# Heavy menstrual bleeding: Investigation, diagnosis & management

**Louise Browne:** Hello, my name's Louise Browne. I work in the translation and education area of Jean Hailes, and we are really pleased to present our first health professional webinar for 2017. Firstly, I'd like to acknowledge the traditional custodians of the land we're presenting on and the lands we're reaching tonight, and pay my respects to Elders past, and present and future. I am sure most of you know that Jean Hailes for Women's Health is a not-for-profit organisation dedicated to improving the knowledge of women's health, combining research, clinical care, and practical education for women and health professionals. Our focus tonight is heavy menstrual bleeding and how to diagnose and manage it. This is a topic that we get many requests for from health professionals. We know it's a problem that affects one in five women of reproductive age. It's something that you will see regularly in your clinical practice. It's a major cause of anaemia, and it's also has an impact on quality of life for many women.

I'd like to introduce our panel with us tonight. We've got a full host of Jean Hailes clinicians. Their bios are on the platform if you'd like to look at them. We've got Marnie Newman on the left who's a women's health GP, we've got Dr. Elizabeth Farrell on my left who's a gynaecologist, and Janine Manwaring who's a laparoscopic surgeon and gynaecologist as well. So tonight we're going to start with each panellist providing some of the key points. Then we'll work through three case studies, some questions and wrap up with some important practice points. So we'll start off with Marnie, who's going to talk about heavy menstrual bleeding and the primary healthcare professionals take on seeing women with this condition.

**Dr Marnie Newman:** Okay, so, good evening. Like many things in general practice, the first thing I need to think about is, is there a problem? How urgent is the problem? Oh sorry, I'm doing that. And what can I do about it? So to work out whether there is a problem, it's a matter of taking history. Is it a nuisance? Is it embarrassing? If you query women, they'll often talk about flooding, interrupting things at school, interrupting things in their work. Are they tired? Are they exhausted? Are they in pain? Are they drained? And the other thing that they sometimes mention is it's so expensive buying all those tampons and pads. Is it interfering with sex? Is it interfering with camping or going away on holidays?

The next thing, after you've worked out how important an issue it is for the woman, is are there actually consequences to her health? The particular one being, is she bleeding so much that she's become anaemic? And thirdly, is it a sign of something else going on? Is the heavy menstrual bleeding a symptom of an underlying cause and something that we ought to be doing something about? How urgent is it? Is she actually acutely distressed either physically or emotionally? Does she need something to stop the bleeding now? Does she need to be referred now? Should you be ringing an ambulance to take her to emergency department? Should you be ringing the next door neighbour to take her there?

What can I do about it? Look, the first thing that we all know from medical student days is that you actually need to examine the woman. You need to do a general examination. You need to work out how emotionally or physically distressed she is, is she anaemic clinically? Is she in pain, is that a sign of something else going on? And then in particular, we ought to be doing a vaginal examination, unless the woman is not yet sexually active, in which case it would be totally inappropriate, and having a feel of her abdomen is an alternative thing to do then. There are some basic investigations that we can do, and we'll go through it in a bit more detail, but we can check her FBE, possibly a thyroid function, maybe her iron studies including ferritin. It's an ideal opportunity to do a sexually transmitted infection screen, check whether her cervical cytology, cervical cancer screening is up to date, whether that be a pap or an HPV test. Is she pregnant? Could she be pregnant? This is obviously something that you need to keep in the back of your mind because you look pretty silly if you've missed it.

There are a number of different medications that we can start off with. There are things that we can do to stop the bleeding quickly, and things we can do that would help the bleeding in future periods. And we will talk a bit more about the place of the oral contraceptive pill, about the place of tranexamic acid, and about the place of nonsteroidal anti-inflammatories. And then as another level of treatment, we'll talk more about different progestogens, both oral and the levonorgestrel IUD. Sometimes we consider doing an ultrasound, and that may be something we do before we refer when we are stuck, or it may be something down the track, because the ultrasound can give useful information on top of the physical examination. And then the bottom line for GPS is if what you're doing is not working, then seek help and refer. The things that are really important not to miss, ectopic pregnancy. And that would usually be when she's presenting with a one-off case of heavy menstrual bleeding and is in pain, but it's not something that the patient always thinks about. The second thing we want to make sure that we don't miss is, is there a cancer?

It's unlikely to cause heavy menstrual bleeding if it's cancer of the cervix, but it's possible. It's usually in association with post-coital bleeding, but you need to keep that in mind. And the same, the other cancer to keep in mind is endometrial cancer. Lastly, is there something that can be fixed? Is there something surgical that, instead of waiting months and trying bits and pieces of treatment, that if we refer to a gynaecologist, might solve the problem for her straight away? And I think we'll come up with answers to some of these things in the next hour or so. So, Janine.

**Dr Janine Manwaring:** Thank you. So, thank you for having us tonight. And I'm going to have a talk to you about the normal menstrual cycle and classification of what is bleeding, when is bleeding normal, when it's abnormal, and the terminology that we use and how that's been changing. So heavy menstrual bleeding, 40 to 60% has no pathological cause found. It is extremely common, as Louise had said earlier, that it's the commonest cause of iron deficiency in the Western world, and it's the commonest cause of chronic illness in the developing world, and subsequently has major costs to the health system and to productivity worldwide. So the most common cause of abnormal uterine bleeding during a women's reproductive years is heavy menstrual bleeding. One in five women have this as an experience during their reproductive life, but then how do we know what is actually classed as normal? So the current definitions of what counts as normal menstruation, frequency between 24 and 38 days for cycles, and that the regularity of it is a variation of less than or equal to seven days between each cycle.

So if a woman has a 24-day cycle and then followed by a 29-day cycle, then that's still considered a regular period. A regular or a predictable duration of less than or equal to eight days. And the volume is something that's been quoted in the past anywhere between five and 80 mils, but obviously that is very difficult to measure. And so also that which does not interfere with the woman's physical, social or emotional quality of life. So it's obviously going to be up to the individual as to whether they think that there is actually a problem with their period. It may be that they don't know what's normal or they're concerned that their period is abnormal or something that they have not previously been comfortable discussing with either friends or their health carers. So previously there were many different terms that were used, and the commonest one was under the umbrella of 'dysfunctional uterine bleeding'.

So menorrhagia, which was defined as prolonged bleeding more than eight days or excessive bleeding more than 80 mls, metrorrhagia, which was irregular and frequent periods, menometrorrhagia, which was prolonged or excessive periods occurring more frequently than normal. So terms that have been very inconsistently used and are quite poorly defined. And so we now have a new system referred to as the PALM-COEIN terminology, and to try and make the reference for abnormal uterine bleeding more consistent. So this is a busy slide, I'm sorry, but this is to try and show the different causes of abnormal uterine bleeding with heavy bleeding, and the structural causes being the PALM side. So looking at polyps, at adenomyosis, at leiomyomas or fibroids, and within this is the subdivision of whether the fibroid is submucosal, so projecting into the uterine cavity, or whether it is something that is outside of the uterine cavity. And the M is for malignancy or hyperplasia.

So there are the structural conditions that can predispose to heavy menstrual bleeding. And then the COIEN side of the coin is the non-structural causes. So coagulopathies, ovulatory dysfunction, so when the anovulatory bleeding cycles that can be common at either end of the reproductive life, endometrial causes, iatrogenic causes, so within different medications there are some that are more common at causing menstrual dysfunction, and then the N is the not yet classified. So with regards to terminology, heavy menstrual bleeding is a subset of abnormal uterine bleeding, and if you're looking at the old dysfunctional uterine bleeding, that that term is encompassed by three main categories, the ovulatory disorders, and this is how that they're written with AUB and then slash O. Slash C is the disorders of haemostasis, and slash E is primary disorders of endometrial function. And so they're things that will predispose a woman to heavier cycles.

