# Heavy bleeding examined

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## The PALM-COEIN acronym ensures a thorough investigation of menorrhagia

MENORRHAGIA or dysfunctional uterine bleeding (DUB) were terms historically used to describe heavy menstrual bleeding.

Heavy bleeding refers to cyclic menses that are prolonged and/or heavy. Affecting one in five women, it is one of the most common forms of abnormal uterine bleeding.

Because the terms menorrhagia and DUB were poorly defined and inconsistently used, in 2011 new terminology was devised by the International Federation of Gynecology and Obstetrics (FIGO).

The revised terminology uses the acronym PALM-COEIN (polyp, adenomyosis, leiomyoma, malignancy and hyperplasia – coagulopathy, ovulatory dysfunction, endometrial, iatrogenic and not yet classified) to guide clinicians through history, examination and investigations.

PALM refers to structural abnormalities and COEIN to non-structural abnormalities.

**Consultation**: Assess medical, gynaecological and family history, current medications and symptoms of anaemia. Menstrual history should include frequency, duration, regularity and volume of period.

Heavy bleeding is objectively >80ml for the period, or loss that subjectively causes physical, emotional or social difficulties.

Ask about the number of pads or tampons used, if bedding or clothing is stained and if menses causes the woman to avoid normal activities. Inquire about pelvic pain or pressure symptoms, difficulties with bowel, bladder or sexual function and previous treatments and outcomes.

**Examination**: Perform a general examination to check for signs of thyroid disease, hyperandrogenism and anaemia.

Abdominal palpation might reveal a pelvic mass (most likely fibroid). Examine vulva, vagina and cervix to rule out lower genital tract causes of bleeding, including cervical swabs and cytology as indicated. Bimanual examination may reveal uterine masses or tenderness.

**Investigations:** Exclude pregnancy, check Hb and iron studies. Other investigations should be carried out as indicated: TSH; endocrine evaluation for hyperandrogenism; coagulation studies.

Endometrial sampling is recommended if the patient is older than 45 or at increased risk of hyperplasia/malignancy (prolonged amenorrhoea; obesity; family history).

Transvaginal pelvic ultrasound can diagnose uterine fibroids and suspected polyps. Note that measurement of endometrial thickness in premenopausal women is not a useful test, because of the limited correlation between thickness and pathology/treatment outcome.

Saline infusion sonography can better assess intra-cavity lesions, and office hysteroscopy can diagnose, sample and potentially treat causes.

**Management:** Non-steroidal anti-inflammatory drugs (NSAIDS) and antifibrinolytics are first-line non-hormonal agents for use during menstruation. NSAIDs can reduce flow by up to 30% and tranexamic acid by up to 50% when taken three times daily for up to five days of the period. NSAIDs may also provide analgesia.

Hormonal treatment is either progestins only (oral, depot IMI, subdermal implant or IUD) or combined oestrogen and progestagen (COCP/Nuvaring).

Progestins can reduce flow 30% (oral) up to or more than 94% (IUD). COCP can reduce flow up to 50%.

Surgical management can include endometrial ablation (85% of women have significant menstrual reduction) or hysterectomy. Fibroid removal may be indicated.

References at medobs.com.au

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### PALM-COEIN classification of abnormal uterine bleeding