Heavy periods are a common complaint in general practice. They can cause huge social inconvenience, functional disability and may occasionally imply serious underlying pathology. Management of menorrhagia in a primary care setting may be thwarted by limited direct access to investigative tools that help in ruling out serious pathology, such as transvaginal ultrasound and Pipelle endometrial sampling. However, despite these pitfalls, there is still much that can be done by the GP to alleviate the problem and improve morbidity.

The history

You can often decipher from the history alone which patient requires urgent referral to secondary care and which patient can be managed within the practice.

Severity of the complaint

How bad is the bleeding? Have the periods just become a little heavier than what she is used to or is she in danger from hypovolemic shock? (This is rare but possible).

Ask about the number of sanitary towels and/or tampons she uses a day. Is she changing them more than once an hour? Does she feel the need to use both simultaneously? Would she ever experience ‘flooding’, i.e. having blood escape onto her clothes or the furniture, in spite of replacing her protection frequently? Is she passing large clots of blood? Does she put a towel under her in the bed at night to save the sheets and mattress? Positive answers to the above questions would suggest severe menstrual loss.

A woman who has been bleeding heavily for months or years may get used to it and only present to you when she begins to experience other symptoms like exhaustion or feeling faint. Ask about these symptoms and consider urgent referral if she has signs of hypovolaemia or anaemia.

Do a full blood count in all cases but other serological investigations, such as coagulation screen, serum ferritin, female hormone assay, thyroid stimulating hormone (TSH) are not necessary unless indicated by other elements of the history and examination. Get an idea of the degree of disruption to the patient’s life and be sure to involve her in the decision making when it comes to her treatment options.

Frequency

Is the bleeding regular? Are the periods monthly? Do they last less than seven to 10 days? Menorrhagia that lasts less than seven to 10 days and occurs on a predictable monthly basis is less likely to be caused by endometrial malignancy than irregular or prolonged bleeding.

Time line

How long has this been going on? Is it getting worse, better or the same? Progressively worsening symptoms might warrant more immediate investigation.

Exacerbating and relieving influences

What, if anything, has she tried prior to seeing you? Additionally enquire if she is using/taking anything that might affect menstrual bleeding (e.g. contraceptive hormones and/or copper IUD, anticoagulants)? Remember, just because a patient is on a medication that may affect menstrual bleeding, it does not guarantee that the menorrhagia is being caused by the hormone. She might also have underlying

Table 1: The history – key information

- Severity of the complaint
- Frequency
- Time line
- Exacerbating and relieving influences
- Obs/gynae history – could she be pregnant?
- Medical history
- Associated symptoms
pathology: consider both. The history may help you decide which is more likely.

**Obs/gynae history**

Could the woman be pregnant? This may be the most frequently misdiagnosed cause of abnormal vaginal bleeding. The first order of business: with any woman presenting with abnormal vaginal bleeding is a pregnancy test carried out in your surgery. Do not rely on a test she might have done at home.

**Medical history**

Is there any known bleeding dyscrasias or any other ailment which is known to have the potential to alter menstrual bleeding (eg. hypothyroidism)?

**Associated symptoms**

The patient needs further investigations to rule out serious pathology if the bleeding is irregular, prolonged (greater than seven days at a time), inter-menstrual, post-coital or associated with other symptoms such as persistent pelvic pain or supra pubic pressure. Diseases such as endometrial carcinoma, large uterine fibroids or polyps, pelvic inflammatory disease, endometriosis, and ovarian carcinoma can sometimes be associated with heavy menstrual bleeding.

**The examination**

Once pregnancy has been ruled out, the woman with heavy menstrual bleeding needs her blood pressure measured and a bimanual pelvic examination done in order to exclude obvious structural anomaly.

The cervix must be visualised to rule out cervical carcinoma or polyps. A smear is unlikely to be helpful in making a diagnosis but offer one if due and an endo-cervical swab for chlamydia/gonorrhoea may be done if indicated.

If the bleed is regular and not prolonged (greater than seven days) and if you have out ruled severe pelvic pain, masses and infection, then you can offer empirical treatments without necessarily referring for imaging or endometrial sampling or indeed gynaecology referral. If the symptoms respond within three to six months then the patient can continue to be monitored in the practice. If there is no improvement or a worsening of the bleed, then referral for imaging and/or sampling is warranted.

**Pharmaceutical management of menorrhagia**

If there is nothing in the history or examination to indicate any sinister cause for the heavy bleeding then a trial of pharmaceutical treatment may be offered. Options include:

- **Mirena IUS** – The use of Mirena in the management of heavy menstrual bleeding has been one of the greatest advances in this area in recent times and has been a blessing for patients and doctors alike. The need for hysterectomy has decreased dramatically since the widespread use of Mirena. If the patient is under 45 years of age and not obese then Mirena can be offered without first obtaining a scan or biopsy. This is recommended as a first-line therapy by the UK’s NICE. If you have ready access to transvaginal ultrasound then it is good to be able to exclude intramural fibroids via ultrasound scan where possible but not essential.

- **Tranexamic acid** – 500mg BD/ TID during the heaviest days). Tranexamic seems to be more effective than NSAIDs in head to head studies.

- **NSAIDs** – eg. mefanamic acid 500mg TID during heaviest days

- **Combined hormonal contraception** – via pills, patches or vaginal ring: As long the woman has no category 3 or 4 contraindications to oestrogen, this can be a very useful option even though it is not licensed for this purpose. COCP can also be offered in conjunction with an NSAID or tranexamic acid.
• **Progestins** –
  – Norethisterone 5mg BD/TID for the week before the period is due or
  – Dydrogesterone 10mg BD during heaviest days or
  – Oral medroxyprogesterone acetate 2.5mg BD/TID/QID for the week before the period is due or
  – IM medroxyprogesterone acetate 150mg IM (lasts 12 weeks).

**Further investigations**

If you have reason to suspect a structural or histological abnormality or if there has been minimal improvement from your attempts to control the bleeding via pharmaceutical products, it is time to do further investigations.

**Pelvic ultrasound scan**

This is the first line tool for suspected structural abnormalities. The transvaginal approach gives more accurate information about the endometrium but these are harder to arrange than transabdominal ultrasound in many areas.

**Pipelle endometrial biopsy**

If a woman presenting with heavy menstrual bleeding is over 45 or obese (or both) then endometrial sampling should be done as a matter of course. Some GPs offer Pipelle sampling as an office procedure but for most of us in primary care an OPD referral is the only way to access this investigation, which often delays diagnosis. GPs can offer pharmaceutical therapies while waiting for the referral.

**Hysteroscopy**

Hysteroscopy might be indicated if the ultrasound scan results are inconclusive.²

**Diagnosis and treatment**

Menorrhagia is not uncommon. It causes a lot of anxiety, social and occupational inconvenience, and may occasionally suggest serious underlying pathology although this is rare. Resources do not allow GPs to always get a diagnosis before offering treatment and this is acceptable as long as higher risk women are identified at presentation. Women who respond to pharmaceutical treatment should be maintained as long as the symptoms persist but women who do not respond within three to six months to one or a combination of empirical treatments should be referred for ultrasound and/or endometrial sampling and, if necessary, secondary referral.

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References

2. National Institute of Clinical Excellence Guidance