**Dr Elizabeth Farrell:** Good evening, I'm going to talk to you today about the consultation and the clinical presentation and assessment. So as with everything that we've heard about, whatever we do, we always have to take a good history. And it's important with heavy menstrual bleeding that we exclude organic disease, that we look at the extent of lifestyle impairment, and we look at whether or not a woman has actually had previous treatments for heavy menstrual bleeding. We need to know what she expects from the treatments, what is it that she wants to know about, what is it she's expecting, the treatment that you give her, to end up with. As Marnie has already said, we need to take, do a general examination, an abdominal examination, and if it's age appropriate, a pelvic examination, and we then need to give up-to-date management options.

Let's look at the reproductive history and what we want to know about when we see someone, a woman with heavy menstrual bleeding. We want to know when her period started, the age of menarche. What are her cycles? How many days does she bleed for? How often does she have a period, does it fit in with what Janine's just told us about, what is considered to be within the normal range of menstrual cycles? Is there a pain or a bleeding pattern that she has each time, or is it different with the different periods. We need to know about whether she's had pregnancies, how have the pregnancies gone, what sort of deliveries she's had? Have there been any major complications during pregnancy? We also need to know about what contraceptive she's using. She may have an IUD, for example, if she has a copper IUD, her menstrual blood flow may in fact be much heavier than if she was to have a Mirena IUD.

We also need to know whether, if she's of an age where she wants to have children, when she would like to have children, and whether that comes into the management of heavy menstrual bleeding at the time she presents to you. And obviously we want to know her sexual history. Now the pattern of bleeding is really, really important, and we need to ask about, maybe asking open-ended questions about how a woman bleeds. Does it worry her? What is it that might have changed? So we want to know about an unusual increase, if the bleeding goes on for more than eight days, if there's flooding or bleeding not contained within the pads or tampons that she uses, and what size of pad or tampon. So for example, if someone has a super tampon, has to wear a pad, is changing it every half an hour because she's losing blood through the tampon and onto the pad, or if she wears maternity pads or night pads and has to change every hour, the impression is that that must be fairly heavy.

So it's important to ask about the frequency of changing, and also whether she passes clots and how big they are. And also whether she's had a history of iron deficiency. Now what should we be ordering in terms of investigations? Well Marnie's told us about some of the investigations that we should be doing. Routine cervical screening, a chlamydia PCR in any age, even in women around the perimenopause, remembering that STIs are increasing in the perimenopausal women, because of them going into new relationships and not often having safer sex by using condoms. We need to do a full blood examination and iron studies or ferritin. And if there is systemic disease expected, we need to make sure that we exclude that. So for example, in perhaps a young woman, we might be doing coagulation screen or platelet function. We may be looking at thyroid function, renal function and autoimmune disorders, which may in fact be the cause of the heavy bleeding.

We'd be doing a transvaginal ultrasound, and hopefully you have access to good ultrasounds. If not, it's important to go to your local radiology group and try and get them to really up the ante with their reports, and make sure that they don't tell you everything's normal without giving you information on endometrial thickness, about ovulation, about size of ovaries, volume of the uterus, fibroids, polyps, and also ovarian cysts. If we're doing an ultrasound for endometrial thickness, we're probably best to do it on day three of the menstrual cycle or immediately postmenstrual. It's going to be the thinnest at that time. If we are looking for ovulation, then obviously we would request the ultrasound to be done in the premenstrual phase. We may not have adequate access in rural and remote areas, so one may have to use your clinical judgment a little bit more. Now what about the investigations that might be done, which might be diagnostic, or they might be in fact treatment as well. But, an endometrial biopsy.

So an endometrial biopsy for abnormal uterine bleeding, particularly in someone around the perimenopause is entirely appropriate. It has a good sensitivity for endometrial hyperplasia,, and malignancy and easy and simple to do. Or it may be an outpatient hysteroscopy or an inpatient hysteroscopy with a biopsy or curettage. And as you can see on the screen, this is an endometrial polyp. So if a hysteroscopy and D&C was performed and a polyp like this was found, then it would actually be a curative procedure. And a woman may need a laparoscopy as well, particularly if there is pain associated with her heavy menstrual period.

**Louise Browne:** Okay, fantastic. I think it's a great introduction to our topic tonight, and we've tried to choose case studies that will sort of be the common ones that you might see, and across the reproductive life span as well. So the first one we're going to look at today and there were quite a few questions that came in with registration, and that was around the management of heavy menstrual bleeding in the adolescent. So hopefully this will answer quite a few of the questions that we did receive. So Jenna's a 16-year-old girl, she's attending the GP for advice regarding heavy periods. We are trying to make these very broad, not put too much into it, because we want it to be relevant to you in the people that you're seeing. So I'll hand over to you money to take us through the GP's consultation.

**Dr Marnie Newman:** Jenna looks really miserable and anxious, and I don't think her mother is present, but her mother may know what's going on, which will be relevant when we're talking about treatment options. She's 16, we really want to know when her menarche was. Has it been just in the last 12 months? Was it in fact when she was 10? Was it five or six years ago, by which stage we would've expected that her periods would've become regular. We need to ask about that regularity. We need to ask about the frequency, and we need to try and pin down her answers to see whether she's just sort of making up what she thinks might be happening, or has she been keeping a record. And there are some gorgeous little apps available that if Jenna doesn't know about, I'm sure her schoolmates will. We need to know what other symptoms there are. Is she in pain? That would be the one that would sort of strike me most strongly, and how much it's affecting her quality of life. Is she missing school? And even more importantly, is she missing parties?

Hopefully you will know Jenna well enough to know, to be able to ask the next question about whether she's sexually active or not. And it's not the sort of question that you ask when her mother is sitting next to her. We need to know about her family history. We need to know, as Liz said, are there signs of a bleeding disorder? And that leads into the next question, does she have signs of bleeding excessively in other parts of her body? Is she bleeding from her gums when she brushes her teeth? Does she bruise easily? Does she have shins that look like bumpy sort of things because she's been bleeding under the skin? And then in medicine as we often do, asking her what she would like to do next. Does something need to be done? So I think now, Janine, what are we going to investigate?

**Dr Janine Manwaring:** You've had a talk to Jenna and now you need to determine, is there an underlying cause that is something that's treatable. Is it something, as Marnie said, that is it in the first 12 months or so since her menarche where anovulation is very common, because the hypothalamic pituitary ovarian axis is quite underdeveloped in the first 12 months or so, and up to 85% of all cycles in the first year after menarche are actually anovulatory. In keeping with that, the diagnosis of PCOS, polycystic ovarian syndrome, in teenagers is a very difficult decision to make because anovulation is so common, and equally, doing an ultrasound, which will often be a transabdominal ultrasound in these age group, is very unreliable and difficult to interpret, with regards to the appearance of the ovaries, because PCO is polycystic-appearing ovaries on ultrasound, which is very common in the younger years and it's not a diagnosis of PCOS by itself. So if you have a younger woman who is having some very heavy periods, and possibly with irregular periods, wondering whether that it may be a PCOS, that if she has prominent androgenic symptoms such as a lot of hair growth on her body, acne, having trouble with significant weight gain, or if her symptoms are quite sustained for two or more years in her teenage years, then certainly you can think about progressing onto hormone screening. But it's a diagnosis to be considering more carefully in the earlier, earlier reproductive years.

With the other point I was going to make, just with regards to younger women, and there's certainly a couple of questions that have come in about what do you do for younger teenagers who have very heavy periods. So if menarche is before 10, then you need to think about could there be a precocious puberty situation? But if a girl has had normal secondary sexual development, over 10, and has had periods beginning, as you would expect, in terms of, in concordance with puberty, but at maybe 10 or 11, then basically she is the same treatment as a 16 or 17-year-old from a hormonal development stage. So it's not the age per se that is the absolute indicator. So back to Jenna. So as Marnie said, we need to establish whether or not Jenna is actually sexually active, and it depends on how long you've known Jenna and her family and who's with her, about being able to broach that question.

