Managing bleeding problems in primary care

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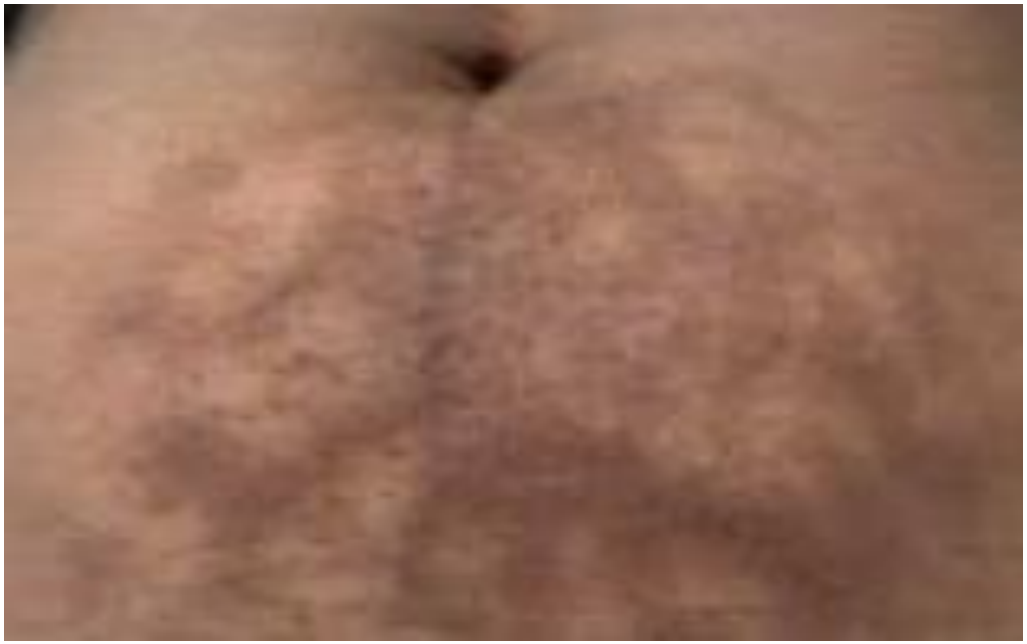
To discuss

- Revision of ‘bleeding problems’ in women
- Logical/evidenced approach to investigation and management
- Treatment options
- ‘Endometrial risk assessment’
- What can we do differently remotely?

‘My daughter’s got a rash’

- *Jenna is a 15 year old who is on the phone triage list.*
- *Mum answers the phone and says her daughter has a rash all over her abdomen which has been there for a few days. She is not unwell. No previous problems with her skin.*
- *It is not possible to talk to Jenna or see the rash over Accurx because she is at school*
- *Arrange to see her in the afternoon clinic*

What are you going to ask?

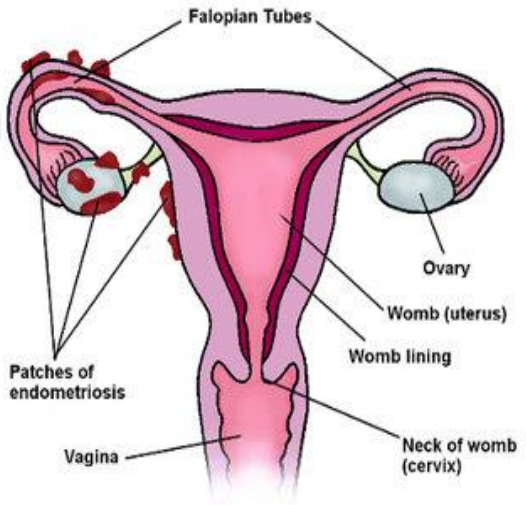


What do we need to know?

- Jenna was 13 when she started her periods
- She has a regular menstrual cycle 5/27-29 with no ‘non-menstrual bleeding’.
- Her periods have always been painful.
- The pain starts 2 days before the period and lasts throughout.
- Plus:
  - Any urinary symptoms?
  - Any bowel problems?
  - Is she sexually active?
  - Any pain during sex?

