and problems associated with a number of treatments or explaining why a treatment she had hoped to receive may not be the best for her.

Assessing the severity of menorrhagia is based largely on a history provided by the women herself. Pictograms to record blood loss (eg Pictorial Blood Assessment Chart – PBAC – scores) can provide some objectivity in assessing blood loss but their reliability has been questioned.^{1,2} Other objective methods of measuring blood loss, requiring the collection of sanitary material, have little role outside of a clinical trial. There is also little correlation between objectively measured blood loss and the perceived impact on a woman's working, family and social life. Problems, such as flooding, being unable to work effectively, cancelled social or sporting activities and sexual difficulties, are all points to raise and discuss. A few women will clearly have a severe problem, as demonstrated by chronic anaemia or admission for blood transfusion, but in most cases, history alone will provide an assessment of how much of a problem an individual woman has. Assessing the regularity of her cycle and whether she appears to be ovulatory or anovulatory is helpful. Symptoms of inter-menstrual or post-coital bleeding and dysmenorrhoea or dyspareunia may point to the presence of intra-uterine or pelvic pathology.

Following investigation, many women can be reassured that no pathology is present and their range of treatment options is wide. For others, such as those with large fibroids or endometrial hyperplasia, their options may only be surgical. A pelvic examination is essential and for most women this will need to be supplemented with a transvaginal ultrasound. Scanning will permit assessment of the endometrium for thickness and signs of an endometrial or fibroid polyp. Within the myometrium, fibroids or signs of adenomyosis may be seen and in anovulatory women, the ovaries may have features to support a diagnosis of polycystic ovarian syndrome.

Current New Zealand guidelines for endometrial sampling are that this should be undertaken in women over 45, with a body mass index over 30 or a family history of bowel cancer.³ To this list can be added women with irregular bleeding or an abnormal endometrium on ultrasound. The chances of any endometrial pathology being present in a slim woman under 45 with regular heavy periods are very low. Hysteroscopy can be reserved for women who appear to



Martin Sowter
FRANZCOG

have a focal endometrial abnormality on ultrasound, where ultrasound visualisation of the endometrium has been sub-optimal, where an abnormal cavity has been seen on ultrasound, or where an inadequate or no sample has been obtained by pipelle biopsy.

Initial treatment options for may include Cyclokapron and NSAIDs. However, most women referred on from primary care will already have found these treatments less effective than they would like and both long-term continuance and satisfaction rates for these treatments are low.⁴ That said, it is often worth reviewing how these treatments have been used as sometimes they have been used only occasionally or at a very low dose.

For the gynaecologist, the Levonorgestrel intra-uterine system (Mirena) is increasingly used as first-line therapy. In some studies, continuance and satisfaction rates over five years approach 80 per cent.⁵ However, one must accept that in other studies nearly 40 per cent of women have requested removal within two years.⁶ Appropriate pre-insertion counselling and support during the first six months of use appears to improve continuance rates.

Two important benefits of Mirena is that it is very effective as a contraceptive and fertility returns as soon as it is removed. Regret post-hysterectomy is a well-documented phenomenon and it seems appropriate to guide younger women towards treatments for menorrhagia that don't preclude them having further children in their current or a new relationship.

For women currently hoping to conceive, Mirena will not be appropriate and Cyclokapron or NSAIDs may be helpful. Many of these women will have anovulatory menorrhagia associated with polycystic ovarian syndrome and will need advice on ovulation induction or weight loss if appropriate. For ovulatory women, any pathology that is causing menorrhagia (for example a fibroid polyp) may also be reducing their chances of conception.

Endometrial ablation provides an important alternative to Mirena for women who have completed their family. A range of devices are currently marketed in Australia and New Zealand, including fluid-filled balloons (Thermachoice, Menotreat), microwave

probes (MEA – Microsulis) and bipolar electrical devices (Novasure). Some, such as microwave endometrial ablation, may be more suitable for women with an abnormal uterine cavity and others, such as thermal balloons, may be associated with a lower amenorrhoea. However, all appear to have similar satisfaction and reintervention rates. In most centres, these devices have largely replaced hysteroscopic resection but it is important that these skills are maintained, particularly for the removal of intra-cavity fibroids. The 'ideal' woman for endometrial ablation is one with a normal or near normal uterine cavity who is over 40 years of age and using permanent contraception, such as tubal ligation or vasectomy. However, many gynaecologists are faced with an increasing number of women for whom hysterectomy poses significant surgical risk and Mirena has failed (for example the morbidly obese woman with fibroids). Endometrial ablation may be less likely to succeed in these women but should be considered.

For some women, hysterectomy remains the best and most effective treatment. Many women attend clinic either wanting a hysterectomy or worried that one will be forced upon them. In an age of multiple treatments, it is important that role of hysterectomy in the treatment of each woman is discussed. The high satisfaction rates associated with hysterectomy must be acknowledged but its higher complication rate and more prolonged convalescence compared with other therapies must be discussed.

A number of newer therapies may also soon be used to treat menorrhagia. This includes the use of anti-progestogens and selective progesterone receptor modulators (SPRMs). Mifepristone has been shown to reduce blood loss by 60 to 100 per cent over three to six months of use, at a dose of five mg to 50 mg but endometrial hyperplasia appears to be a concern unless used at a low dose.⁷ Another SPEMRM Asoprinil has also recently undergone FDA trials and appears to produce reversible amenorrhoea without any oestrogen deprivation.⁸ Other SPRMs are being developed and may come on stream in future years. Lower dose frameless and smaller sized Levonorgestrel releasing alternatives to Mirena are also being developed and may be available in future years.^{9,10}

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If you would like to contribute to *O&G* or have any questions relating to the publication, please contact:

Louise Pobjoy
Communications Officer
RANZCOG
254-260 Albert Street
East Melbourne VIC
Australia 3002
(e) lpobjoy@ranzco.edu.au
(t) +613 9412 2915

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