Abnormal Uterine Bleeding

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Faculty/Presenter Disclosure

• Faculty/Presenter: Julia Carter

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Objectives:

• To use the SOGC guidelines to work through three real cases of premenopausal Abnormal Uterine Bleeding (AUB)

  – What is AUB? Types of AUB?
  – Evidence-based investigations – Station 1
  – Management in your office – Station 2
  – What gyne might do – Station 3
SOGC guidelines – [www.sogc.org](http://www.sogc.org)

- **Abnormal Uterine Bleeding in Pre-Menopausal Women (Replaces No. 106, Aug. 2001)**
  *published May 2013*

- **The Management of Uterine Leiomyomas (Replaces, No. 128, May 2003)**
  *published February 2015*

- **Endometrial Ablation in the Management of Abnormal Uterine Bleeding**
  *published April 2015*
What is Abnormal Uterine Bleeding (AUB)?

• “any variation from the normal menstrual cycle”
  — SOGC guideline “Abnormal Bleeding in Pre-Menopausal Women” (2013)

• Woman’s experience and impact on QoL determine the degree to which intervention may be required

• AUB includes
  – Menorrhagia
  – Metrorrhagia
  – Menometrorrhagia
Ovulatory or non-ovulatory?

• **Ovulatory bleeding**
  – Regular
  – Molimina (premenstrual symptoms – breast tenderness, bloating)
  – May have dysmenorrhea

• **Anovulatory bleeding**
  – Irregular, lack of molimina, dysmenorrhea less likely
  – More common near menarche and perimenopause
  – More likely to be associated with endometrial hyperplasia and cancer
Case One – Luisa

- 38 y.o. G0P0
- BMI 34, non-smoker, generally healthy
- No current partner, unsure if she wants kids
- c/o heavy periods x 2+ years
- Past 3 months, has bled irregularly, for up to a month at a time, with variable flow; not painful
- Occasionally gets breast tenderness and bloating before a period, but not always
- US 2011 showed small fibroids, otherwise normal
- Gradually anemic – Hg 130, 118, 112, 108
  - Didn’t want to go on iron tablets or OCP; doesn’t like taking pills
  - “Juicing” to lose weight – referred to PCN dietician to try and help her increase dietary iron
Case One (continued)

• While visiting family in Argentina, had an extremely heavy period
• Hg dropped from 108 to 88 – saw a gyne in Argentina
• Given DMPA 50 mg injection weekly x 6 weeks to self-administer (sub-q?)
• She found 50 mg hard to administer, so gave herself the whole vial each week (150 mg?) and has now run out
• Now amenorrheic; has lost weight (!) but doesn’t like the side effects of DMPA
What investigations would you order now?
Investigations

- Hg now 92, sTSH 3.10
- Pap NIL 1.5 years ago; repeated – NIL
- Endometrial biopsy normal
  - Endometrial thickness 6 mm (luteal phase)
  - Normal in a premenopausal woman:
    - Up to 4 mm (follicular phase)
    - Up to 16 mm (luteal phase)
    - Up to 4 mm (post-menopausal)
- US showed modest enlargement of fibroids – 3 intramural fibroids, ranging from 1 to 2 cm in size; no endometrial thickening
Management in your office

• What treatment would you offer her?
What gyne might do next
Gyne plans...

- Likely anovulatory bleeding +/- fibroids contributing to blood loss
- Desire to maintain fertility; not needing contraception currently
- Many options (but patient acceptability?)
  - CHC, cyclic progestin (12-14 days), DMPA, LNG-IUS
- Offered LNG-IUS – agreeable
- If not effective, then hysteroscopy, ? fibroid resection (or trial of ulipristal, but she has no drug plan)
Case Two - Carolyn

• 53 y.o. G3P3; non-smoker, BMI 23; husband vasectomy
• CEO of a small IT company with offices in Calgary and Toronto, where she has a second home
• Doesn’t come in often, and when she does, she is in a rush, and often about to leave the province
• Ex-skier with severe OA right knee, booked for TKA
• PH: retinal artery occlusion, hypertension, uterine polyps (removed)
• FH: ovarian ca (but she has had genetic testing and is BRCA neg), colon ca
• You get a copy of her pre-op consultation...
Case Two (continued)

- “Workup revealed mild anemia of 117 with a normal MCV”

- “She has short cycles, 23-25 days, with 5 days of heavy bleeding. At night, she requires multiple changes to a full diaper to prevent extravasation onto the bed sheets...This has been going on for about 4 years.”