Endometriosis – ‘the missed disease’

- Endometrial-like tissue outside the uterus.
- Mainly a disease of reproductive years, hormone mediated and associated with menstruation
- Common - affecting 5-10% of women of reproductive age
- Diagnostic difficulty – average time to diagnosis 7.5 yrs
- Treatment outcomes poor with high recurrence rate
- Acute and long-term complications



APPG report 2020

Survey:

95% said their endometriosis impacted their wellbeing negatively

42% said they often had time off school with their symptoms

12% had missed exams

35% had reduced income due to endometriosis

8 years on average from onset of symptoms to making a diagnosis

Prior to diagnosis

- 58% visited the GP over 10 times
- 21% visited hospital doctors over 10 times
- 53% went to A/E – 27% went 3 or more times

‘Think’ endometriosis

- Suspect endometriosis (including in women aged under 17) presenting with 1 or more:
  - Chronic pelvic pain
  - Period related pain affecting daily activities and QoL
  - Deep pain during or after sexual intercourse
  - Period related or cyclical:
    - gastrointestinal symptoms - painful bowel movements
    - urinary symptoms - haematuria or dysuria
  - Infertility associated with 1 or more of above

NICE National Institute for Health and Care Excellence

NICE guideline

Endometriosis: diagnosis and management

NICE guideline
Published: 6 September 2017
nice.org.uk/guidance/ng73

If you had been able to see the rash on Accurx….

POLL:

Does she need to be examined further?

- Yes
- No

How would you manage her?

POLL:

- Treat with tranexamic acid
- Treat with naproxen
- Start a combined oral contraceptive
- Start a progesterone-only pill
- Refer for Ultra Sound scan
- Refer to gynaecology

Endometriosis treatment options

Ambition - to stop bleeding

Hormonal (contraceptive)

- Levonorgestrel-releasing intrauterine system (LNG-IUS)
- Combined Hormonal Contraception (CHC)
- Long-cycle or long-acting progestogens

Non-hormonal (non-contraceptive):

- NSAIDs – i.e. ibuprofen
- Other analgesia
- Neuro-modulators

Surgery

- Remove or destroy endometriotic lesions

Resources: Endometriosis: diagnosis and management NICE guideline [NG73]: 2017 https://www.nice.org.uk/guidance/NG73

Learning Points

- There will be as many women with endometriosis as there are with diabetes, asthma or back pain
- A menstrual diary is a useful tool
- Early treatment reduces long-term complications
- Consider referral to secondary care if symptoms change or continue,
  or for patient choice.
- Offer psychological support
- Endometriosis UK - www.endometriosis-uk.org

‘My periods are so heavy’

Sara was a 37 year old who was referred for hysteroscopy because of persistent heavy bleeding while using Nexplanon.

She had an US scan performed by her GP which had demonstrated a thickened endometrium at the fundus consistent with an endometrial polyp

Hysteroscopy normal endometrium with small septum.

What do we need to know?

And…

Always had heavy periods

2 x pregnancy both complicated by post-partum haemorrhage

What should have been done?

Blood tests.

FBC in all women with HMB

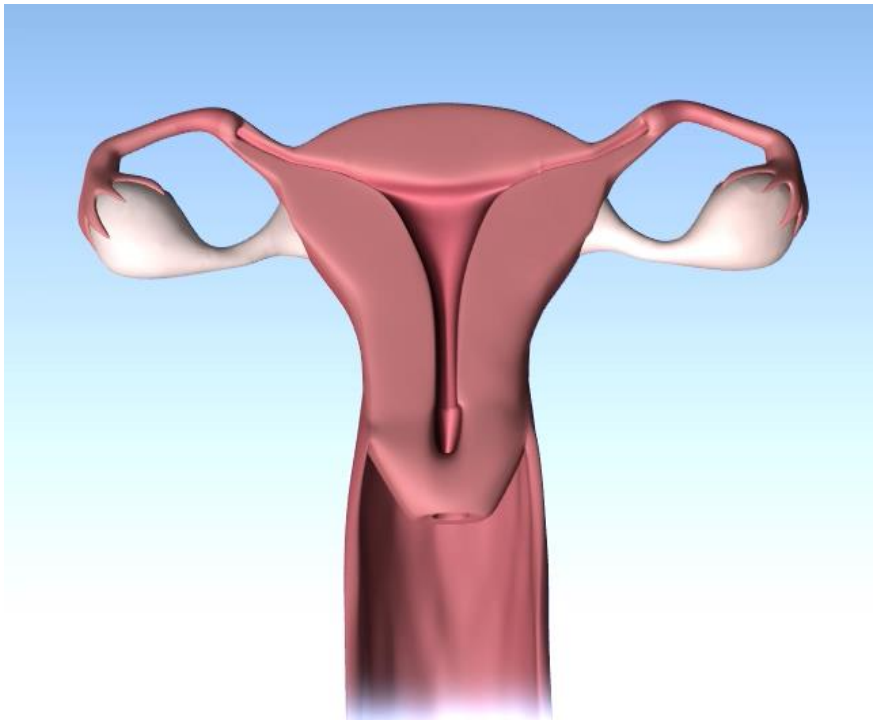
Tests for coagulation disorders in women who:

