Royal College of Obstetricians & Gynaecologists

Advice for Heavy Menstrual Bleeding (HMB) Services and Commissioners

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HQIP
Healthcare Quality Improvement Partnership

RCGP Royal College of General Practitioners

Contents

1. Background

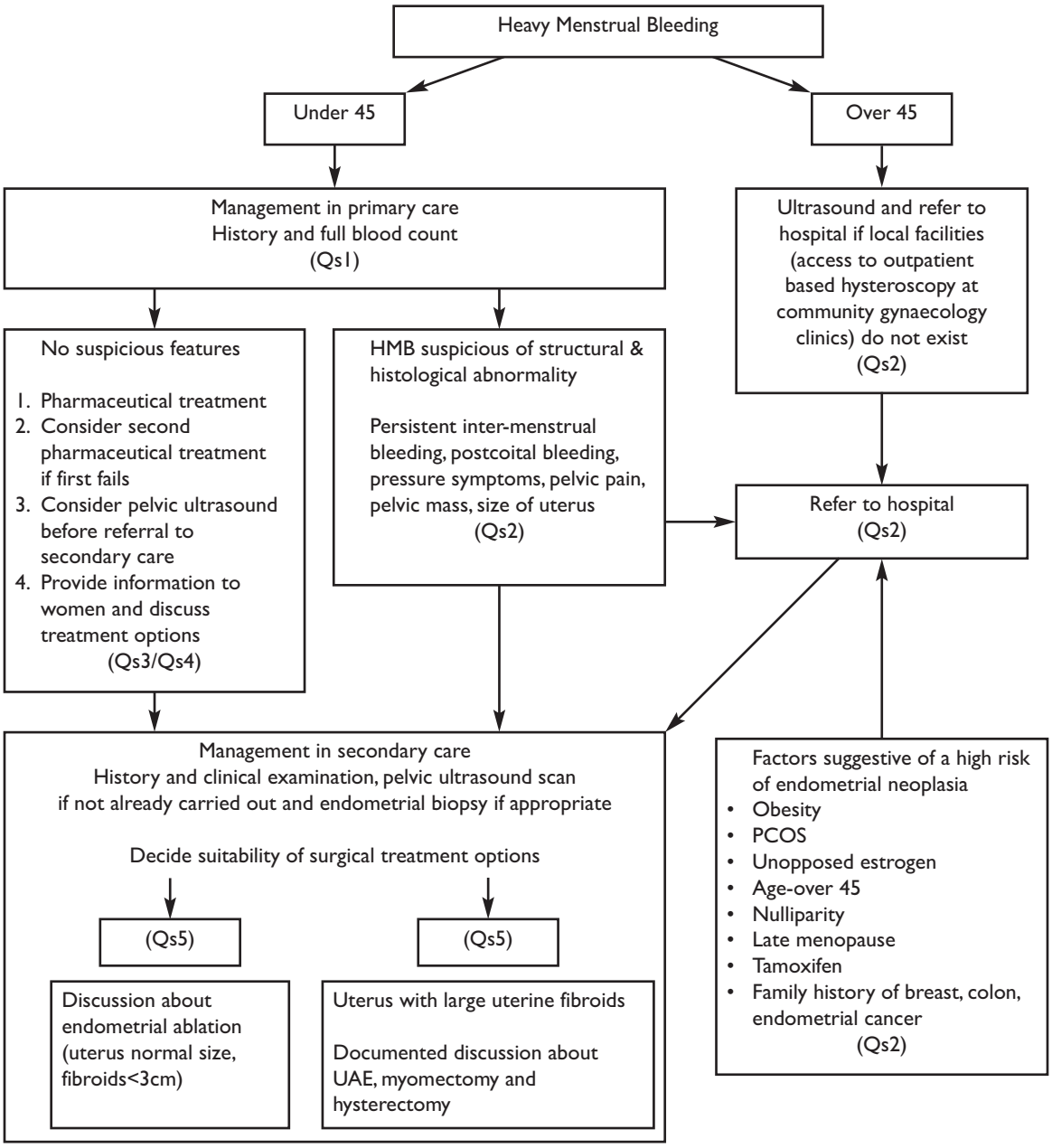
Heavy menstrual bleeding (HMB) is a prevalent condition that affects 20–30% of women of a reproductive age[1]. It can occur alone or in combination with other symptoms such as dysmenorrhoea (painful periods) and is frequently associated with endometriosis and adenomyosis or uterine fibroids. Several treatment options can be administered in primary care with varying levels of effectiveness. In England and Wales, about 80 000 women a year with HMB are referred for the first time to secondary care and approximately 30 000 undergo surgical treatment[1, 2].

