

# Shared Decision Making Aid for Heavy Menstrual Bleeding

## Heavy Periods: What are my options?

This decision aid is designed for you to discuss with your health care professional and help reach a shared decision that works for you. It aims to help you answer three key questions about your healthcare:

- What are my options?
- What are the benefits and risks of each option for me?
- How can I get support from my healthcare professional to make a decision that is right for me?

Heavy menstrual bleeding (HMB) is excessive menstrual blood loss that affects your quality of life. It remains one of the most common reasons for seeing a gynaecologist, with 1 in 20 women aged between 30 and 49 years consulting their GP every year due to heavy periods or menstrual problems. If heavy periods are affecting your quality of life, you can be offered various treatment options. This document lists the possible benefits and risks of the options available to you for heavy periods. Some of the treatments listed here may not be suitable for you depending upon your individual circumstances. The aim of treatment is to improve your quality of life.

Your health care professional will ask you about your periods and any concerns you have. You may be offered an internal examination and further tests like hysteroscopy (where a small telescope is used to get a view inside your womb) and/or ultrasound scan to find the cause of heavy periods. Your health care professional will then discuss and document available treatment options to help you make a decision that is right for you considering your preferences, any other medical issues (like medical conditions, obesity, previous surgery etc.), whether you have fibroids (including size, number and location), polyps, any problems with your womb lining, adenomyosis and any other symptoms such as pressure and pain. If you try one treatment and it doesn't work, you can try the other available options.

### **YOUR OPTIONS INCLUDE:**

- **Monitoring** – Wait and see how things go without any active treatment. This can be either monitoring you carry out yourself or monitoring with a health care professional. You can consider opting for other available treatments at any stage.
- **Hormonal treatment** – Levonorgestrel-releasing intrauterine system e.g. Mirena® or hormone tablets like combined oral contraceptives or progestogens either in the form of tablets or a 3 monthly injection or implant.
- **Non-hormonal treatment** – tranexamic acid or nonsteroidal anti-inflammatory drugs (NSAIDs).
- **Surgical treatment** – endometrial ablation, uterine artery embolization, myomectomy or hysterectomy.

## MONITORING

Option	Benefits	Possible side-effects/risks
Watchful waiting without any active treatment	<p>No side effects</p> <p>You can choose alternative treatment option at any time.</p> <p>Your periods will eventually stop-average age of menopause in the UK is 51.</p>	<p>Heavy periods may affect quality of your life</p> <p>Periods may get worse</p>

**HORMONAL TREATMENT WITH LEVONORGESTREL-RELEASING INTRAUTERINE SYSTEM (LNG-IUS): First treatment option** to consider if there is no known cause for your symptoms or you have small fibroids (less than 3 cms) or you have suspected or known adenomyosis. May be a suitable option for fibroids more than 3 cms, depending upon their size and location.

Option	Benefits	Possible side-effects/risks (see footnote)
<p>Levonorgestrel-releasing Intrauterine system (LNG-IUS)</p> <p>A small plastic device that slowly releases the hormone progestogen is placed into your womb through your vagina</p> <p>Helps to thin the lining of the womb</p> <p>Involves a minor procedure (approximately 10-15 minutes in total) usually in the clinic setting. Majority of women experience moderate period type discomfort during fitting which can be helped by simple painkillers like paracetamol.</p>	<p>Considered to be the most effective treatment option</p> <p>Up to 95% reduction in total menstrual blood loss</p> <p>May take up to 6 cycles for it take effect so you are advised to wait for 6 months to see the full benefit</p> <p>1 in 4 women will have no periods at all after 6 to 12 months of insertion</p> <p>Can help to reduce period pain</p> <p>It lasts five years but can be removed at any stage</p> <p>It is a very effective long-acting contraceptive as well, so it is not suitable for those trying to conceive.</p> <p>It does not affect your fertility after removal.</p>	<p>Common: unpredictable bleeding that may last for 6 months or sometimes longer: usually, but not always, light and settles down; hormone related problems such as breast tenderness, acne or headaches, which if present are generally minor and short-lived</p> <p>Less common: no periods at all</p> <p>Rare: damage to the wall of the womb at the time of IUS insertion (1.4 in 1000)</p> <p>Needs replacing every 5 years</p>

**Side-effects/risks are classed as:**

**Common = 1 in 100 chance, Less Common = 1 in 1000 chance, Rare = 1 in 10 000 chance, Very rare = 1 in 100 000 chance**

**If LNG-IUS is not suitable or you do not want it, treatment options to consider include:**

**NON-HORMONAL TREATMENT:** These can be started while you are awaiting further tests and can be continued for as long as you wish if it helps you