- HMB since menarche
- Personal or family history suggesting coagulation disorder

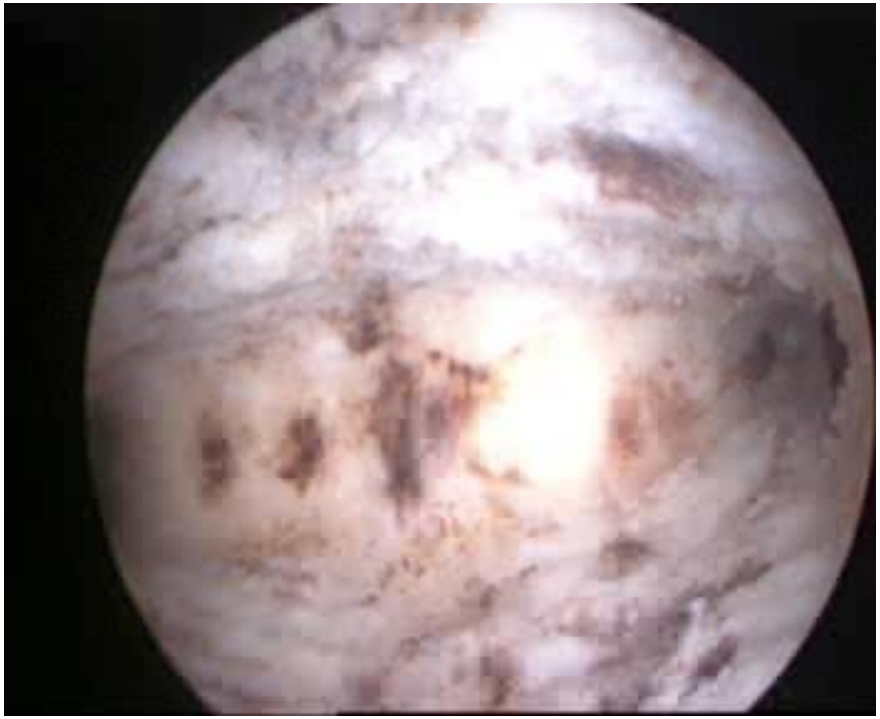
Unless other symptoms present DO NOT routinely test for:

- Ferritin
- Hormones
- Thyroid function

Novasure ® endometrial ablation



Post - treatment



‘My periods are so heavy’

- *Maria is a 42-year-old teacher at the local primary school. She phones for an appointment because her periods have been getting heavier and over the past six months, she has had a few ‘accidents’ at work.*
- *Last night she ‘flooded’ and had to change the bedding at 4 am.*
- *She felt dizzy when she got up this morning and has already changed her pad 10 times today.*
- *Her husband is concerned because she always seems tired and encouraged her to phone for an appointment.*

- What do we need to know?

What do we need to know?

History is important to determine:

- Do you need to see Maria?
- Do you need to admit Maria?
- What investigations does she need?
- What treatment are you going to give her now?
- What treatment are you going to recommend?

