Twenty minutes of Heavy Menstrual Bleeding

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FIGO terminology

Polyp
Adenomyosis
Leiomyoma
Malignancy & hyperplasia

→ **Submucosal**
→ **O**ther

Coagulopathy
Ovulatory dysfunction
Endometrial
Iatrogenic
Not yet classified

Hormonal treatment

- First line evidence based treatment of AUB-O, AUB-E and AUB-C

To some extent useful for AUB-L and AUB-A

The current status of hormonal therapies for heavy menstrual bleeding

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EEC containing COCP's

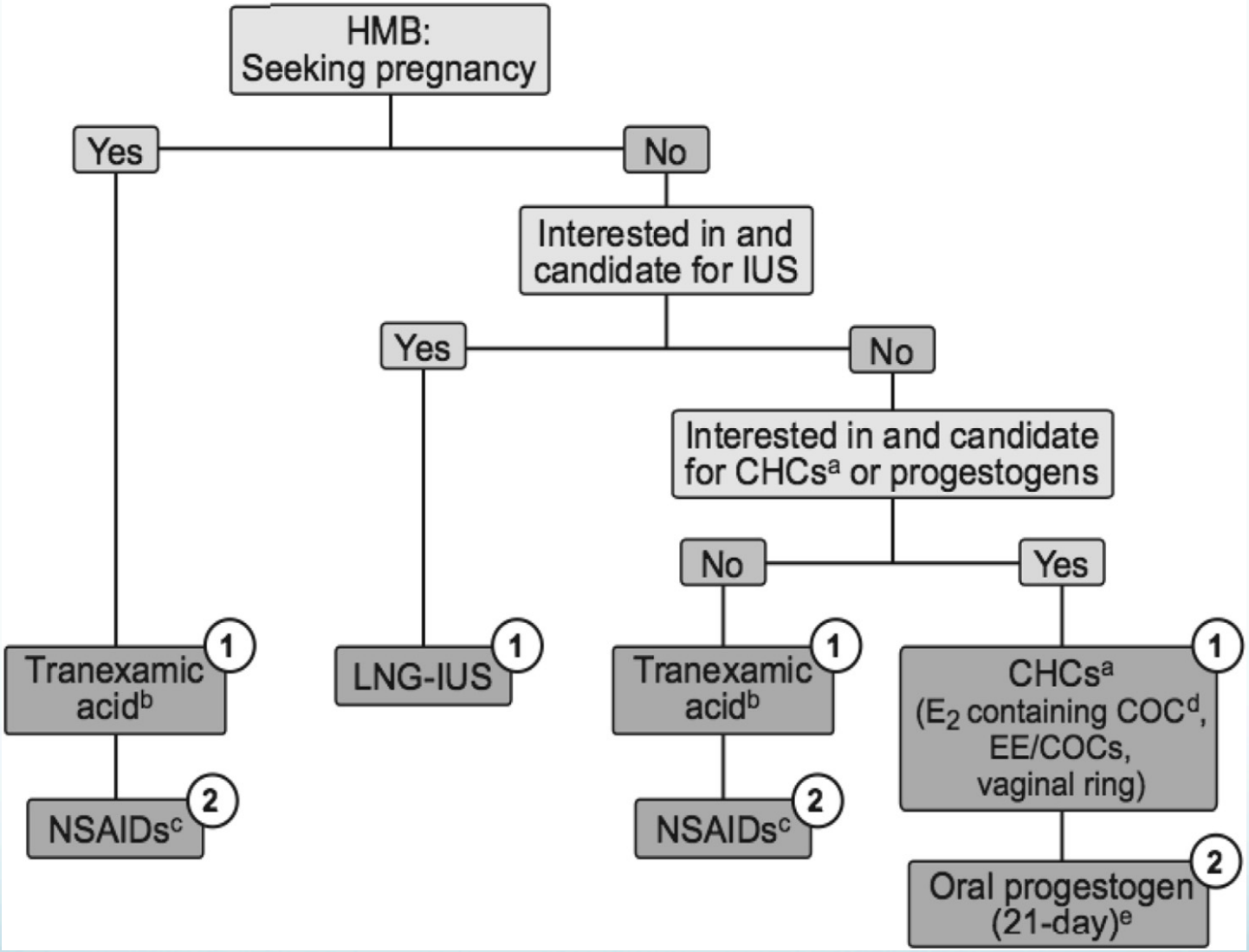
- 30 ug + 150 LNG reduced MBL by 35% (Egypt)
- 20 ug EE + 1 mg NE reduced MBL by 68% (Canada)
- Long cycle NE 5 mg tid days 5-26 reduced MBL by 70%
- Nuvaring reduced MBL 69% (and better tolerated than NE) with 77% continuation rate
- Estradiol valerate (Qlaira/Zoely) reduced by 60%

Oral progestins

- Luteal phase (10-14 days/month) have minimal or no effect on bleeding compared with NSAID's TA or LNG-IUS = ABANDON
- Extended cycle (days 5-26) NE 5mg TID reduced MBL by 87% by 3 months, compared with LNG-IUS, but patient satisfaction poor with only 22% choosing to continue treatment = POORLY TOLERATED

LNG-IUS

- 82% mean reduction in in measured MBL in 3 months
- Significantly better than other medical therapies in multiple randomized studies
- A Cochrane review recently concluded the whilst surgical treatment gave more objective control at 1 year, QOL did not differ at 5 or 10 years between women assigned to surgical or LNG-IUS Rx