Options	Benefits	Possible side-effects/risks
<p>Tranexamic acid</p> <p>Involves taking 2 tablets orally, 3 times a day, from the day your period starts for up to 4 days each month</p>	<p>This is non-hormonal treatment, so it has none of the side-effects of hormones</p> <p>Up to 58 % reduction in total menstrual blood loss</p> <p>Suitable for women trying to conceive as it does not affect your fertility</p>	<p>Less common: indigestion; diarrhoea; headaches</p> <p>Does not reduce length or pain of periods</p> <p>This is not a contraceptive.</p>
<p>Non-steroidal anti-inflammatory drugs (NSAIDs) e.g. ibuprofen and mefenamic acid.</p> <p>Involves taking tablets orally from the start of your period or just before, until heavy blood loss has stopped; usually three times a day, for up to five days</p> <p>Reduces your body's production of a substance linked to heavy periods</p>	<p>Helps with period pain as well</p> <p>Up to 50 % reduction in total menstrual blood loss</p> <p>Also suitable for women trying to conceive as it does not affect your fertility</p>	<p>Common: indigestion; diarrhoea.</p> <p>Rare: worsening of asthma in sensitive individuals; peptic ulcers</p> <p>This is not a contraceptive.</p>
<p>Tranexamic acid plus NSAIDs</p>	<p>May work better than the above medications taken on their own</p>	<p>Side effects: as for the individual medications.</p>

## HORMONAL TREATMENT

Options	Benefits	Possible side-effects/risks
<p>Combined oral contraceptive pills (COCs)</p> <p>Involves taking a tablet containing oestrogen and progestogen-- every day for three weeks, stopping for a week and then repeating.</p>	<p>Helps with period pain.</p> <p>Up to 40 % reduction in total menstrual blood loss</p> <p>It is an effective contraceptive</p> <p>It does not affect your fertility after you come off the pills.</p>	<p>Common: mood change; headache; nausea; fluid retention; breast tenderness</p> <p>Rare: blood clots in legs/lungs: risks increase with age and body weight</p> <p>Forgetting to take pills may cause irregular bleeding</p>
<p>Oral progestogen (Norethisterone)</p> <p>Involves taking tablets orally 2 to 3 times a day from day 5-26 of your menstrual cycle (counting first day of your period as day 1)</p> <p>Helps thin the lining of the womb</p>	<p>Up to 80% reduction in total menstrual blood loss in the long term</p> <p>It does not affect your fertility after you come off the pills.</p>	<p>Common: weight gain; bloating; breast tenderness; headaches; acne (usually minor and transient)</p> <p>Rare: depression</p> <p>This is not a contraceptive</p>
<p>Progestogens in the form of injection or implant used mainly for their contraceptive effects can also help reduce menstrual blood loss</p> <p>Long acting progestogens are either injected every 12 weeks, usually into the buttock or</p> <p>Implant into the arm that lasts for 3 years</p> <p>Thins the lining of the womb</p>	<p>Mainly used as an effective contraceptive</p> <p>Up to 50 % reduction in menstrual blood loss</p> <p>Bleeding may stop completely in some women</p> <p>It does not affect your fertility in future.</p> <p>However, sometimes, it can take a while for periods to return and for you to be able to conceive after discontinuing progestogen injection or implant.</p>	<p>Common: weight gain; irregular bleeding; absence of periods; premenstrual symptoms</p> <p>Less common: osteoporosis (largely recovers after stopping treatment)</p>

## SURGICAL TREATMENT

Options	Benefits	Possible side-effects/risks
<p>Endometrial ablation</p> <p>Involves surgery to destroy the lining of the womb by a variety of methods:</p> <ul style="list-style-type: none"> <li>• Radiofrequency ablation (Novasure)</li> <li>• Thermal balloon endometrial ablation (TBEA)</li> </ul> <p>Technique involves inserting a device into the womb through the vagina and cervix to destroy the lining with radiofrequency energy (Novasure) or heated fluid (Thermal balloon).</p> <p>Can be done under local or general anaesthesia.</p>	<p>Minimally invasive surgery</p> <p>Can be done in out-patient clinical settings if you prefer</p> <p>Considered to be the best surgical treatment for reducing blood loss in women with no fibroids</p> <p>Saves/preserves the womb</p> <p>Novasure ablation seems to be more effective in reducing the blood loss compared to other ablation techniques with 9 out of 10 women experiencing significant reduction in blood loss &amp; about 5 in 10 women experiencing no bleeding at 12-month follow-up.</p>	<p>Common: vaginal discharge; irregular bleeding; increased period pain or cramping (even if no further bleeding); need for additional surgery:</p> <p>Less common: infection</p> <p>Rare: damage to womb (very rare with newer available techniques)</p> <p>If performed under general anaesthetic, there is a small added risk from the anaesthetic.</p> <p>Is not a contraceptive, so you will be advised to use contraception as pregnancy after the procedure carries increased risks.</p> <p>This is a permanent solution and cannot be reversed. It is not suitable if you want to consider pregnancy in future.</p>
<p>Uterine artery embolization (UAE)</p> <p>This involves blocking the blood supply to the fibroids causing them to shrink.</p> <p>Treatment option to be considered depending upon the size (3ms or more), location and number of fibroids, and the severity of the symptoms.</p>	<p>Helps shrink the fibroids and reduce the bleeding</p> <p>May be suitable for you if you wish to consider pregnancy in future</p>	<p>Common: persistent vaginal discharge; post-embolization syndrome – pain, nausea, vomiting, abdominal pain and fever</p> <p>Less common: need for additional surgery; premature ovarian failure (1 to 2 in 100 women, particularly in women over 45 years old); haematoma</p>
<p>Myomectomy</p> <p>Surgery to remove fibroids either through your vagina using a thin telescope, called a hysteroscope or through a cut in your abdomen (key hole or open surgery)</p>	<p>Helps remove whole or part of the fibroids and reduce the bleeding</p> <p>May be suitable for you if you wish to consider pregnancy in future</p>	<p>Major surgery</p> <p>Less common: Bleeding, infection, adhesions, recurrence of fibroids, damage to womb, need for further surgery</p>