But it's very important that we consider, could she be pregnant? And then also, could it be a sexually transmitted infection such as chlamydia. With regard to bleeding disorders, they're more common than we used to think, and as we get more information and understanding about factor deficiencies, that we are picking up more things like early mild von Willebrand's disease, or some platelet function abnormalities that predispose this younger person towards lifelong heavy periods. So if somebody has always had heavy periods, if they've got a strong family history of heavy periods, if they've had problems with bleeding sustained after surgical treatment, after dental extractions, those sort of things ring alarm bells for, could there be an underlying bleeding disorder? So in a young woman who's presented pretty much from menarche having heavy periods, that, could it be one of these underlying things, and probably up to 50% may have a bleeding disorder.

So you think, as well as checking the full blood count, that also a coagulation profile, von Willebrand factor and platelet function analysis, and they're tests that are specific to particular labs as to what they will actually, which ones that they will process. That would be something that you would need to discuss with the particular lab you use, especially if you're not in an urban centre. But also remember to check the thyroid function and her iron studies, particularly with ferritin, because younger women can certainly drop their iron levels to significantly low levels before they will start to drop their haemoglobin.

So pelvic ultrasound is usually not needed as a first line investigation in young women, because as we've mentioned, that most of them will be TA, the last line is transabdominal scanning, and you do get very limited information with regards to the uterus, the endometrial thickness, the presence of any functional problems such as polyps or fibroids. They're very uncommon anyway in young women, and if it's a transabdominal scan you'll get very limited useful information from that. As I said, polycystic-appearing ovaries are very common and usually not an ongoing or related problem. And congenital malformations won't cause heavy bleeding, you're more concerned about a delayed period if you've got a developmental abnormality. So in older women, then you do often move more quickly to a pelvic ultrasound, but it would not necessarily be a first line investigation in someone that was young.

**Louise Browne:** So can I, I just want to, a question's come in from Choudhary who's asked, is there any role of FSH/LH progesterone as part of the initial investigation, initial consultation?

**Dr Janine Manwaring:** No. Not if she's already pubertal. So with the hormone levels, again won't be established as far as if you were screening for PCOS. If the FSH and LH were very elevated or very low, then she wouldn't be menstruating at all.

**Louise Browne:** Okay, good. And there's no 'too young' to treat heavy menstrual bleeding?

**Dr Janine Manwaring:** If they're over the 10-year-old puberty, then they've attained about 98% of their height of their capacity in terms of growth, and so you're dealing with the same body as an 18 year old.

**Louise Browne:** Yep. Okay, great. So Liz, we move on to management.

**Dr Elizabeth Farrell:** Well I'd like to open it up a little bit. What do you two think about, what's this young woman's cause of her bleeding?

**Dr Marnie Newman:** So I am going to assume that she's been having periods for a few years, they're still a bit erratic, she's not sexually active and she's a bit, sort of, miserable and missing a few days of school each term. So I think we need to do something. I don't think we need to do a lot in terms of investigation. What I'd be doing first of all is checking what I think her dietary iron intake is like. Does she have white bread and Vegemite for breakfast or does she have, is she vegetarian, is she vegan, is she eating green leafy vegetables, is she eating red meat, is she eating legumes such lentils and peas and beans?

**Dr Elizabeth Farrell:** What do think is the likely cause?

**Dr Janine Manwaring:** So if she's already been menstruating for a few years and she's having quite regular periods, then there's a relatively high possibility of her having a mild underlying clotting abnormality. Now it may not be something that we can measure yet, but that it would be high on my list as well as just checking what a haemoglobin and a ferritin are, to do a clotting factor study.

**Dr Elizabeth Farrell:** Would you think so too or would you have a different viewpoint?

**Dr Marnie Newman:** Look, I guess I agree with Janine in terms of it being relatively common. It's probably not something, as a GP, that I would measure very often. I'm not sure—

**Dr Elizabeth Farrell:** Well interestingly, I had a phone call today from a GP who has a 13-year-old with very heavy menstrual bleeding and her menarche was 12 months ago. So it fits in with this picture of, probably, anovulation. And there's some data that suggests that maybe it's even up to two or three years after menarche, before regular ovulation is actually established. And so I think that's one of the things, it's very simple that, we have to think about the anovulatory cycles. But then if she's some years post menarche, you would be thinking, wouldn't you, of something like a coagulopathy or bleeding disorder.

**Dr Marnie Newman:** And if she had a coagulopathy, how much difference would that make to what we use in terms of treatment?

**Dr Elizabeth Farrell:** So I think if we look in terms of treatment, you've said that she's not sexually active, but if she was sexually active you'd be really considering whether or not she needs contraceptive needs. But I think the first thing is to look at whether or not she's iron deficient, and, or anaemic, and to treat that. And I think we have to be, it's so easy to give an iron infusion these days. We've got the new Ferinject. As long as general practices have the right facilities, it can be done as an outpatient, they can come in, have their iron infusion and go home. And their ferritin and their iron will rise much more quickly than if you give oral iron. It takes much longer. And I don't know whether there are actual ferritin levels under which there are criteria about under which you can give an iron infusion, but I remember at one of, a lecture that one of our senior consultants gave, he said that the quickest way of getting the iron and ferritin up was by giving an infusion if the ferritin was under 50. So that's still within the normal range, but under 50, he thought that that was by far the best way, when you have this picture of heavy menstrual bleeding.

**Dr Marnie Newman:** So, if the menstrual bleeding has caused loss of iron in quite an acute fashion and it's dropped quite dramatically in a short period of time, then my understanding is that the sonner, that giving an iron infusion is a good way to get on top of that. Provided, as you said, that they're well set up in particular to cope with the unlikely but horrible event of an anaphylactic reaction to the intravenous iron.

**Dr Elizabeth Farrell:** Yeah, well I've looked up some of the guidelines, and they even have guidelines for rural and remote places, in Northern Territory they've got a set of guidelines, they're very clearly set up so that it's quite possible to give it in very far distant places where you don't have access to the services that we luckily can. So I think that's very important, is to improve the iron deficiency and treat it appropriately. And the possible treatments. So in this particular young girl, what would you initially recommend?

**Dr Janine Manwaring:** So if I'd established, as we've all discussed, so to establish whether or not she is close to menarche, whether her cycles are regular or still quite irregular, what her contraceptive needs are, whether or not she does need an iron infusion. Then to discuss with regards to management, and also whether she's having an issue with pain, we'd then look at either needing medical treatment, or conservative treatment with the iron, and whether that treatment would be either hormonal or non-hormonal in nature. And that would then be tailored to the individual discussion with her and support people for her.

**Dr Elizabeth Farrell:** So we know that the anti-inflammatories can actually reduce blood flow as well as be a treatment for menstrual pain. So that's a possibility and that can be used just on the heavy days of the bleeding. But also tranexamic acid, an antifibrinolytic agent, widely used in Europe for a first-line treatment for heavy menstrual bleeding, and just given at the time of the heavy days, and usually given maybe two or three or four days and it can be given up to three or four times a day. And it's very effective in reducing blood flow up to about 50%.

**Louise Browne:** Could you use those together, Liz?

**Dr Elizabeth Farrell:** Yes you could. Yes you can. Because one can be, particularly if the young woman has pain, absolutely. And then we have, if this young woman has anovulatory bleeding which is causing her heavy menstrual bleeding, then we would be considering looking at using the progestins. If you were using a progestin, which ones would you use in Jenna?

**Dr Marnie Newman:** So she could either use the combined oral contraceptive pill or just a progestin by itself. And people often have a very fixed idea about whether they want to be on the Pill or they don't want to be on the Pill. So they might come in saying, 'All my friends are on it, it's been really good for their skin, that's what I want.' Or they might come in saying, with their mother saying, 'Oh look, it might make her sexually active before her time,' but we'll let that one go. I'm not sure that that's the case, but often women do have very strong ideas about what they need.

