

EVIDENCE OF EFFECTIVENESS

Menstrual problems currently present a major burden in health care in physical, financial, temporal and personal terms. For women at home or in the workforce prolonged or heavy bleeding can be a major problem. The management options currently available for dysfunctional uterine bleeding (DUB) are:

- *reassurance* • *diagnosis* • *drug treatments* • *surgical treatments*

Reassurance

Not all women will want active drug therapy after explanation, reassurance and advice about the range of normality of the menstrual period.

Drug treatments

A recent review of the evidence of effectiveness of drug treatments suggests that for many women DUB can be successfully treated in primary care¹. Tranexamic acid, mefenamic acid, danazol, naproxen and the levonorgestrel releasing IUCD are all considered efficacious in reducing blood loss. Norethisterone and ethamsylate are not recommended^{2,3}. Tranexamic acid (Cyclokapron) has been shown to be the most effective treatment, but with slightly more side effects than Mefenamic acid (Ponstan). The benefit of Mefenamic acid is that it will also reduce menstrual pain. Cyclical norethisterone (Primolut N) should not be prescribed for menorrhagia. The recommendation is either Mefenamic acid or Tranexamic acid as the first choice drug in menorrhagia.

Surgical diagnosis and treatment

Three main types of surgical procedures are used to treat DUB: dilation and curettage (D&C), removal of the uterus and cervix (hysterectomy) and removal of the lining of the womb (endometrial ablation). Recent evidence suggests that D&C does not offer a credible option for women with DUB diagnostically and has no therapeutic value^{4,5}. The aim in West Pennine is therefore to reduce the rates of D&C in the district by the replacement of D&C with newer minimally invasive diagnostic techniques (e.g. hysteroscopy) and through first line medical management in primary care.

REFERENCES

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- 3 Bonnar, J. Sheppard, B.L. *Treatment of menorrhagia during menstruation: randomised controlled trial of ethamsylate, mefenamic acid, and tranexamic acid. BMJ. 1996;313:579-313*
- 4 MacKenzie, I.Z. Bibby, J.G. *Critical assessment of dilation and curettage in 1029 women. The Lancet. 1978:566-568*
- 5 Coulter, A. Klassen, A. MacKenzie, I.Z. McPherson, K. *Diagnostic dilation and curettage: is it used appropriately? BMJ. 1993: 306: 236-239.*



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Management of dysfunctional uterine bleeding in women under 40 in whom pregnancy has been excluded and who have no IUCD

Persistent/increasing dysfunctional uterine bleeding affecting quality of life

INITIAL ASSESSMENT

- Additional symptoms: blood stained vaginal discharge/inter menstrual bleeding/post coital bleeding/dysmenorrhoea/dyspareunia/PMT symptoms/symptoms suggestive of anaemia.
 - vaginal examination, if appropriate cervical smear
 - FBC, urine analysis, if appropriate TFT's and blood glucose.
 - further examination and investigations as indicated.
- NB. women on the pill with breakthrough bleeding should have pill adjusted or stopped before a diagnosis of DUB is made.*

Abnormal gynaecol finding

Refer to gynaecologist

Systemic cause identified

If necessary refer to appropriate speciality

No abnormal findings

DISCUSS AND AGREE TREATMENT PLAN WITH PATIENT

If bleeding is agreed to be within acceptable limits

Reassurance only

Patient prefers treatment

Contraception required

YES

NO

Non-hormonal option suitable for regular heavy bleeding

Hormonal option for irregular bleeding <21&>35 day cycle

- Appropriate combined hormonal contraceptive if no contraindications.
- Consider other options eg. depoprovera
- Progestogen releasing IUCD*.

** NB. the hormone releasing coil is not currently registered in the UK as a treatment for menorrhagia*

NON-HORMONAL THERAPY

- Anti-fibrinolytics eg. tranexamic acid.
- Appropriate NSAID eg. mefenamic acid.

NB. Norethisterone and ethamsylate are not recommended²³

HORMONAL THERAPY

- Combined hormonal contraceptive.
- Danazol.
- Progestogen in 2nd half of cycle.
- Progestogen releasing IUCD*.

Symptoms persist

If appropriate consider further trial of alternative option

Symptoms persist after 3-6 months of treatment

Discuss with patient and if further treatment required consider

Referral to gynaecologist for consideration of TCRE, or hysterectomy depending on findings of preliminary hysteroscopy

Continue with medical treatment