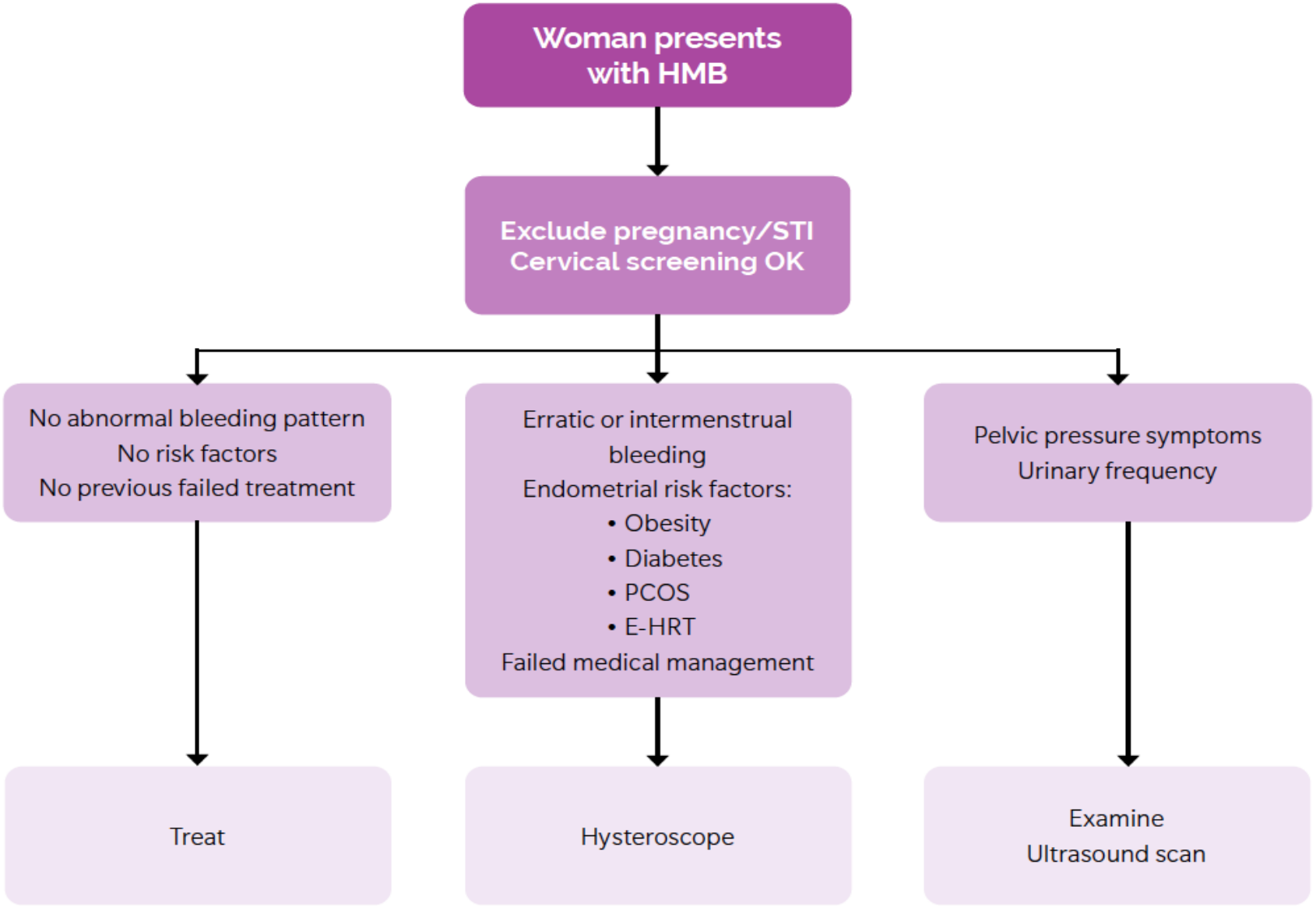
What do we need to know?

- Assess impact
  - Does your monthly bleeding affect your daily life?
- ‘Structural’ concerns
  - Pressure
  - Urinary frequency
- Endometriosis/adenomyosis
  - Dysmenorrhoea
  - Dyspareunia
- ‘Histological’ concerns
  - Inter-menstrual bleeding
  - Endometrial risk factors
  - Failed medical management

What are you going to do?