**Dr Elizabeth Farrell:** What if Jenna was 13?

**Dr Janine Manwaring:** I would still have the discussion about the different treatments that are available and whether or not she's got regular cycles. You can still look at using the anti-inflammatories or tranexamic acid. Going back to how I said that once a girl is menstruating, she's already attained 98% of essentially her adult reproductive self—

**Dr Elizabeth Farrell:** So she could grow just a little bit.

**Dr Janine Manwaring:** So that's something that, so I'm quite happy to sway around the Pill, basically.

**Dr Elizabeth Farrell:** And if you give her the Pill, that was a question that I've been asked, if you give her the Pill, does it actually stop the growth?

**Dr Janine Manwaring:** No. So it slows, it might reduce her final growth by a few percent. So you might be talking a centimetre possibly.

**Dr Elizabeth Farrell:** That might be very important.

**Dr Janine Manwaring:** It might be very important.

**Louise Browne:** If you're very short.

**Dr Janine Manwaring:** Yes, exactly. But it's all in balance with how much you're spending on tampons, I think. But it's often getting around the individual belief systems or concerns about hormonal treatment, and once I've explained to both the girl and the parent, mother, whoever that's with her, that it's not about sex but it's about periods, and that we're trying to improve the cycle control from a bleeding point of view, and given appropriate information, then most people will be happy with that. But sometimes if there's very strong beliefs or concerns then it can be quite challenging. Some of the advertising is very much pitched at, sort of, the young hip, sexually active woman and that's not a great thing to give some families. So it's just about how you approach it. But it's important to say that the hormones, you're not trying to address about sex, about contraception.

**Dr Elizabeth Farrell:** So if, she's 16, so do you see a role for the implant or the IUD in a 16-year-old, and in what circumstances would you use that, use either?

**Dr Janine Manwaring:** Would you use?

**Dr Marnie Newman:** I think that's a really good question. I think the answer to that is influenced both by what the practitioner has a feeling for as well as what the patient wants. But we certainly know that the evidence is there that progestogens, either as cyclical oral ones or an Implanon IUD or a levonorgestrel intrauterine device are all very effective ways of reducing heavy menstrual bleeding. Obviously the tablets are sort of easy to prescribe. You don't need to do anything, except that the patient does need to be able to count, and sometimes it's not as easy as it seems, hard to remember these days what the date is let alone...

**Dr Elizabeth Farrell:** So would you be inclined to use an oral contraceptive or recommend an implant or IUD? I mean would you normally put an IUD in a teenager of this age?

**Dr Marnie Newman:** Look, thanks for bringing that up. Because there's obviously a very strong feeling, especially from mothers thinking that IUDs are only for women who've already had children, and that's obviously a furphy that we need to dispel. Because it's completely appropriate and completely safe to use one of the Mirena, levonorgestrel IUDs in a woman who's nulliparous. What about putting it in Janine? Is it more difficult in an adolescent?

**Dr Janine Manwaring:** Not necessarily, but it depends on the age of the adolescent and also whether or not she's been sexually active. I put them in under local anaesthetic in nulliparous women, I've, maybe 18-year-old, 19-year-old, but younger than that, I mean it is still a fairly invasive procedure if you've only recently, years, sexually active. So it wouldn't be a first line for me in someone in the younger teenage years, but certainly I use them with young girls who have a lot of trouble with endometriosis or adenomyosis and heavy periods.

**Dr Elizabeth Farrell:** I think that's really a very important area. And of course we've actually had a question about—

**Louise Browne:** We've got a couple of questions.

**Dr Elizabeth Farrell:** About whether or not small levonorgestrel IUS is available, so it's been approved of, but I think there's been a marketing decision that in Australia it will not be marketed to us and so, therefore, is not going to be available for us to use. And I think that's, unfortunately, a bit sad, because it has many, I think many uses. It would be a three-year IUD, easier and smaller to get in and possibly great use in the perimenopause and also in these young women with adenomyosis and endometriosis, particularly in teenage years.

**Louise Browne:** I've just got two questions that I'd like to quickly address before we move on to our next case study. One is from Jane who says, 'I've always considered tranexamic acid a bandaid, a temporary short-term measure while waiting for another intervention or diagnosis. Is it okay as a longer-term therapy?

**Dr Elizabeth Farrell:** I think the answer to that is yes, it is okay as a longer-term therapy and in fact it's been widely used as a first line and long-term treatment in Scandinavia for quite many years. Would you agree with that?

**Dr Janine Manwaring:** Yes. So the action of the antifibrinolytic is with stopping the degradation of the platelet plug that happens with bleeding, and just before you glaze over with talk of the clotting cascade, but it's actually not a bandaid per se, but it is preventing the clot, the breakdown that's happening at every vessel level, so that the woman's physically bleeding less into her uterus from her endometrium. And so it's not a bandaid on the sense of the, well yes, if there is an underlying problem that will still be there, but really it's another choice in helping to manage those symptoms. I mean I guess if you said that she's got a tendency towards heavy periods because of a very mild von Willebrand's factor deficiency, that that's still going to be there, if you are giving her tranexamic acid or if you're giving her oral contraceptive pill, but that you're managing the symptoms.

**Dr Elizabeth Farrell:** But the thing is that, very often, just reducing blood flow, even if it's 20 or 30% up to 50%, often that will be sufficient for a woman to say, 'I'm very happy continuing to use it.' So it's not a stopgap measure, it can be used in the long term.

**Louise Browne:** Last question, Rosemary, who's from the NT, she says, 'Any concerns about bone density with progestogens in early teens?'

**Dr Elizabeth Farrell:** If used long term, if it's used for a number of years, yes, but in the short term I don't think that's a problem. Do you?

**Dr Janine Manwaring:** And not with oral progestogens. So there's the concerns that have been looked into before in long-term use of Depo-Provera, and there's not a lot of data on it, but there's a suggestion that after several years of amenorrhoea with Depo-Provera, because it switches off all ovulatory function, is that you can get a decrease with bone density, but that will go back to the normal baseline within about a year or so of stopping.

**Dr Elizabeth Farrell:** But you can also do that, you can also have the same effect if you give the oral progestins continuously, where it's actually suppressing oestrogen, so you've got the same actual effect.

**Dr Janine Manwaring:** I don't think so many people do that though. And certainly using the oral progestogens as the sole treatment, I think, is less and less common. Because they often have more side effects.

**Louise Browne:** Okay, Sabah has asked about the small IUD, we've already covered that. And there's no outside time that you can use tranexamic acid, from what you've just said.

**Dr Elizabeth Farrell:** No.

**Louise Browne:** Okay, good. Let's move on to Thuy, our next case study. So she's a 35-year-old, presents with heavy menstrual bleeding, and she's also had more bleeding following a miscarriage. So Marnie, over to you.

**Dr Marnie Newman:** So I think the first thing to clarify is how long this heavy menstrual bleeding's been going on for. So is it something that's just related to the recent miscarriage that just happened in the last month or two, or has it in fact been there for the last 10 or 20 years, but now that she's possibly busy with other children, with life in general, she's decided that she's exhausted and it's time to do something about it? So, trying to work out the urgency of the situation would make a lot of difference into what your next step was. If it was specifically related to the miscarriage in terms of timing, then I would do a vaginal examination, see if there's uterine tenderness, see if there's uterine bulkiness, see if there's something abnormal on the cervix, and probably do an STI screen as well. If I was then stuck, I would then refer her on. Relating to the timing of things is also working out how unwell she is. Does she have, I don't know, endometritis or something? Has she got a fever, is she in pain, has she got dyspareunia, does she need some urgent treatment? Or is it something that's been a problem for her ever since she was a teenager, and in which case we'd probably manage her in a not dissimilar way to Jenna.

