Primary Care
Women's Health Society

Mang

Top tips

Management of heavy menstrual bleeding

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Heavy menstrual bleeding (HMB) is common, with a prevalence over 50% in some studies[1]; it can significantly impact on physical and psychological health[2]. It is critical to establish a safe and respectful environment for women to share their experience and to use the woman's priorities to guide your management, using a shared decision-making process.

1 It's quality not quantity that counts

- If a woman reports struggling with HMB then we should take that symptom seriously, no matter how many pads she is getting through in a day.
- Quantifying her loss (e.g. by asking about frequency of pad changes, use of double protection or flooding) can be useful, but the answers to these questions shouldn't be used to minimise the significance of the bleeding to her.

2 You might need more than one consultation

- This can be a lengthy history to take, plus the possible need for an examination; for those with strict 10 minute consultations, it can be tricky to fit it all in.
- Don't be afraid to bring the woman back if you need more time, or if she needs time to think about her options after you have outlined your possible management strategies.

3 Tranexamic acid

- It is more effective than non-steroidal anti-inflammatory drugs (NSAIDs) at reducing blood loss[3,4].
- Start as soon as possible; this could be just before the period is about to start.
- It can be prescribed or bought over the counter.
- It is generally well tolerated but take a clotting history – contraindicated if active thromboembolic disease or a history of venous/arterial thrombosis[5].

4 NSAIDs

- Mefenamic acid is no better than other NSAIDs at reducing blood loss[6]; it is more expensive and the tablets are larger. It is however licensed for this purpose[7] whereas other NSAIDs are used off licence.
- It carries a higher risk of toxicity than other NSAIDs[8]; toxicity has been seen at 60mg/kg[9] – depending on the body weight, that may be well under twice the prescribed dose.

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5 Hormonal treatment

- Be aware of hormonal hesitancy[10] and take every opportunity to counter worries which are not evidence based.
- The only combined oral contraception (COC) which is licensed for HMB is Qlaira; it is more expensive than other options, which are regularly used for this off-licence.
- Consider tailored use of the COC (tricycling, flexible extended use or continuous use) – this is off-licence but the College of Sexual and Reproductive Health recommend that all women are given this information[13]. It can also be used with the combined patch or vaginal ring.
- If combined hormonal contraception (CHC) isn't suitable, consider a progestogen only pill (POP) or cyclical progestogens such as norethisterone (licenced) and medroxyprogesterone acetate (MPA - unlicensed)[1,14,15]. MPA is less thrombogenic than norethisterone and the latter shouldn't be used in women for whom CHC would be contraindicated[17].
- The levonorgestrel intrauterine device (LNG-IUD) can also be used first-line and reduces blood loss by more than any other first-line options. It should only be used if there is no identified pathology other than fibroids <3cm or suspected/diagnosed adenomyosis[2].
- Be culturally sensitive; spotting from the POP or LNG-IUD can be very disruptive for patients, in some cases disallowing them from religious rituals. Let her know the options and help her to make the best decision for her as an individual.

6 Think about drug interactions

- Many of our patients will be taking weight loss injections privately, often without the GP being informed.
- Tirzepatide reduces the effectiveness of oral contraception; always ask if the woman is taking a weight loss injection[18].
- Think also about herbal medications such as St. John's wort which may interact[19].

7 Don't be afraid to refer if needed

- Consider referral with fibroids ≥ 3cm or if primary care medical treatment has failed[2].
- Secondary care may offer gonadotrophin-releasing hormone antagonists, endometrial ablation or surgery such as myomectomy or hysterectomy.
- It is worth assessing the woman's expectations before referral; if she would not want to accept any of the treatments offered in secondary care, there may be no point in referring.
- Continue to try the various primary care options, including LNG-IUD (referring for fitting if it isn't something that your setting offers).

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 The PCWHS aims to educate primary care clinicians about women's health, i.e. the health of those who were registered female at birth. Our resources therefore all use the words woman/women and the pronouns she/her. Where patients have a gender identity which is different from their sex registered at birth, communication should be sensitive and respectful of the patient's pronouns.
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Resources

- NICE guidelines on HMB.
- Patient information leaflet on tailored pill taking.
- CoSRH guideline on CHC.
- NHSE decision support tool on HMB.
- Interventions for heavy menstrual bleeding; overview of Cochrane reviews and network meta-analysis

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