POLL:

- Arrange an ultrasound scan
- Refer gynae
- Give her tranexamic acid
- Give her medroxyprogesterone acetate


Woman presents with HMB
Exclude pregnancy/STI
Cervical screening OK
No abnormal bleeding pattern
No risk factors
No previous failed treatment
Erratic or intermenstrual bleeding
Endometrial risk factors:
• Obesity
• Diabetes
• PCOS
• E-HRT
Failed medical management
Pelvic pressure symptoms
Urinary frequency
Treat
Hysteroscope
Examine
Ultrasound scan

So with Maria….

- FBC or prescribe iron.
- No examination required unless smear due.
- Provide treatment at first visit for short term use.
- Provide information about treatment options:
  - Medical - reversible
  - Surgical – permanent
- Signpost to relevant on-line resources. NICE endorsed shared decision making aid
- Manage remotely
- Review for further discussion.

Heavy Menstrual Bleeding treatment options

Treatment options

Hormonal

- Levonorgestrel-releasing intrauterine system (LNG-IUS)
- Combined Hormonal Contraception (CHC)
- Long-cycle or long-acting progestogens

Non-hormonal (non-contraceptive):

Tranexamic Acid
NSAIDs – i.e. ibuprofen

Surgery

- Endometrial ablation
- Hysterectomy: refer to Evidence based intervention policy

Resources: Heavy Menstrual Bleeding NICE guideline [NG88]: 2018 https://www.nice.org.uk/guidance/NG88

‘I’ve got a lump in my tummy’

Marsha a 26 year old black Nigerian student phones for a consultation.

She has a lump at the bottom of her abdomen.

She first noticed it 3 months ago.

Her periods are very heavy and last for a week

Increased urinary frequency

Denies any SI – ‘never had sex’

‘Lump’

o/e 16 week sized uterus

Refuses pregnancy test as no risk.

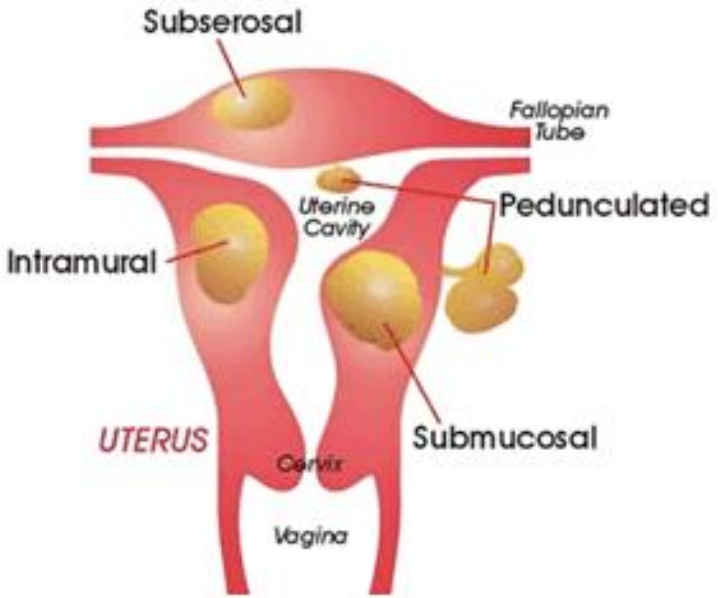
What are you going to do?