So I'm going to assume for a minute that I'm stuck as to what to do. I'm feeling really uneasy about her and I've referred her to you, Janine.

**Louise Browne:** Pass the baton.

Exactly. Phone a friend.

**Dr Janine Manwaring:** So the approach with Thuy is the two factors with, you've got the recent miscarriage and then you've also got the heavy bleeding. And as Marnie said, you need to determine whether or not this is acutely related to the miscarriage or whether it's been an ongoing problem. So from the, could it be related to the miscarriage side of things, as well as knowing the timeframe, essential that you do a betaHCG. Could she be pregnant again or could it be retained pregnancy tissue or a complication of pregnancy such as a molar pregnancy, not common things, but pretty easy to get them to wee on a stick, and do a serum if you are concerned. So if it was the other side, with possible retained products, is that usually a transvaginal scan will give you a good idea if there's something within the uterus. A a lot of the time it may just be blood clot, and these are in the early days following miscarriage, but important to not forget.

If it's more that it's a long-term thing and that it's become more obvious after the miscarriage, then to go back to the basics things once again, similar to what we talked about with Jenna, that you need to know what haemoglobin is essential to know what the iron levels are, the ferritin, thyroid function as a baseline, but not if it's been something that's been normal within the last 12 months. Here it's not so important to go straight to clotting studies, unless it has been a very long-term thing that has never previously been investigated. And within that, whether she does have any of those other concerning factors with regards to bleeding disorders that I'd mentioned earlier. So we've done the basic blood tests and then with regards to an ultrasound, almost all of the time now you'll be able to explain to the woman the benefit of a transvaginal scan rather than a transabdominal scan, that you have a much better view of what's happening with regards to her uterus with, the endometrium, if there are fibroids, whether or not there's a submucous component of the fibroids. Whether or not there is an appearance of any adenomyosis, which is essentially like endometriosis within the muscle layer of the uterus, and can predispose to very heavy painful periods. Whether or not there are any polyps. With regards to the endometrial thickness, as Liz was explaining earlier, that it's important where in the menstrual cycle that it is measured as to what you can interpret from it.

So there are no set criteria within reproductive years for what is normal for an endometrial thickness, as opposed to postmenopausal bleeding where there are very definite criteria for what is normal and what's a higher-risk endometrial thickness. So we often will see people, women that have been referred in, because that they've had heavy periods and that they've got an endometrial thickness of 15 millimetres, and that doesn't mean anything, in, you need to know on its own, it doesn't mean anything unless there's an abnormal appearance or perhaps if that's very early in her cycle within the first week, then that makes you suspect, could it be underlying pathology? So just a bit more about the polyps, fibroids, endometrial thickness, that this is something that is very challenging for a lot of people who are not spending a lot of their time in women's health, and that within more remote communities with primary health practitioners that aren't medically trained to understand what the report signifies, that when you get this report coming back saying 'this woman's got a one centimetre fibroid that's intramural, please investigate further'.

And so fibroids are very common, more common the older the woman gets. So up to 30, 40% of women by the time they're in their mid-forties would have detectable fibroids, and same with polyps, that they're not as common, but they're very common. And the majority of them aren't associated with heavy bleeding at all. So more significant if there is that submucous component, so projecting into, of varying percentage, projecting into the endometrial cavity, and because women get pelvic ultrasounds for a lot of different problems and that they get them very commonly, and then fibroids are reported very commonly because they're common, that that will coexist, and then A equals B. And so it's important to be able to, as we were talking about earlier with the, talk to your local ultrasound provider, and to really nut it out with them about what's important and what things you need to know. Polyps, that the vast majority of them are benign even in later years. If they're small, then a good one in four will regress. And so really if they're symptomatic, then you look at treating them with removing them surgically. Asymptomatic, then if there's increased risk for hyperplasia, if they're large, if they're multiple, or if there's fertility concerns, then something to think about, whether or not they need treatment.

**Dr Elizabeth Farrell:** I'm going to talk to you a little bit about management, and as you can see, we've got an algorithm here from a very good paper that you've got the reference there on your screen. So if we look at heavy menstrual bleeding in terms of someone who's seeking pregnancy, then you can see from the diagram that if it's a 'yes', then you're looking at using non-hormonal therapies such as tranexamic acid and nonsteroidal anti-inflammatories. But if it's a 'no', then she may very well be interested in an IUD. And if that's a 'yes', then she can go straight to the levonorgestrel IUD. And we know that that is really the best way of managing, conservatively, heavy menstrual bleeding. If she's not interested, well then we are looking at combined hormone contraceptives or progestogen. And if that's a 'no', then we go back to using the tranexamic acid and/or the nonsteroidal anti-inflammatories.

If it's a 'yes', well then we are looking at the combined hormone contraceptives. And the one that has an indication for heavy menstrual bleeding is the oestradiol valerate and dienogest contraceptive, which is known as Qlaira, that has an indication for heavy menstrual bleeding. But obviously most of the oral contraceptives will, in fact, reduce menstrual blood flow. Of course we could use the oral progestogens, and as you can see down the bottom there, the second choice would be to use the oral progestogens, but to use them for 21 days, not to use them just in the premenstrual phase, but to actually use them for three weeks. So what do you think about that?

**Dr Marnie Newman:** So can I just, getting back to counting. So if we're using the oral progestogens for 21 days, that means from day five of the menstrual cycle through to day 26?

**Dr Elizabeth Farrell:** Yes. Or you can use three weeks on and one week off. That's the easiest way to do it, is to have that, so you've got a four-week regimen, so it's a bit like being on the oral contraceptive pill. You have three weeks of active pills and one week of inactive.

**Dr Marnie Newman:** So getting something that sort of sounds good helps the patient, doesn't it?

**Dr Elizabeth Farrell:** Yes, so three weeks on and one week off is a really good cycle. Would you agree with that? But this chart is basically saying that in a woman of this age, the ideal treatment for heavy menstrual bleeding is really the levonorgestrel IUD, as long as she's not wanting to have further pregnancies.

**Louise Browne:** So we've had a question that has taken the first option, let's say, we're assuming she wants pregnancy, this patient has been tried with tranexamic acid and NSAIDs with no improvement. So is that when they should be referring on to a gynaecologist, do you think? Or is there another, what would their next point be?

**Dr Elizabeth Farrell:** Well, the first thing depends on the actual dose of the tranexamic acid that's been given. And if you look at the requirements then it's two tablets, three or four times a day, on the heavy days up to five days of the heaviest days of the period. So if that's not controlling it, then really further investigation and yes, ongoing referral needs to be done to see whether or not there's something else.

**Dr Marnie Newman:** And while waiting for an appointment using the tranexamic acid, actually, can I just point out that one of the reasons that tranexamic acid gets bad press is because they really need a better name for it. Don't you think? People come in and say, 'You're going to prescribe an acid for me? Goodness gracious.' And then the trade name's no better with all those 'k' sounds. Anyway, I think that's the way—

**Dr Elizabeth Farrell:** So what you are trying to say is—

**Dr Marnie Newman:** While they're waiting for an appointment to see a gynaecologist, what about using tranexamic acid in conjunction with an NSAID at the same time?

**Louise Browne:** Which this question was.

**Dr Marnie Newman:** Oh, she was on both of them simultaneously.

**Louise Browne:** But no effect.

**Dr Elizabeth Farrell:** So this is where is you'd have to then push for an urgent appointment.

**Louise Browne:** And making sure that those doses are right.

**Dr Elizabeth Farrell:** Correct.

**Louise Browne:** Because they may not be using as much as, you've suggested.

**Dr Janine Manwaring:** And just one thing that I hadn't mentioned but before, but a pearl from a haematologist recently, that somebody who is iron deficient and anaemic bleeds more than someone who isn't iron deficient, because basically the red blood cells, there's not enough of them to make it to the sides, to the vessels with the platelets to make the clot. And so that if you actually give them iron, that that will reduce people's bleeding. So with this woman, with all of them, that basically when you're further investigating them, just really make sure about their iron levels. And it sounds like we're banging on about it a fair bit, but it's quite amazing and that since these newer formulations are available that don't have the same scary risks that used to have with anaphylaxis, and 20 minutes and that women are up and about and makes a huge difference.

