Management of Heavy Menstrual Bleeding

Policy for hysteroscopy and hysterectomy

Policy Author: Rotherham Clinical Commissioning Group
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Introduction:

This policy has been developed to reflect the 2007 NICE guideline Heavy Menstrual Bleeding¹ and the HMB specific recommendations issued by the Royal College of Obstetricians and Gynaecologists in their 2008 document Standards of Gynaecology².

The NICE definition of heavy menstrual bleeding emphasises the importance of the patient’s experience over the volume of blood lost: "Excessive menstrual blood loss which interferes with the woman's physical, emotional, social and material quality of life." NICE recommend interventions should be aimed at improving quality of life, and advocate the provision of patient information to enhance understanding and aid decision making.¹

Policy Summary:

Hysteroscopy for HMB will only be funded if one of the following criteria is met:

- Trans vaginal ultrasound scan provided inconclusive results.
- Trans vaginal ultrasound scan was suggestive of an endometrial pathology (e.g. polyp or submucous fibroid).
- As part of an ablative procedure.
- Inter-menstrual bleeding over the age of 40yrs
- Scan suggests thickened and cystic appearance/hyperplasia

Funding will not be provided for dilatation and curettage (D & C) as a standalone diagnostic or a therapeutic tool in the management of HMB.

Hysterectomy for HMB will only be funded if all the following criteria are met:

1. A levonorgestrel intrauterine system or LNG-IUS (e.g. Mirena) has been trialled for at least 6 months (unless contraindicated* or declined by patient) and has not successfully relieved symptoms.

2. A trial of at least 3 months each of two other pharmaceutical treatment options has not effectively relieved symptoms (or is contraindicated, or not tolerated). These treatment options include:
   - NSAIDs e.g. mefenamic acid
   - Tranexamic acid
   - Combined oral contraceptive pill
   - Oral and injected progestogens
3. Surgical treatments such as endometrial ablation, thermal balloon ablation, microwave endometrial ablation or uterine artery embolisation (UAE)** have either been ineffective or are not appropriate, contraindicated.

*Contraindications to LNG-IUS use include suspected or confirmed untreated sexually transmitted infections (STIs), pregnancy, pelvic inflammatory disease (PID), distorted or small uterine cavity, active trophoblastic disease, genital malignancy and Immunosuppression.**

**UAE may be appropriate for some women with HMB associated with uterine fibroids.

Additional recommendations:

- Patients should be provided with information on all the treatment options including their outcomes, complications and risks in a format they can understand (e.g. a leaflet).
- Patients should have the opportunity to participate in decision making that relates to their care.
- LNG-IUS fittings must only be undertaken by appropriately trained staff, and where possible this should take place in primary care/a community setting.

Rationale:

Guidance from NICE and the Royal College are in agreement that the aim of treatment for HMB should be improved quality of life and that patients should be supported to make informed decisions regarding their care.

The first line treatment for HMB should be the LNG-IUS, (unless contraindicated or declined by the patient), as this has been found to reduce menstrual blood loss by 90% in patients with HMB5-6. The LNG-IUS has been shown to be equally effective in improving quality of life and psychological well being as hysterectomy7-8 and NICE developed a decision-analytic model in which the LNG-IUS was found to generate more QALYs at a lower cost than other medical or surgical management, making it (in theory) the most cost effective treatment9. The evidence compiled by NICE suggests that it may take at least 6 months before the full effect of treatment may be seen.

Both NICE and the Royal College recommend that any medical treatment should be trialled for at least 3 menstrual cycles, and that a second medical treatment should be offered if the first does not successfully relieve the symptoms. By utilising the non surgical treatments, patients can be managed in primary care and are protected from the complications associated with surgery. If these non surgical treatments do not successfully relieve the symptoms, the patient and clinician may go on to consider surgery.

The Royal College recommend that endometrial ablation or resection be considered in preference to hysterectomy. This is because hysterectomy is associated with considerable risk, with 1 in 30 patients experiencing a major adverse event during or just after surgery. Mortality rate ranges from 0.4-1.1 per 1000 operations, and many patients require several days in hospital and weeks to months recovery time at home10. The complication rate and length of admission is inconvenient for the patient and costly to the NHS, hence ablation techniques can offer a safe, effective alternative.

Dilatation and curettage (D & C) will not be funded for the treatment of HMB or as a lone diagnostic tool as there is insufficient evidence of its effectiveness11. This is in keeping with national guidelines and consistent with policies by other Clinical Commissioning Groups across the country.

Ultrasound is the first line investigation for HMB, however hysteroscopy may be indicated if there is a need for further imaging, for example if a polyp or submucous fibroid is suspected, or if there is suspicion of malignancy and a biopsy is necessary. Hysteroscopy has been found to be safe and sensitive diagnostic procedure which can be undertaken in a community setting, and once identified polyps and submucosal fibromas can be removed during the same consultation12.

References:

1.  [https://www.nice.org.uk/guidance/cg44/chapter/1-Guidance](https://www.nice.org.uk/guidance/cg44/chapter/1-Guidance) (accessed 2016)


4. Lethaby AE, Cooke I, Rees M. Progesterone/progestogen releasing intrauterine systems for heavy menstrual bleeding. (Cochrane Review). In: Cochrane Database of Systematic Reviews 2005; Issue 4