Fibroid management

- Check FBC
- Correct iron deficiency
- Reduce/stop bleeding
- US scan
- Refer

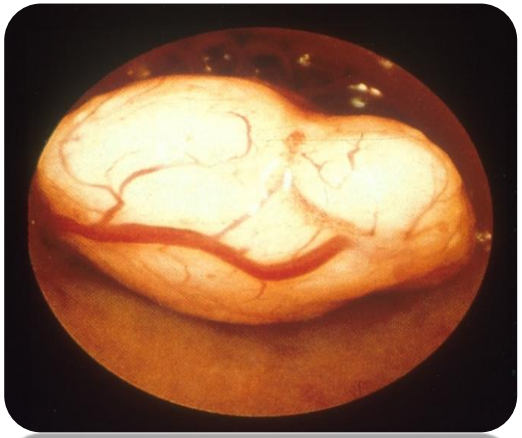
Fibroids

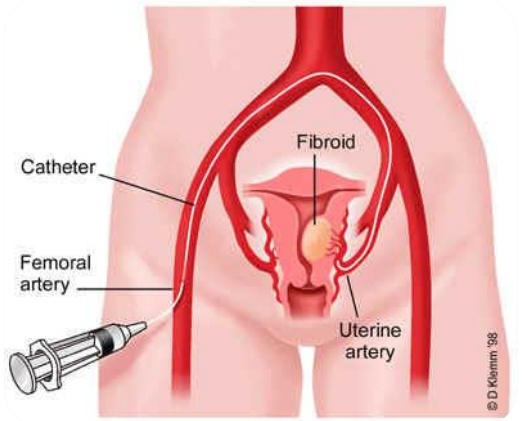
- Asymptomatic
- Heavy Menstrual Bleeding
- Pressure symptoms
- Pain
- Any bleeding pattern
- Incidental finding on imaging



Treatments

- LNG-IUS
- Medical management
- GnRH analogues
- Esmya
- Myomectomy
- Fibroid embolization
- Hysterectomy





‘I **need** a hysterectomy’

- *Gemma is a 46 year old woman who works in the local supermarket.*
- *She is well-known to the practice because of her regular attendance at the diabetic clinic and dietician.*
- *She has recently started having very heavy periods.*
- *It is embarrassing for her at work as she now needs regular breaks to change her pad and has ‘flooded’ a few times when working on the checkout.*
- ***‘I NEED a hysterectomy’***

- What do we need to know?

Be concerned about..

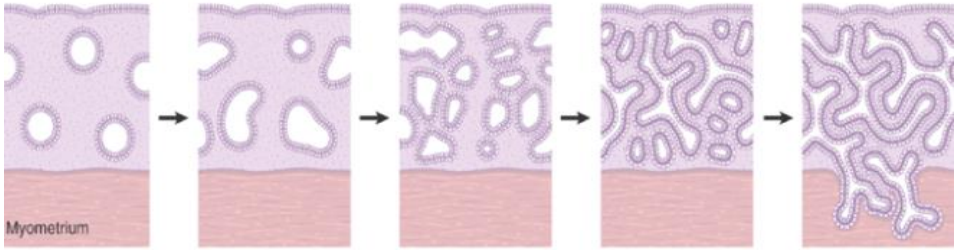
- Women with:
  - persistent inter-menstrual bleeding
  - persistent irregular bleeding
  - obesity
  - anovulatory cycles of peri-menopause or PCOS
  - inadvertently prescribed oestrogen only HRT
  - prescribed tamoxifen

- Women in whom previous treatment has been unsuccessful

Endometrial hyperplasia

Definition:

Irregular proliferation of endometrial glands with an increase in the gland to stroma ratio when compared with proliferative endometrium.



‘I’ve been bleeding again’

- *Audrey is aged 62 and retired from her job as a librarian 2 years ago. She phones the practice for an appointment.*
- *She really doesn’t want to make a fuss but she has had some vaginal bleeding – ‘spotting’ for a few days.*
- *She had a similar problem last week but if only lasted for a day and by the time she decided to phone for an appointment it had stopped.*

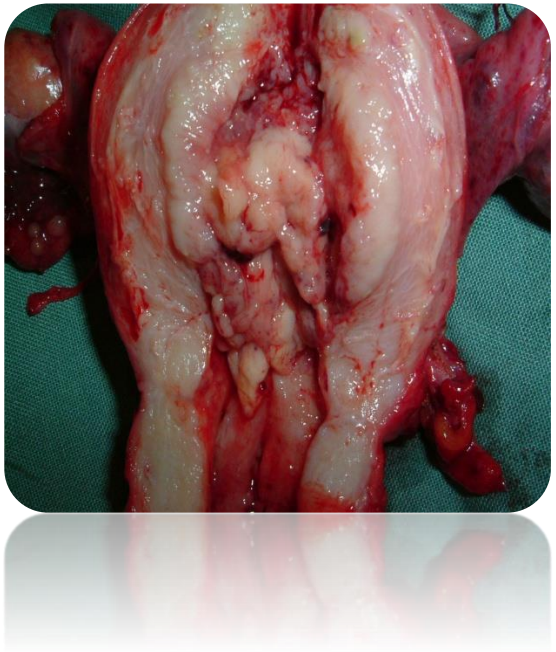
- What do we need to know?