**Dr Elizabeth Farrell:** So that's another good reason for doing an iron infusion

**Dr Janine Manwaring:** Yeah, and much more effective than blood transfusions.

**Louise Browne:** We've got some more questions, but I think we might just go to the third case study. Maybe a couple of these questions will be covered by this, and then we should have time at the end for some more questions. So we've got Ayesha, who's a 47-year old-woman presenting with flooding periods, feeling exhausted.

**Dr Marnie Newman:** Oh, so there are lots of things, thoughts, that come to mind in a 47-year-old woman. First of all, thinking through the things that we've already thought about with Jenna the teenager, with Thuy the woman in her thirties, is she anaemic? Does she have enough iron to stop making the cycle even worse? Is she pregnant? It's certainly possible to get pregnant when you're 47. If you're trying to get pregnant, it's not so likely, but if you're trying not to get pregnant, then it certainly can happen. And most important of all, is she perimenopausal? Is she in a state of hormonal chaos just like the teenager? And is that what's causing her bleeding? The last point up on the slide there is, as we get older, the risk of serious things happening increases, and could it be a cancer? Has she had screening? Now I'm not sure that there is such a thing as screening for endometrial cancer, and there's certainly not such a thing as screening for ovarian cancer, I'm just going to throw that in as a by the by. I guess if she's saying that her periods are heavy, but what she's really meaning to say is that she bleeds after sex, maybe she's got a cervical cancer and we certainly should be looking. And more importantly, does she have risk factors for endometrial cancer? Is she overweight? Does she have polycystic ovary syndrome?

**Dr Janine Manwaring:** Family history.

**Dr Marnie Newman:** Family history, thank you for that. So should we be thinking about all of those things? But the thing that really strikes me is that point about—

**Dr Elizabeth Farrell:** How heavy is she is.

**Dr Marnie Newman:** —how perimenopausal—

**Dr Elizabeth Farrell:** What her weight is.

**Dr Marnie Newman:** Yeah, in terms of a risk factor. So the other point that I haven't got up there on the slide, is asking her what drugs she's on, because there are a number of medications, both prescribed, over the counter, and from naturopaths, that can cause bleeding. Now sometimes that's done on purpose, that she might be on aspirin because she thinks it reduces her risk of having a stroke. She might be on, there are a number of products that naturopaths prescribe that can make bleeding more likely. So is there any iatrogenic or self-induced cause for her bleeding?

**Dr Janine Manwaring:** And the big one is fish oil, with that, is that right?

**Dr Marnie Newman:** Yeah. So fish oil is good for your heart, but, or might be good for your heart.

**Louise Browne:** We have got some, I do want to cover the natural therapies thing. We might do that afterwards actually, because there's been a comment too, so we'll get to that.

**Dr Janine Manwaring:** Yeah, don't take fish oil for your heavy periods. So investigations. Back to the betaHCG again, that it's very, very important for lots of reasons that you don't miss it if she's pregnant. And exactly the same first two lines as you would've done with Thuy earlier on. So hormone levels are the next tricky thing to work through your minefield. So it's the interpreting of pelvic ultrasounds in younger women, it's the interpreting of menstrual-related endometrial thickness on an ultrasound, and here the trouble with when to do hormone levels in the perimenopausal time.

**Dr Elizabeth Farrell:** Not.

**Dr Janine Manwaring:** And the answer is, thank you, Liz, not. So basically they are in a tremendous state of flux. If they are menopausal and that their FSH is continually elevated, they won't be bleeding. And if you are concerned that someone's in the perimenopause, you are looking at what their symptoms are, but also with their bleeding and then with the other symptoms that they may be experiencing.

But an FSH is going to tell you very little. And so there's a lot of women who will come in and say, 'I'm 45, I was hoping that I was going to be going through menopause. My GP has just done a hormone test and says that I won't be going through menopause until I'm 50', and I'm presuming that's because it was normal and that the average age of menopause was 51, or a crystal ball or something. But basically you don't need to do them. With regards to endometrial sampling, that this is the age group where it's becoming more important because of the higher risk of a structural pathology underlying heavier bleeding. So if a woman's over 45, or if she's having persistent abnormal uterine bleeding despite treatment, so like the woman that we had the question about a little bit earlier, or if she's got that increased risk of endometrial hyperplasia, then an office endometrial sample is simple, Liz talked about it in a little bit more detail earlier.

There's not many general practitioners within urban settings that would do them, but certainly it's something that is, things that people can be trained in doing. It can be combined with a hysteroscopy, which can be done as an awake procedure or under a general anaesthetic, or it is, got quite a good sensitivity when it's done on its own. Hysteroscopy is involving a small diameter fibre optic, usually a fixed scope, going through the cervix to visualise the uterine cavity. So you can take the sample with that at the same time. There are very few outpatient facilities within Australia. It's the gold standard basically everywhere else in the world. And they are being developed. There's a few within Victoria, there's some within the other states, and they have an excellent diagnostic rate, a very low false negative rate. And so that's something that women can have as a walk-in walk-out within a clinic, local anaesthetic, and generally a very good take-up for that as a very simple investigation. If need be, then you can progress to a general anaesthetic, and really that would give you, potentially, a larger diagnostic sample from a curette.

But a curette not a curative procedure, it's still a diagnostic procedure, because whatever's the underlying cause, unless there's a polyp that you've removed or a submucous fibroid you've removed, the underlying cause is still going to be there. Importantly with endometrial ablations being more common, we also need to rule out any abnormal histopathology before an ablation is undertaken. So an endometrial ablation means that there's a destruction of the endometrium, of the lining of the uterus back to the muscle layer, to try to reduce the amount of bleeding that is happening. And there's different products that are on the market, that there are the original hysteroscopic-based techniques. So that's something that requires a lot more hysteroscopic surgical ability than the newer techniques. But they have pros and cons to both, but they're comparable in their outcome. So about 85% of women are happy with the result of these, about half have no periods, about half have very light periods.

So it can be an extremely successful way of managing heavy bleeding towards the last years of a woman's reproductive life. There's about 15% of women who aren't happy, either that they've got ongoing bleeding problems or that they've got pain issues. That's more common, the younger the woman is when she has the ablation. So they do seem to have a lifespan to them. And with the newer ablations, you can't have more than one in your lifetime. So it's not contraceptive, and they're not recommended if you're planning to have future pregnancies, because they are reported, but certainly those pregnancies have much higher risks with regards to any complication, either of getting pregnant, staying pregnant, or the placenta coming out after the baby.

**Dr Elizabeth Farrell:** Thank you. So of course ablation, when you go to have another look after an ablation, after some time, the uterine cavity can be quite scarred, and you may not have much endometrium at all. So it's something you would have if you're not contemplating further pregnancy. I actually got rung today by a colleague about, she'd just seen a 48-year-old who'd had a spontaneous pregnancy, and was wondering where to send her. So that can happen.

**Dr Janine Manwaring:** Another conversation.

**Dr Elizabeth Farrell:** Yes. So obviously the management will depend on the cause of the bleeding. Very important to exclude endometrial hyperplasia and endometrial carcinoma. A very small percentage of women in this age group will present with heavy menstrual bleeding and have endometrial cancer. So even a small change in menstrual flow is important to take note of in this particular age group. Once again, Ferinject has become my favourite treatment for iron deficiency, as you obviously imagine after my talks this evening, and my conversation. Important to treat systemic disease. Remember that in the perimenopause, thyroid dysfunction is not an uncommon disorder that takes place at this stage. And if surgical intervention is required, then obviously refer to a gynaecologist.