Over the past 20 years, there have been new developments in the management of women with HMB, namely the levonorgestrel releasing intrauterine system (IUS) (a cost-effective first-line treatment especially when fertility preservation is desirable), endometrial ablation (as an alternative to the definitive treatment hysterectomy) and uterine artery embolisation (UAE) (as an alternative to myomectomy and hysterectomy for uterine fibroids).

The National Institute for Health and Care Excellence (NICE) has issued a clinical guideline (2007)[3] and quality standard (2013)[4] for the management of women with HMB (Figure 1). The Royal College of Obstetricians and Gynaecologists (RCOG) included guidance on the management of women with HMB in their standards for gynaecology (2008)[5].

The RCOG, on behalf of HQIP, also conducted a four-year national audit from 2010 to 2013 to examine the care received by women with HMB and to assess patient outcomes and experience of care[1, 2, 6, 7]. The lessons learnt from this audit have informed the development of this advice for the provision of HMB services. The purpose of this advice, endorsed by the Royal College of General Practitioners (RCGP), is to ensure that effective and patient focused clinical care can be delivered nationally in primary and secondary care.

Figure 1. NICE quality standards[4] for managing HMB (see key for quality statement (Qs))



Key: NICE QS47 2013

Quality statement 1: Diagnosis – initial assessment
Women presenting with symptoms of HMB have a detailed history and a full blood count taken.

Quality statement 2: Diagnosis – physical examination
Women with HMB in whom a structural or histological abnormality is suspected have a physical examination before referral for further investigations.

Quality statement 3: Drug treatment
Women with HMB without suspected structural or histological abnormalities are offered drug treatment at the initial assessment.

Quality statement 4: Interim drug treatment
Women with HMB who are undergoing further investigations or awaiting definitive treatment are offered tranexamic acid or non-steroidal anti-inflammatory drugs at the initial assessment.

Quality statement 5: Access to endometrial ablation
Women with HMB and a normal uterus or small uterine fibroids who choose surgical intervention have a documented discussion about endometrial ablation as a preferred treatment to hysterectomy.

Quality statement 6: Access to interventions for uterine fibroids
Women with HMB related to large uterine fibroids who choose surgical or radiological intervention have a documented discussion about uterine artery embolisation, myomectomy and hysterectomy.

(In NICE QS47, some quality statements may refer to additional guidelines and standards)

2. The National HMB Audit

This 4-year audit consisted of an organisational audit of acute NHS providers in England and Wales and a prospective audit of patient-reported outcomes for women with HMB.

In the organisational audit[7], we found that:

- Two-thirds of hospitals do not have a dedicated menstrual clinic.
- Almost half of hospitals do not have a written protocol in place for the management of HMB.
- Over 10% of hospitals do not provide women with written information about HMB and the treatment options.

In the prospective audit[6], women at their first outpatient visit reported on prior treatment received in primary care. We observed that:

- Almost one-third of women had not received treatment in primary care before referral to secondary care.
- Only 6% of women had an IUS inserted as first line treatment in primary care.
- Prior to referral to secondary care, almost half of women had three or more visits to the GP regarding their HMB.
- The management of women with HMB differed by ethnicity. Non-white women had more frequent visits to their GP.