What do we need to know?

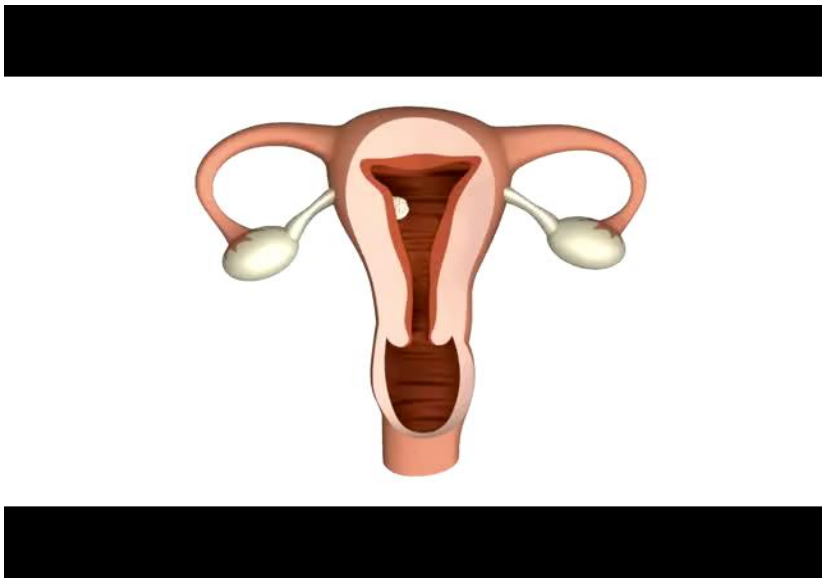
- Is she sure the bleeding is vaginal?
- What is the nature of the bleeding – i.e. signs of anaemia if heavy
- Is she up-to-date or had previous problems with smear tests
- Is she taking any hormones – i.e. HRT

Post-menopausal bleeding (PMB) (occurring in women not using HRT)

- Bleeding that is not obviously a period occurring over 12 months since their last menstrual bleed is a red flag symptom because 5-10% of women will have endometrial cancer



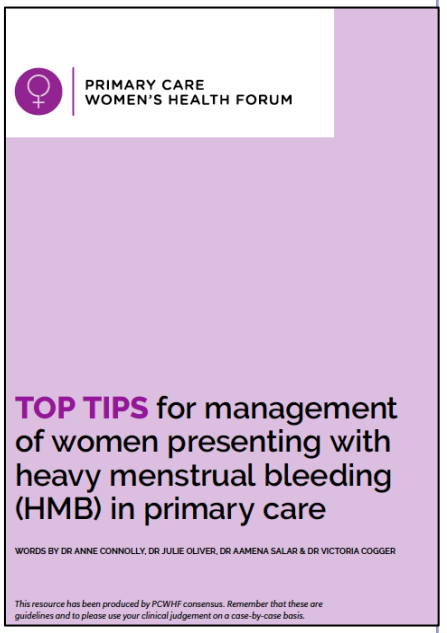
Myosure



- Audrey attended the PMB clinic.
- An USscan demonstrated a thickened endometrium of 16mm.
- At hysteroscopy she was found to have an endometrial polyp
- Biopsy demonstrated benign findings only
- Myosure in the outpatient setting is perfect treatment option.

HMB management top tips

1. Do not quantify – ask how it affects her
2. Clarify the bleeding pattern and pressure symptoms
3. Risk factors/when to worry
4. When to examine
5. Know which basic laboratory investigations recommended
6. Know when to scan
7. Know when to 'scope
8. Treat on the day
9. Know the management pathway – you can't go back from an irreversible procedure
10. Understand NEA
11. Hysterectomy is risky and a procedure of limited clinical value for benign, non-fibroid, problems



Any questions?