Options	Benefits	Possible side-effects/risks
<p>Hysterectomy (major surgery to remove the womb and/or neck of the womb) -this may be total hysterectomy (removal of womb and neck of the womb) or subtotal (removal of womb only, keeping the neck of the womb)</p> <p>Hysterectomy is an option if:</p> <ul style="list-style-type: none"> <li>• Other treatment options haven't worked for you (unsuccessful) or</li> <li>• Other treatment options are not deemed suitable for you e.g. due to presence of large fibroids or</li> <li>• Heavy bleeding is significantly disrupting your life or</li> <li>• You do not wish to try other treatment options</li> </ul> <p>and</p> <ul style="list-style-type: none"> <li>• You fully understand the benefits and risks involved and</li> <li>• You don't want to keep your womb or to have a child in future</li> </ul>	<p>Your periods stop permanently</p> <p>No need for further treatment for periods</p> <p>Contraception not needed.</p>	<p>Major surgery</p> <p>Cannot be reversed and you cannot conceive after this</p> <p>Common: infection</p> <p>Less common: bleeding during surgery (more likely if you have fibroids when a hysterectomy is carried out); damage to other abdominal organs, such as the bladder or bowel;</p> <p>Can affect the way your bladder works (frequent passing of urine, urinary leakage)</p> <p>Can have a psychological effect on you and can affect your sexual feelings</p> <p>Rare: thrombosis (DVT and clot on the lung)</p> <p>Very rare: death</p>
<p>Hysterectomy.....</p> <p>This involves surgery and hospital stay. It may be undertaken via</p> <ul style="list-style-type: none"> <li>• Vaginal route</li> <li>• Abdominal route –opening the tummy</li> <li>• Laparoscopic route (key hole)</li> </ul> <p>Depending upon your individual clinical situation and taking your preferences into consideration</p> <p>If you or your specialist is considering removal of your ovaries, the potential risks and benefits should be fully discussed with you.</p>		<p>Removal of ovaries at the time of hysterectomy: menopausal like symptoms and may need hormone replacement therapy</p> <p>Risk of early menopause even if your ovaries are not removed during hysterectomy</p>

Written by Mrs. G Kumar, Consultant Gynaecologist, Wrexham Maelor Hospital, BCUHB: August 2018. 1st updated 27<sup>th</sup> Nov 2019, 2<sup>nd</sup> update on 20<sup>th</sup> March 2020 & endorsed by NICE, Nov 2019 & March 2020

Reference: NICE (National Institute for Health and Care Excellence) guideline (NG 88) on Heavy Menstrual bleeding, updated November 2018 and NICE Quality Standards on HMB (QS 47), updated March 2018

This document will be reviewed and updated by the author as and when new evidence becomes available and in line with updates to NG 88 and QS 47.

Additional sources of reference:

1. Heinemann K, Reed S, Moehner S; Do Minh T: Risk of uterine perforation with levonorgestrel-releasing and copper intrauterine devices in the European Active Surveillance Study on Intrauterine Devices: *Contraception* 91 (2015) 274-279
2. Gallinat A: An impedance-controlled system for endometrial ablation: five-year follow-up of 107 patients; *J Reprod Med* 2007; Jun;52(6): 467-72
3. Sharp HT: An overview of endometrial ablation; UpToDate; Jan 2018.
4. Clark TJ, Samuel N, Malick S, Middleton LJ, Daniels J, Gupta JK: Bipolar radiofrequency compared with thermal balloon endometrial ablation in the office: a randomized controlled trial; *Obstet Gynecol* 2011;117 (1):109-118
5. Uterine Artery Embolisation in the Management of Fibroids; Joint report from the Royal College of Obstetricians and Gynaecologists and the Royal College of Radiologists. Published: 23/12/2013.

**For you to write:**

What is important for me?

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My preferred treatment option/s:

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Mutually agreed plan of care:

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