The prospective audit[2, 7] also found that one year after the first outpatient visit:

- Women of non-white ethnicity and those from more socio-economically deprived areas had a lower surgical intervention rate and reported smaller improvements in their condition than white women or those from less deprived areas.
- Women who underwent surgical treatment reported the most severe symptoms and worst quality of life but had the greatest improvement in the year after the first outpatient clinical visit.

Finally, the results of this audit indicate that women with HMB treated in hospitals that have implemented the RCOG Standards for Gynaecology[5] report slightly better outcomes and experiences.

3. Implications for service delivery

Comparing the results of the audit with the recommendations in the clinical guideline (2007)[3] and quality standard (2013)[4] issued by NICE and the RCOG Standards for Gynaecology (2008)[5], we conclude that:

- The existing local referral pathways between primary and secondary care should be reviewed given that nearly a third of women reported that they had not received any treatment for their HMB in primary care. This review should not only carefully explore the reason why some women do not receive treatment in primary care but also recognise that for some women immediate referral is an appropriate option, for example for women with large fibroids.
- Care provided to women of non-white ethnicity and those from more socio-economically deprived areas should be reviewed as these women are less likely to have surgical treatment and they report smaller improvements of their conditions than white women. A greater awareness of cultural differences and enhanced access to dedicated menstrual clinics may further improve how the individual needs of women are being met.
- For patients with severe symptoms and a poor quality of life, surgical treatment could be considered earlier in the decision making process for treatment as it produced the greatest improvement in this group of women.
- Information for patients should be further improved. About 10% of the hospitals reported that they did not provide written patient information about HMB and the available treatment options.
- Written protocols for the management of women with HMB should be more widely available as only about 50% of the hospitals report having such a protocol in place.
- The organisation of gynaecology outpatient clinics may need to be reviewed given that only one third of hospitals reported that they had a dedicated menstrual clinic.
- Hospitals should continue to compare themselves against their peers with regards to the treatments they offer to women with HMB given the considerable variation that we observed across hospitals in treatments offered in secondary care. The results of each of the participating hospitals presented in Appendix 5 in the National HMB Audit Final Report[7], can be used for that purpose.

In addition, the RCOG Standards for Gynaecology[5] recommend annual monitoring of the care that women with HMB receive. Clinical care should be monitored against the following criteria summarised from the RCOG Standards for Gynaecology and NICE quality standards:

In primary care

The proportion of women:

- Presenting with HMB who have a detailed history and a full blood count taken.
- Found to be anaemic who were appropriately treated.
- Without suspected structural or histological abnormalities, who are offered hormonal and/or non-hormonal treatment at the initial assessment.
- Without suspected structural or histological abnormalities, who are offered IUS at the initial assessment.
- With suspected structural or histological abnormalities who had a physical examination before referral for further investigations.
- Who had a pelvic ultrasound scan before referral to secondary care.

In secondary care

The proportion of women:

- Who did not have pelvic ultrasound scan before referral to secondary care.
- Aged 45 and above and/or with high risk factors who did not have an endometrial biopsy.
- With a normal uterus, who were offered endometrial ablation in preference to hysterectomy.
- With a large fibroid uterus offered UAE.
- Who have completed a quality of life questionnaire specific to HMB.

4. Implications for commissioners

We recommend that:

- Commissioners should have a women's health clinical lead to champion the implementation of an integrated care pathway for women with HMB across both primary and secondary care.
- Commissioners should ensure that,
  - All women can be offered the full range of treatments (especially the full range of surgical options), investigations and interventions as defined in the guidance provided by NICE and the RCOG.
  - Mechanisms are in place to monitor the care that women with HMB receive in primary and secondary care.
  - Adequate training is provided to all clinicians in primary care involved in the provision of HMB services, especially IUS insertion.
- Commissioners review access to first line treatments in primary care and the process of referral to secondary care of women who need more specialised assessment and treatment.