Some of you who live in rural and remote areas may, of course, do hysteroscopies and polypectomies and obviously endometrial biopsies. But in the bigger centres then obviously referring on to a gynaecologist is appropriate. I just thought I'd remind you of the doses of tranexamic acid. It's a 500 milligram tablet, and it's two tablets, three to four times a day, on the heavy days up to about five days. Also, we can use the nonsteroidal anti-inflammatories in the same way. Obviously as you're well aware, it should be taken with food. Then the oral progestins, once again for 21 days. The oral contraceptive pill, either cyclically, or we can give it continuously if it's a monophasic pill. And that would be important in younger women who perhaps have a diagnosis of endometriosis, where we are wanting to suppress the cycle. And obviously in this particular age group of Ayesha, the levonorgestrel IUD is a very successful treatment for heavy menstrual bleeding, being contraceptive as well, and it can probably stay in for longer in the perimenopausal phase. And I know the Family Planning say up to 10 years—

**Dr Janine Manwaring:** Potentially.

**Dr Elizabeth Farrell:** —of contraception. Yes, at this stage. So even though it's after five years, the hormonal levels will reduce, there is still some treatment, there's still contraceptive efficacy. If a woman is perimenopausal and she's on oestrogen replacement therapy with the Mirena, or you're using the Mirena after the menopause, then it must be changed at five years to adequately suppress the endometrium.

**Louise Browne:** Oral progestogen starts on day, someone's just asked what day of the cycle?

**Dr Elizabeth Farrell:** Well, when we first started, we'd usually started about, like the Pill, up to day five, and then they can just go into the 'three weeks on, one week off' cycle.

**Dr Janine Manwaring:** But mostly the women that you'd be looking at instituting that with wouldn't have regular periods so, yep. Very briefly, just because I don't think we've harped on enough about the IUD, the Mirena, tonight, but one of the questions was, what is the most effective, and that is not the most effective to have it on the outside, but the Mirena, the average reduction in menstrual flow in the first 12 months is 94%. So it just is so, so much better than anything else that we've ever had. And within that first 12 months, about one in five women, their endometrium is just so thin that there's nothing to bleed. So that's why they are amenorrhoeic. It's important to warn them about that because frighteningly, I do have some women coming back saying they want it out because they're not bleeding anymore. And that number goes up to about 50% of women within two years are amenorrheic. So we actually, looking at records that we've got within Victoria, we do half the number of hysterectomies we did 10 years ago, and it's because of that of that.

**Dr Elizabeth Farrell:** Mirena.

**Louise Browne:** It's not called the Mirena?

**Dr Elizabeth Farrell:** Levonorgestrel.

**Dr Janine Manwaring:** It's the only one that's available!

**Dr Marnie Newman:** The other thing that we've sort of just mentioned in passing is the progestogen implant.

**Dr Elizabeth Farrell:** The levonorgestrel implant.

**Dr Janine Manwaring:** Which is very effective as well.

**Louise Browne:** Okay. I've got a board full of calls. So are you okay, do we need to go, do you want to say more about the implant or, no? Okay, so let's go back to someone who asked this very early on, and I can't remember if we covered it. Ovarian causes for menorrhagia, we're not using menorrhagia anymore, but, heavy bleeding heavy menstrual bleeding.

**Dr Elizabeth Farrell:** Menorrhagia's gone out the window, out the door.

**Louise Browne:** Okay. We're not using that. We're moving on from menorrhagia.

**Dr Janine Manwaring:** The ovulatory, so that's the AUB slash O, and that's more in the anovulation category. So that's what the O stands for.

**Dr Marnie Newman:** But it doesn't mean an ovarian cancer.

**Dr Elizabeth Farrell:** I don't know there are any ovarian causes of heavy menstrual bleeding.

**Louise Browne:** Because PCOS is—

**Dr Janine Manwaring:** Anovulatory.

**Dr Elizabeth Farrell:** Anovulatory.

**Louise Browne:** Yeah. Okay. We've got a question around Primolut five milligrams, TDS, for endometriosis treatment. Is this covered for contraception?

**Dr Janine Manwaring:** No.

**Dr Elizabeth Farrell:** TDS?

**Dr Janine Manwaring:** It's not licensed for contraception.

**Dr Elizabeth Farrell:** It's not licensed. It's not licensed.

**Dr Janine Manwaring:** So it may have contraceptive effect, but it is not licensed for contraceptives.

**Louise Browne:** Okay. Beautiful. Jane has asked, patients ask what risk of fibroids becoming malignant? I always reassure, can you give me any statistics?

**Dr Janine Manwaring:** The rate of a fibroid being malignant is somewhere around the one in a thousand figure. It's a very hotly discussed topic around the world for various reasons. But the thought is that fibroids, the vast majority start as cancer, not that they're there for 10 years and then they become cancer.

**Dr Elizabeth Farrell:** So the idea is that there's not usually a malignant change, whereas the majority of women have benign fibroids and they remain benign.

**Dr Janine Manwaring:** So you don't need to monitor them every 12 months or something to check for size unless there's a change in symptoms.

**Louise Browne:** Okay. Sorry, I just had one that's disappeared. A 20-year-old patient taking Provera, five milligrams BD, due to spotting from depot for one year, already excluded other causes. How long can she use Provera for that purpose?

**Dr Janine Manwaring:** She can continue it. So she's just got two different sources of hydroxyprogesterone acetate. So there's no problem with doubling up with hormones. That was another question about whether you can add in a progestogen along with the Pill or Mirena or an Implanon implant, and that there's no harm in doubling up with trying to get amenorrhoea. It's just for how long that's an acceptable—

**Dr Elizabeth Farrell:** So would you be concerned in a 20-year-old giving depot plus added Provera continuously for a period of time?

**Dr Janine Manwaring:** I'd want to explore what other options had been discussed. And that's from a lack of oestrogen—

**Dr Elizabeth Farrell:** So you're going to get low oestrogen levels.

**Dr Janine Manwaring:** Yes.

**Dr Elizabeth Farrell:** So therefore she hasn't even got to the age of reaching her peak bone mass.

**Dr Janine Manwaring:** Yeah, because with the implant and with the IUD, it doesn't suppress your ovarian hormones like the Provera and Depo-Provera do.

**Dr Elizabeth Farrell:** But the implant does suppress ovulation.

**Dr Janine Manwaring:** Does suppress ovulation, but you've still got a lower level of your own oestradiol.

**Louise Browne:** Okay. For perimenopausal bleeding, after excluding pathology, can we provide Mirena as a GP, following an ultrasound excluding thickened endometrium but without hysteroscopy or endometrial biopsy?

**Dr Janine Manwaring:** Yep.

**Dr Elizabeth Farrell:** Absolutely.

**Louise Browne:** Sounds like it's the answer for a lot of people. Any age limit to start the oral contraceptive?

**Dr Janine Manwaring:** No.

**Dr Elizabeth Farrell:** No. But one has to exclude risk factors, don't you think?

**Dr Janine Manwaring:** I'm assuming younger, or older?

**Louise Browne:** Oh, it doesn't say. It says 'age limit'.

**Dr Janine Manwaring:** Sorry, I was thinking age younger.

**Louise Browne:** I was thinking young, too.

**Dr Elizabeth Farrell:** I was thinking age older.

**Dr Janine Manwaring:** I'll go the young side of the table.

**Louise Browne:** I think they actually mean upper. So it's about risk, isn't it?

**Dr Janine Manwaring:** Yeah.

**Dr Elizabeth Farrell:** You wouldn't really consider starting the pill in somebody, what, over, in the perimenopause anyway.

