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ADDRESS FOR CORRESPONDENCE

Mary J Renfrew
Professor of Mother and Infant Health,
Department of Health Sciences,
University of York, Area 4,
Seebohm Rowntree Building,
Heslington, York YO10 5DD
E-mail: mjr505@york.ac.uk

Heavy menstrual bleeding:
delivering patient-centred care

The last decades of the 20th century saw rising rates of surgery for heavy menstrual bleeding with associated high costs and morbidity.[1,2] GPs have been implicated as contributing to this as referral rates vary widely between practices and high referral rates are significantly associated with high operative rates.[3] GPs have also been criticised for being dismissive of menstrual problems and not addressing patients' concerns.[4] A NICE guideline has been published recently which could lead to better primary care management of heavy menstrual bleeding and improve patients' quality of life.[5]

In the past, heavy menstrual bleeding has been defined in terms of volume of menstrual blood loss.[6] However, volume of loss is not routinely measured in clinical practice and there is a poor correlation between measured loss and women's perceptions of their blood loss.[7] It was thought that psychological problems could explain the lack of correlation between measured and perceived blood loss, but we now know that the relationship between heavy menstrual bleeding and psychiatric illness is no different to the relationship between psychiatric illness and other physical symptoms.[8] There are several alternative explanations. Firstly, for individual women a change in volume of loss may be more significant than absolute volume of loss, for instance in leading to concern that something might be wrong or in challenging menstrual concealment strategies.[4,9] Secondly, women's ability to contain heavy loss depends on their social circumstances; for example, women in jobs without easy access to toilets may have particular difficulty in managing heavy menstrual loss.[10] Finally, it has been shown that the presence of other menstrual symptoms, such as pain, mood changes, and irregular bleeding all influence the impact of heavy menstrual bleeding.[9,11]

Clinicians may remain concerned that by focusing on the impact of symptoms rather than attempting to objectively assess volume of menstrual loss they may be missing significant underlying pathology. The NICE guideline provides a thorough summary of the epidemiology of uterine pathology. It highlights that although there is a lack of research in primary care, studies from secondary care show that the association between fibroids and heavy menstrual bleeding is less strong than previously thought. Furthermore, persistent intermenstrual bleeding is probably a more significant symptom than heavy menstrual bleeding in predicting endometrial cancer and this is very uncommon in women aged less than 45 years.

The NICE guideline provides a useful new definition of heavy menstrual bleeding based on impact on quality of life rather than measured blood loss:

> *'Heavy menstrual bleeding should be defined as excessive menstrual blood loss which interferes with the woman's physical, emotional, social, and material quality of life, and which can occur alone or in combination with other symptoms. Any interventions should aim to improve quality of life measures.'*[5]

The implication of this new definition is that clinicians should focus primarily on assessing the impact on daily life, rather than on notions around assessing volume of loss. Focusing on the impact of heavy menstrual bleeding addresses patients' concerns and should lead to more patient-centred care. The NICE guideline dealt only with heavy menstrual bleeding rather than other menstrual symptoms (such as menstrual

pain). However, the full guideline alludes to the importance of other menstrual symptoms and, as discussed above, there is evidence that other symptoms have a powerful influence on the degree of impact of periods on daily life. Concentrating on all menstrual symptoms rather than heavy menstrual bleeding alone should lead to more effective management of menstrual problems through choosing treatments that address menstrual comorbidity (such as non-steroidal anti-inflammatory drugs [NSAIDs] for pain). This shift in emphasis marks an important step forward in the care of heavy menstrual bleeding.

The NICE guideline also highlights other recent developments. There is strong evidence for the effectiveness of the levonorgestrel-releasing intrauterine system, such as Mirena® (Schering–Health), in reducing volume of menstrual bleeding and improving quality of life.[12] Accordingly, the NICE guideline ranks treatments, suggesting that the levonorgestrel-releasing intrauterine system should be considered first, followed by tranexamic acid, NSAIDs, or combined oral contraceptives. The NICE guideline is right to highlight the importance of the levonorgestrel-releasing intrauterine system, which is probably under-used in the UK at present and which is not available in all general practices. A numbered ranking system may add clarity to the guideline and aid construction of algorithms, for instance in local guidelines. However, such a ranking system seems surprising in a condition where choice between treatments is clearly related to a number of complex issues including contraceptive preferences, attitudes to pill-taking compared to insertion of a device, attitudes to hormonal treatments, and presence of other menstrual symptoms. From an evidence perspective it is also a little surprising, given that, as yet, there is no published comparison of quality of life or patient satisfaction between levonorgestrel-releasing intrauterine system versus tranexamic acid.

The role of levonorgestrel-releasing intrauterine system as an alternative to surgery for heavy menstrual bleeding, the emphasis on quality of life, and the recognition of the importance of other menstrual symptoms mean there is a strong imperative to ensure that patients fully understand the different treatment options. It has been shown that, among women referred to secondary care, provision of information followed by a structured interview to clarify preferences was associated with a lower subsequent rate of surgery and improved satisfaction when compared with those offered information alone or usual care.[13] In primary care, a decision aid has been shown to improve menorrhagia-specific quality of life and reduce decisional conflict about treatments.[14] The provision and discussion of information regarding treatment options is an important challenge that should be taken up in primary care.

The NICE guideline makes some subtle, but significant, changes in recommendations regarding the assessment of heavy menstrual bleeding, compared with previous guidelines.[6] In doing so they acknowledge that they are basing their recommendations on guideline development group discussions as more evidence is needed regarding which element of history, examination, and investigations are most relevant for women reporting heavy menstrual bleeding. The guideline states that treatment for heavy menstrual bleeding (except levonorgestrel-releasing intrauterine system) may commence without physical examination if there is no history of intermenstrual bleeding, postcoital bleeding, pelvic pain, or pressure symptoms. A full blood count is still recommended for all women complaining of heavy menstrual bleeding. Treatment failure in women aged 45 years or over is an indication for further investigation, but not necessarily among younger women. Previous guidelines recommended bimanual examination for all women presenting with heavy menstrual bleeding and further investigation in all women with treatment failure. These recommendations potentially mean that some treatments can be commenced without bimanual examination, which may have formed a barrier to treatment in some practices where female practitioners or chaperones were less available. In addition, further investigations will focus on those more likely to have underlying pathology.

Although more rational use of investigations, increased use of the levonorgestrel-releasing intrauterine system, and greater provision of information may all have a positive impact on care, a shift in emphasis away from measured blood loss and towards quality of life may be even more important in improving the management of heavy menstrual bleeding. This means that, as well as excluding serious disease, we will be assessing and treating the symptoms that really matter to our patients.

Miriam Santer
GP, Ruston Street Clinic, London

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ADDRESS FOR CORRESPONDENCE

Miriam Santer
Ruston Street Clinic, Ruston Street, London, E3 2LR.
E-mail: miriamcsanter@yahoo.co.uk