- You call her in to discuss investigation and management prior to her TKA
What investigations would you order now?
Investigations

• Repeat Hg 116
• FIT neg, referred for colonoscopy due to FH
• Pap NIL 2 years ago
• US normal
• Endometrial biopsy normal
Management in your office
Challenging due to her Med Hx

- CHC contraindicated (htn, retinal artery occlusion)
- Tranexemetic acid contraindicated
- NSAIDs might raise BP
- DMPA – concern re. bone density since close to menopause
- Cyclic progestin?

LNG-IUS?
What gyne might do next
Gyne plans...

• Offered NSAIDs and Mirena
• Did not perform pap or hysteroscopy
• Did not think an endometrial ablation would help
• She elected to proceed with a Mirena
Case Three - Monique

• 39 y.o. G0P0 – living C.L., no plans for kids, on OCP; PH idiopathic angioedema; BMI 25, non-smoker

• Normally sees your colleague
  – In to discuss diarrhea x 5 days, now improving
  – On review of her Hx, you note she has had 3 years of painful, heavy periods (regular), getting worse
  – Last visit, she said that she was losing “A pint a day” during her period
  – Didn’t think your colleague believed her, so she mentions it to you
Case Three (continued)

- Hg range from 130-138 over the past 3 years
- Had an US 2 years ago, which showed 2 fibroids – 3.5 cm (deviates the endometrium, increased Doppler flow), and 1 cm – both subserosal; endometrium 1-2 mm
- Has tried a variety of OCPs, NSAIDs
- Has been offered progestin-IUS but doesn’t want something inside her
- Sees gyne in a few weeks and plans to request a hysterectomy
What investigations would you order?
What treatment would you offer while she waits to see gyne?
Investigations

- Hg 126
- US: “Prominent hyperattenuating submucosal fibroid in the region of the uterine fundus; a second smaller fibroid also seen arising from the anterior wall”
What gyne might do next
Case 3 continues...

- She declined any Rx from you, preferring to wait to see gyne
- Sees gyne: “She had asked about a hysterectomy but I suggested she consider conservative therapies first. She is not keen on a Mirena IUD so I suggested an endometrial ablation and resection of the fibroid.”
- Ablation booked for 6 months later
3 days later, presents to ER with acute hemorrhage, somewhat hemodynamically unstable

- Last Hg 126
- Hg 110 at 9 a.m.
- Hg 103 at 3 p.m.
- Serum bHCG neg
- US: fibroid is smaller (2.2 cm); endometrial thickness 2 mm; large volume of free fluid
- CT scan: hemoperitoneum, uterus distended with blood
Case 3 continues...

- Emergency myomectomy – “large submucous fibroid filling the uterine cavity which was removed completely”
- “I could not complete the endometrial ablation due to excessive fluid absorption”
- 2 months later, periods are starting to normalize
- She feels great! Energy better, cognitive abilities improved
If she had used ulipristal after you saw her...

- Ulipristal has the most rapid documented onset of action and control of bleeding
- 80% of women achieve pictorial blood assessment chart score < 75 within 7 days
- Pictorial Blood Assessment Chart:
  - Scoring Pads (score per pad):
    - Lightly soaked: 1 point
    - Moderately soaked: 5 points
    - Heavily soaked: 20 points
  - Scoring Tampons (score per tampon)
    - Lightly soaked: 1 point
    - Moderately soaked: 5 points
    - Heavily soaked: 10 points
  - Clots
    - Small: 1 point
    - Large: 5 points
- A score of $\geq 100$ points indicates probable menorrhagia (correlates with alkaline hematin method = gold standard)
Conclusions

• Use the SOGC guidelines (download them today!)
  – Don’t do hormone testing or coagulation studies unless otherwise indicated
  – Don’t order MRIs – rarely helpful

• LNG-IUS can be very helpful in most non-fibroid-related AUB (and some fibroid-related AUB) – consider learning how to insert IUDs

• Consider using ulipristal (Fibristal) for fibroids – works quickly, good side effect profile

• Don’t forget about tranexemic acid (Cyklokapron)