**Dr Janine Manwaring:** No. But if they're on it already, then you potentially can continue it.

**Louise Browne:** How about you, Marnie? What would be your upper limit for a woman wanting the Pill?

**Dr Elizabeth Farrell:** Starting on it.

**Louise Browne:** Starting on it.

**Dr Janine Manwaring:** And for heavy bleeding rather than contraception.

**Dr Marnie Newman:** I actually probably would use it. Now I'm wondering whether I shouldn't be, but if—

**Dr Elizabeth Farrell:** For heavy menstrual bleeding, I think this is the question.

**Louise Browne:** This question doesn't actually say.

**Dr Marnie Newman:** So if I had someone with minimal cardiovascular risk factors, non-smoker not overweight, I think I would use a 20 microgram Pill. Certainly up to the age of 50.

**Dr Elizabeth Farrell:** There are no actual guidelines about when to cease oral contraception in women without risk factors. So I think it becomes on an individual basis, we usually say about 50, but there are no guidelines to tell us exactly.

**Louise Browne:** And we've got another one. What's the cutoff for endometrial thickness to consider referral for D&C?

**Dr Elizabeth Farrell:** That's impossible to answer.

**Dr Janine Manwaring:** Yeah, so if we're talking about bleeding within a woman's reproductive lifetime, so premenopausal bleeding, then there's not a set cutoff. So it's depending on what her bleeding pattern is. Is it regular, is it not regular? Does she have intermenstrual bleeding? Does it look suspicious for a polyp on the ultrasound. There's more and more, often a report also of potential hyperplasia on a report which is for endometrial thickness, which you can't actually diagnose from an ultrasound alone. So it comes down to the quality of the reporting and matching it with what the woman's symptoms are, and her individual risk factors.

**Dr Elizabeth Farrell:** You might actually do an endometrial biopsy.

**Dr Janine Manwaring:** Yeah, so, but it depends on the facilities and—

**Louise Browne:** And where you are.

**Dr Janine Manwaring:** Yeah.

**Louise Browne:** I did want to comment on a question, or a comment, that came in earlier, was, we do have a lot of people that tune in to our webinars who work in the complementary medicine field, and she's just expressing her concern about the first line treatment for, we're talking about the first case study, so 16-year-old woman being prescribed the oral contraceptive or an IUD as the first line. She says, I'm a medical herbalist, I've used other modalities for years and see girls having problems, basically, when they start this type of medication. There are safe and effective natural therapies which can be used with no complicating factors, and save the heavy duty medication for if it doesn't work, basically. I mean, that's her opinion. And I'd just like to point out that in the resources folder there's a sheet, an information sheet that's been put together by Sandra Villella who's the Jean Hailes naturopath, and it looks at a number of different things used for heavy bleeding and some research that supports that. So I just want to say we are considering those. We couldn't have everyone on the panel. I take her point, I don’t know whether anyone would like to comment on that.

**Dr Janine Manwaring:** I think, we weren't saying that it was a first line, and that we look at the conservative treatments, at the non-hormonal treatments, but just because someone's in their teens doesn't exclude them from the hormonal treatments.

**Louise Browne:** But there are options that people could explore if they wanted to as their first option?

**Dr Janine Manwaring:** They're not going to come and see one of us to explore the complimentary treatments.

**Louise Browne:** But there are options available if people want to head in that direction. And we do have that information sheet that you can download. So look, we've had fantastic questions. We probably can't get to them all. I do know that someone's made a comment about the fish oil that we are able to access being a little bit dodgy, and that there's not actually the omega3 in it that we think. Norman Swan mentioned it on the health report yesterday, my husband was telling me about it last night. So I think it is important to know where the fish oil is being sourced, and that it doesn't have a good shelf life and it oxidises and loses its effectiveness. But we're not advocating it for the use of heavy menstrual bleeding anyway, are we? It does cause—

**Dr Janine Manwaring:** Heavy bleeding.

**Louise Browne:** Heavy bleeding. So we're going to wrap up. I'm going to start with Marnie, to finish this up.

**Dr Elizabeth Farrell:** There you go.

**Dr Marnie Newman:** So, this is, what do you write on your prescription pad when the woman comes in with, oh, I was going to be terrible and say blood between the legs, but really, really distressed. What do I do now? So norethisterone, we're not meant to be promoting trade names, but most of us know that as Primolut, it's a five milligram tablet, so it's two tablets, four times a day. You get that started as soon as possible. She may need to take that sort of level of medication for two or three days and then ease it down. If that's not controlling her, then she can, in addition or as an alternative, use tranexamic acid. The doses are similar to what Liz had talked about before, two tablets, four times a day. And if that's not controlling her, then sometimes they do need to go to the emergency department.

In the emergency department, my understanding is they probably use similar medications but in even higher doses. So that's what you write on your prescription pad when somebody comes in with acute severe bleeding. Now when they come in, thank you for changing the slide, again this is just a reminder what to put on your prescription pad, as these are sort of the order of efficacy and of acceptance to people. On the first line, all of equal efficacy, tranexamic acid and/or one of the nonsteroidal anti-inflammatory drugs, or the combined hormonal contraception, either the combined oral contraceptive pill or the vaginal ring. So that's our first line management. As a second line management, there's the oral progestogens, we've talked about that in a little bit of detail. Norethisterone for, what I've got written up there is day five to 26, but it's much easier to remember for three weeks on and one week off. And then on the last line, not because it's least effective, but just because most GPs do not insert intrauterine devices themselves, either the levonorgestrel IUD, which is fantastic, or the etonogestrel implant. So that's the take home message for what to prescribe. And finally...

**Dr Elizabeth Farrell:** So I just want to wrap up by saying that heavy menstrual bleeding is a cause of diminished quality of life and physical functioning. It's important to actually diagnose what the cause is and to treat appropriately. And once again, I put the hand up for the iron infusion as the fastest way to improve the ferritin. And I think in the perimenopause, we're always worried about endometrial hyperplasia, that even a small change in bleeding pattern may indicate pathology. Thank you.

**Dr Janine Manwaring:** And the last thing I was going to say was that if you're not sure, then phone a friend, that, ask for another opinion. There aren't necessarily hard and fast rules, that we've been having a discussion amongst ourselves so that if things aren't fitting into an easy pattern, then you can ask for advice from others.

**Louise Browne:** There was someone asking about Implanon on and being unpredictable bleeding, but I don't know that we're going to have time to do it, but what we might do—

**Dr Marnie Newman:** Except to say yes.

**Louise Browne:** It does. Okay. And so anyway, that's confusing. So we might address that afterwards and we'll pop it on the website once the webinar is up in the library, which will be about next week. There is something that I wanted to mention just because Jean Hailes has responded to it. The Australian Commission on Safety and Quality in Healthcare is currently developing a new clinical care standard on heavy menstrual bleeding. So they're hoping that that will be about around in the middle of the year. We'll probably put a link to it on our website once that's up. And there'll be an information sheet you can pass on to women as well. There's lots of resources, articles, links in the resource tab on the right hand side of the screen. You can download the slides for future reference. We will finish up. So thanks for joining us. It's great to be back and doing our webinars again for 2017. We hope you've enjoyed tonight. Please give us some feedback at the end. It's very valuable for us. It helps us plan our future webinars. It's the reason we're doing tonight because you asked for it last year, which is fantastic. It helps us know what's needed by health professionals working around Australia. Please don't forget to complete the evaluation. You'll find the link on the screen under 'feedback'. If you need your CPD points, you have to fill in the evaluation. And thanks for our fantastic panel. They've been excellent as usual. And yeah, we look forward to seeing you for our next webinar in a couple of months' time. Thanks.

End of transcript

Information about the podcast

This podcast series has been made possible by the NSW Government's Menopause Awareness Campaign. For help talking about menopause, download the [Perimenopause and Menopause Symptom Checklist](https://www.jeanhailes.org.au/resources/perimenopause-and-menopause-symptom-checklist) and take it with you to your next medical appointment. For more information visit: <https://www.nsw.gov.au/women-nsw/toolkits-and-resources/perimenopause-and-menopause-toolkit>

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