Royal College of Obstetricians & Gynaecologists

BSGE BRITISH SOCIETY for GYNAECOLOGICAL ENDOSCOPY

BRITISH GYNAECOLOGICAL CANCER SOCIETY

Joint RCOG, BSGE and BGCS guidance for the management of abnormal uterine bleeding in the evolving Coronavirus (COVID-19) pandemic

This consensus statement provides a framework for the management of women with abnormal uterine bleeding (heavy menstrual bleeding (HMB), inter-menstrual (IMB), postmenopausal bleeding (PMB) or post coital bleeding (PCB)) during the current pandemic. These are frequent symptoms that impair quality of life and raise concerns about gynaecological cancer.

The statement provides national guidance on reinstating gynaecological services for the assessment and management of AUB according to the clinical priority framework produced by the RCOG[1]. It also affords a framework to aid contingency planning for individual health care practitioners, service managers and commissioners to mitigate the effects of reductions in human and physical resources on our service.

Our objectives are:

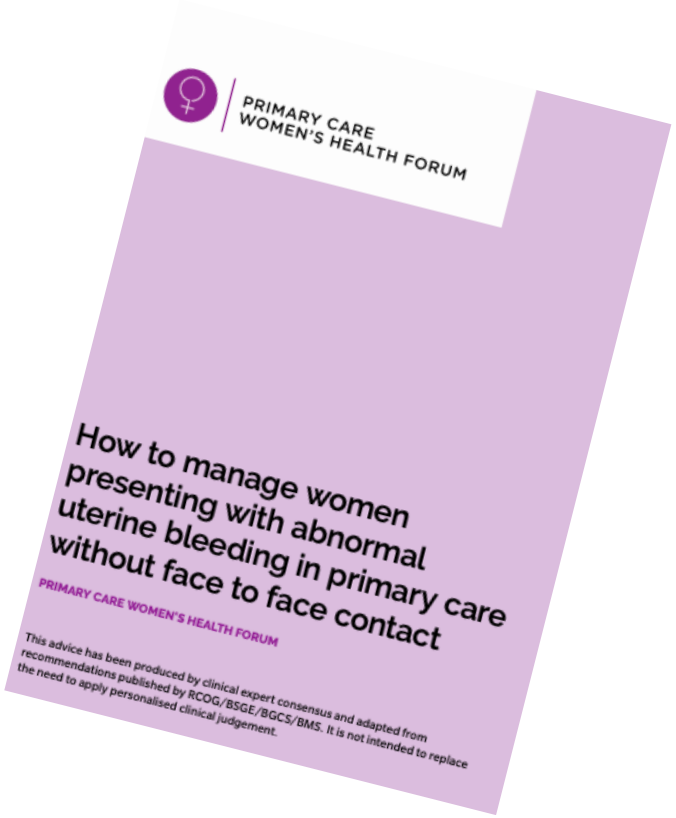
1. To reduce the risk of person to person (horizontal) transmission of the virus SARS-CoV-2, which causes COVID-19.
2. To make the best use of limited human and physical resources.
3. To provide access to timely, safe and effective management of abnormal uterine bleeding during times of disruption to normal healthcare provision.

For planned and elective care outpatient or inpatient care, only patients who are asymptomatic should attend, ensuring they can comply with normal social distancing requirements. This may require alternative ways of scheduling appointments, restructuring of waiting areas and wards and / or reducing outpatient, testing and surgical capacity. Local protocols and national guidance should be followed[2].

Heavy Menstrual Bleeding

- Women with HMB should initially be managed by remote communication. They should be reassured that the risk of malignancy is negligible[3].
- A relevant clinical history should be taken to elucidate the severity of the symptoms, the possibility of anaemia and the likely cause.
- If there are no symptoms of anaemia, or if present anaemia is likely to be mild, NICE recommended medical treatment should be prescribed after exclusion of contraindications[4]. To reduce the need for face to face interaction, consider the use of oral medications initially in preference to intrauterine hormonal devices.
- Women should be referred as an emergency to secondary care for further management if:

18/05/20 v3



PRIMARY CARE WOMEN'S HEALTH FORUM

How to manage women presenting with abnormal uterine bleeding in primary care without face to face contact

PRIMARY CARE WOMEN'S HEALTH FORUM

This advice has been produced by clinical expert consensus and adapted from recommendations published by RCOG/BSGE/BGCS/BMS. It is not intended to replace the need to apply personalised clinical judgement.