In support of these recommendations, we have developed a checklist to improve (enhance) the integration of primary and secondary care services for women with HMB in order to support a seamless care pathway (Figure 2). We strongly encourage clinicians in primary (and secondary) care to use this checklist, which we believe will help to streamline evidence-based care for women presenting with HMB.

This guidance has been produced on behalf of the RCOG by

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Figure 2. Checklist for the management of women with HMB

Royal College of Obstetricians & Gynaecologists

Royal College of General Practitioners

Royal College of Obstetricians and Gynaecologists
Checklist for the Management of Women with Heavy Menstrual Bleeding (HMB)

GP information	
Usual GP:	
Referring GP:	GP No.:
Practice Address:	
Practice Telephone:	Practice Fax:
Signature:	Date:

Patient information	Date of Birth:
Patient's Name:	Ethnicity: White ☐ Mixed ☐
Address:	Asian ☐ Black ☐
Telephone Home:	Chinese or other ☐
Telephone Work:	Hospital No.:
Mobile:	NHS Number:
The patient needs: Interpreter ☐ Lipspeaker ☐ BSL interpreter ☐	

Ethnicity

White
British, Irish, any other white background

Mixed
White and Black Caribbean, White and Black African, White and Asian, any other mixed background

Asian
Indian, Pakistani, Bangladeshi, any other Asian background

Black
Caribbean, African, any other black background

Chinese
Chinese, any other ethnic group

Patient information

Has received information about HMB (Qs1)	☐
Has detailed history taken and high risk factors identified (Qs2)	☐
Has had a full blood count performed, any anaemia treated (Qs1)	☐
Has no identifiable risk factors and is below the age of 45	☐
Has been offered IUS as a first line of treatment (Qs3)	☐
Has been offered other hormonal and/or non-hormonal treatment (Qs4)	☐
Has had a pelvic ultrasound scan (enclose report) (Qs3)	☐
Current BMI (weight (kg)/height (m)^2)	
Current blood pressure (mmHg)	
Has transport home (patient must not drive)	☐
Has an escort home and a carer for 24 hours if required	☐
Past History:	
Current Medication:	
Allergies:	
Attached are the results of relevant investigations undertaken by the GP	☐
Therefore is suitable for day care surgery Yes ☐ No ☐	

High risk factors
Persistent inter-menstrual bleeding, postcoital bleeding, pressure symptoms, pelvic pain, pelvic mass, obesity, PCOS unopposed estrogen, age-over 45, late menopause, tamoxifen, family history of breast, colon, endometrial cancer

Drug treatments for HMB
Tranexamic acid
Non-steroidal anti-inflammatory drugs, combined oral contraceptives, oral progestogen (norethisterone), injected progestogen

Reason/Indication for referral to secondary care:

High risk ☐	Not high risk but age>45 ☐	Failed pharmacological treatment ☐	Pelvic mass/ uterine fibroid ☐
Proposed secondary care management			
• Ultrasound scan if not previously done • Endometrial biopsy/ outpatient hysteroscopy	• Outpatient hysteroscopy	• Ultrasound scan if not previously done • Endometrial ablation	• Uterus with large uterine fibroids • Documented discussion about UAE, myomectomy and hysterectomy

Please include a referral letter if there is additional relevant information

References

1. Royal College of Obstetricians and Gynaecologists, London School of Hygiene & Tropical Medicine, Ipsos MORI, *National Heavy Menstrual Bleeding Audit: First Annual Report*. 2011, RCOG Press.
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4. National Institute for Health and Care Excellence (NICE), *Heavy Menstrual Bleeding. NICE quality standard 47*. 2013, NICE.
5. Royal College of Obstetricians and Gynaecologists, *Standards for Gynaecology. Report of a Working Party*. 2008, RCOG.
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7. Royal College of Obstetricians and Gynaecologists, London School of Hygiene & Tropical Medicine, Ipsos MORI, *National Heavy Menstrual Bleeding Audit: Final Report*. 2014, RCOG Press.