key points

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Heavy menstrual bleeding has been defined as 'excessive menstrual blood loss which interferes with a woman's physical, social, emotional, and/or material quality of life'. Heavy menstrual bleeding affects 25% of women of reproductive age and is estimated to be the fourth most common reason for gynaecological referrals. Each year, 30,000 women undergo surgical treatment for heavy menstrual bleeding in England and Wales.

The International Federation of Gynecology and Obstetrics (FIGO) has classified abnormal uterine bleeding (AUB) according to the acronym PALM-COEIN. The components of the PALM group are structural and defined by imaging or histopathology: Polyp; Adenomyosis; Leiomyoma; Malignancy and hyperplasia. The COEIN group are not structural and include: Coagulopathy; Ovulatory dysfunction; Endometrial disorders; Iatrogenic; and Not otherwise classified.

Women should be asked about pelvic pain which might suggest endometriosis and pressure symptoms which might suggest significant fibroids. Examination is appropriate if there is intermenstrual or postcoital bleeding and, if the woman is actively bleeding, may identify the source of the bleeding. Chlamydia testing should be carried out at the time of examination or as a self-taken swab where examination is not indicated. A urine pregnancy test and full blood count should be performed.

Women should be referred for transvaginal ultrasonography if the uterus is palpable abdominally or if there are associated symptoms of pressure or pelvic pain. Women should be referred, ideally in combination with hysteroscopy, for gynaecological assessment if there is persistent intermenstrual bleeding, persistent irregular bleeding (or risk factors for endometrial pathology including obesity, PCOS and tamoxifen use). Women in whom treatment has failed should also be referred. In addition, most studies suggest that endometrial sampling should be considered for all women over the age of 45 years.

Treatment can be commenced without investigation where the history and examination suggests there is no structural or histological abnormality. Primary care treatment is also appropriate for those with a normal ultrasound or fibroids < 3 cm in diameter which are not impinging on the endometrial cavity. First-line options are tranexamic acid and/or ibuprofen/mefenamic acid. Hormonal options are the COCP or cyclical progestogens. The levonorgestrel intrauterine system is a good option for women planning to use this method for at least 12 months and is more effective than the COCP in reducing menstrual blood loss. Surgical treatment can be considered if pharmacological treatments have not worked.