HMB:
Seeking pregnancy
Yes
No
Interested in and candidate for IUS
Yes
No
Interested in and candidate for CHCs[a] or progestogens
No
Yes
Tranexamic acid[b]
1
NSAIDs[c]
2
LNG-IUS
1
Tranexamic acid[b]
1
NSAIDs[c]
2
CHCs[a] (E_2 containing COC[d], EE/COCs, vaginal ring)
1
Oral progestogen (21-day)[e]
2

International guidelines

- All new guidelines from Canada, Finland, France, UK, and USA now recommend medical therapy as first line treatment of HMB
- The Australian Commission on Safety and Quality in Health Care 2017 report: Hysterectomy and endometrial ablation
- State and territory health departments to ensure that women who have heavy menstrual bleeding have been offered clinically appropriate treatment options, as described in the Heavy Menstrual Bleeding Clinical Care Standard, before they are placed on a waiting list for hysterectomy.
- MBS descriptors are expected to change, and professional colleges to promote training and education for LNG-IUS insertion.

Trouble shooting in clinical practice

- Choosing the most appropriate medical therapy
- Skilling up for LNG-IUS insertion
- Counselling patients on short and long term expectations of the LNG-IUS, especially bleeding patterns
- Patient selection to avoid complications of LNG-IUS insertion (perforation)
- Deskilling of the gynaecology workforce: a problem when hysterectomy is necessary

Avoiding perforation

- The nulliparous patient
- The patient with a tight cervix
- The recently pregnant patient
- The retroverted uterus
- Appropriate pain relief for insertion
- If it isn't going in easily..DESIST!

Ongoing bleeding with LNG-IUS

- Have you thought about CANCER
- Have you thought about POLYPS
- Have you thought about SUBMUCOUS FIBROIDS

Submucous fibroids

Ongoing spotting LNG-IUS

- Spotting declines with time (couselling) but consider likelihood of other pathologies
- Persistent and prolonged spotting more likely in patients receiving the IUS for HMB than contraception alone
- Can trial additional medical therapies
- If unsuccessful or unsuitable and fertility no longer required consider endometrial ablation before hysterectomy

Endometrial ablation

- First and second generation
- Not contraceptive
- Pregnancy dangerous after EA
- Day surgery technique
- Requires a normal or only modestly enlarged uterus
- Not generally suitable if substantially submucous fibroids
- Best outcomes in women closer to the menopause

EA outcomes

- The Cochrane Database of Systematic Reviews examined the topic of EA alone, and noted that 88% of women had an improvement in menstrual bleeding within one year following treatment for second generation EA techniques, and 35% reported amenorrhoea at one year.
- 26% required additional treatment (mostly hysterectomy) within five years of initial treatment. Patient factors for requiring additional treatment include younger age, parity greater than three, previous caesarean section and pre-operative dysmenorrhoea.

- The rates of amenorrhoea with LNG-IUD for the treatment of abnormal uterine bleeding after one year has been reported at 35% at two years.
- Irregular bleeding was the most common reason for removal. Additional treatment for the treatment of HMB reported to be approximately 25%.
- When EA was compared to LNG-IUD, subjective control of bleeding was more likely to have occurred in the LNG-IUD group. There was no difference in patient satisfaction at two years between the two groups. 11 There appeared to be higher rates of hysterectomy (24% vs. 3.7%) and lower rates of patient satisfaction in the EA group at 5 years compared to the LNG-IUD group.

What about EA + LNG-IUS?

- **Title:** Long term menstrual outcomes 5 years post Endometrial Ablation with concurrent insertion of Levonorgestrel Intrauterine Device in women seeking treatment for benign heavy menstrual bleeding
- **Authors:**
- Dr Melissa Yeoh M.B.B.S.
  Dr Melissa Buttini M.B., B.S FRANZCOG.

EA + LNG-IUS

- A cohort of 148 consecutive patients who had undergone EA and concurrent insertion of LNG-IUD at least 5 years post treatment were identified. Seventy-six of these patients consented to and undertook a phone questionnaire to determine patient satisfaction and if there was need for more definitive management. Long term qualitative data relating to menstrual patterns were obtained by chart reviews and phone interview of a total of 98 patients.

EA+ LNG-IUS

- **Results** : Patient satisfaction was very high with an overall average rate of 9.6/10 at an average of 75 months. Complete amenorrhoea at greater than five years was 53.9%.
- 27.6% patients describing light PV spotting on average every 3.3 months, lasting and average 2.1 days.
- Eight hysterectomies were performed in 98 subjects subsequent to the original procedure.
- **Conclusions** : EA with concurrent insertion of an LNG-IUD is an effective treatment for benign HMB with high rates of patient satisfaction and low rates of hysterectomy in up to 5 years of follow up in this cohort.

This is slide 20

- Impossible to do justice to the topic of HMB in 20 minutes!
- Other treatments not discussed: Fibroid embolization, laparoscopic myomectomy, Esmya, MRI guided focused ultrasound.
- But for most patients, treatments will be increasingly medical vs surgical.
- A closer relationship between GP's and specialists focused on minimally invasive techniques is likely to give their patients the best, most targeted and safest outcomes.
- Remember: the menopause is coming!