

Abnormal Uterine Bleeding in Premenopausal Women



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Abnormal uterine bleeding (AUB) can be defined as vaginal bleeding arising from the reproductive organs. This may include dysfunctional uterine bleeding, that is associated with disruption of the normal pituitary-ovarian endocrinological balance or bleeding associated with underlying pathology (Table 1). The goal of the health-care provider in the care of such women is to establish the underlying cause for the bleeding and to tailor the therapy to the patient's problem in the least invasive, most cost-effective way. Such an approach facilitates the return of the woman to her work, her family and her activities of daily living as expeditiously as possible.

A complete history and physical should rule out underlying medical disorders or medications associated with bleeding. Generally, a good menstrual history will differentiate between dysfunctional uterine bleeding (DUB) or endocrine issues causing the bleeding and anatomical issues. Most frequently the former will be associated with less regular menstrual flow, the latter heavier but regular menses with or without intermenstrual bleeding. Physical examination, in particular the abdominal and pelvic examinations, will evaluate the patient for fibroids, local vaginal or cervical lesions. Pap smear and endometrial biopsy should be part of the assessment tools of all practitioners caring for women. Cervical and endometrial pathology, either pre-invasive or invasive neoplasia should be ruled out. Blood work should be minimized; the appropriate investigations can be found in Vilos, *et al* SOGC Guidelines

Meet Chloe

Chloe is a 42-year-old executive in a large corporation. She complains of severe menorrhagia resulting in anemia and fatigue. She has nightmares of having an "accident" during a presentation at work. Chloe came to the office where she related her menstrual history, as well as the significant impact of her problem on her quality of life. Her history was otherwise unremarkable.

She has no desire for future fertility and requests something to control her bleeding and to restore her to her previously enjoyed level of health.

Chloe is otherwise healthy and her physical examination is normal, including her pelvic examination.

Turn to page 12 for more on Chloe.

for the Management of Abnormal Uterine Bleeding.¹ Despite a normal pelvic examination, pelvic ultrasound, particularly sonohysterography, can pick up endometrial cavity abnormalities requiring a hysteroscopic surgical approach.

First-line treatments

In the absence of underlying pathology, medical therapy should be considered in the first instance (Table 2). If tolerated and in the absence of contraindications, a combined low dose of the OC pill can be very effective especially with ovulatory DUB. Many other agents can be used but are not generally tolerated by



Table 1

Abnormal uterine bleeding (AUB) pathology

- Fibroids especially cavitory (submucosal fibroids)
- Endometrial polyps
- Endometrial hyperplasia/endometrial cancer
- Cervical dysplasia/cancer
- Cervical polyps

Table 2

AUB therapies

- Medical therapy: hormonal, tretinoin, NSAIDs levonorgestrel-releasing intrauterine system (LNG-IUS)
- Endometrial ablation-hysteroscopic or global
- Hysteroscopic myomectomy
- Uterine artery embolotherapy
- Hysterectomy

Chloe's case cont'd

- Chloe underwent her investigations; all were negative including a sonohysterogram showing a normal cavity
- She underwent an in-office global endometrial ablation under local anaesthesia and oral medications
- She remains amenorrheic since the procedure and is very pleased with her new level of freedom

Take-home message

- The evaluation of most causes of AUB is within the scope of practice of primary care providers
- There are a number of less invasive options for the management of AUB
- Even hysterectomy can be accomplished using minimally invasive techniques

patients for long periods of time. The levonorgestrel intrauterine system is not yet indicated for the treatment of menorrhagia but clearly is useful in patients with normal endometrial cavities also requiring effective, reversible contraception and therapy.²

Uterine artery embolization has a role to play in women with intramural fibroids associated with bleeding or “bulk” symptomatology.³

Second-line therapies

Effective minimally, invasive surgical therapies have been available for treatment of menorrhagia since the early 1990's. Hysteroscopic endometrial ablation is an effective modality for properly selected patients. Global endometrial ablation technologies performed under local anaesthesia in a non-hospital setting are available in Canada, but there are barriers to the access to these outside the hospital setting and cost containment precludes widespread availability in the hospital environment. It is important to note that there is no role for dilatation and curettage in the treatment of abnormal bleeding. Cavitory abnormalities such as fibroids and polyps are easily treated hysteroscopically. This can be performed with an endometrial ablation concurrently.

Definitive treatment

Hysterectomy has, in the past, had a significant role in the management of patients with AUB. Such invasive surgery should be reserved for treatment failures and for those with additional concomitant diagnoses requiring this approach. Should hysterectomy be chosen, the least invasive approach should be taken. The SOGC Guidelines on hysterectomy³ recommends the vaginal approach if feasible, adding the laparoscopic if this facilitates the vaginal approach.

Laparoscopic total and subtotal hysterectomy can be utilized in appropriately selected patients. The open, abdominal approach should be minimized in this algorithm. Choosing the least invasive surgical route allows the patient to return to her optimal functional level more rapidly.



Management of Abnormal Uterine Bleeding: Premenopause

Abnormal uterine bleeding is defined as changes in frequency of menses, duration of flow or amount of blood loss. The normal menstrual cycle lasts 28 ± 7 days, the flow lasts 4 ± 2 days and the average blood loss is of 40 ± 20 ml.

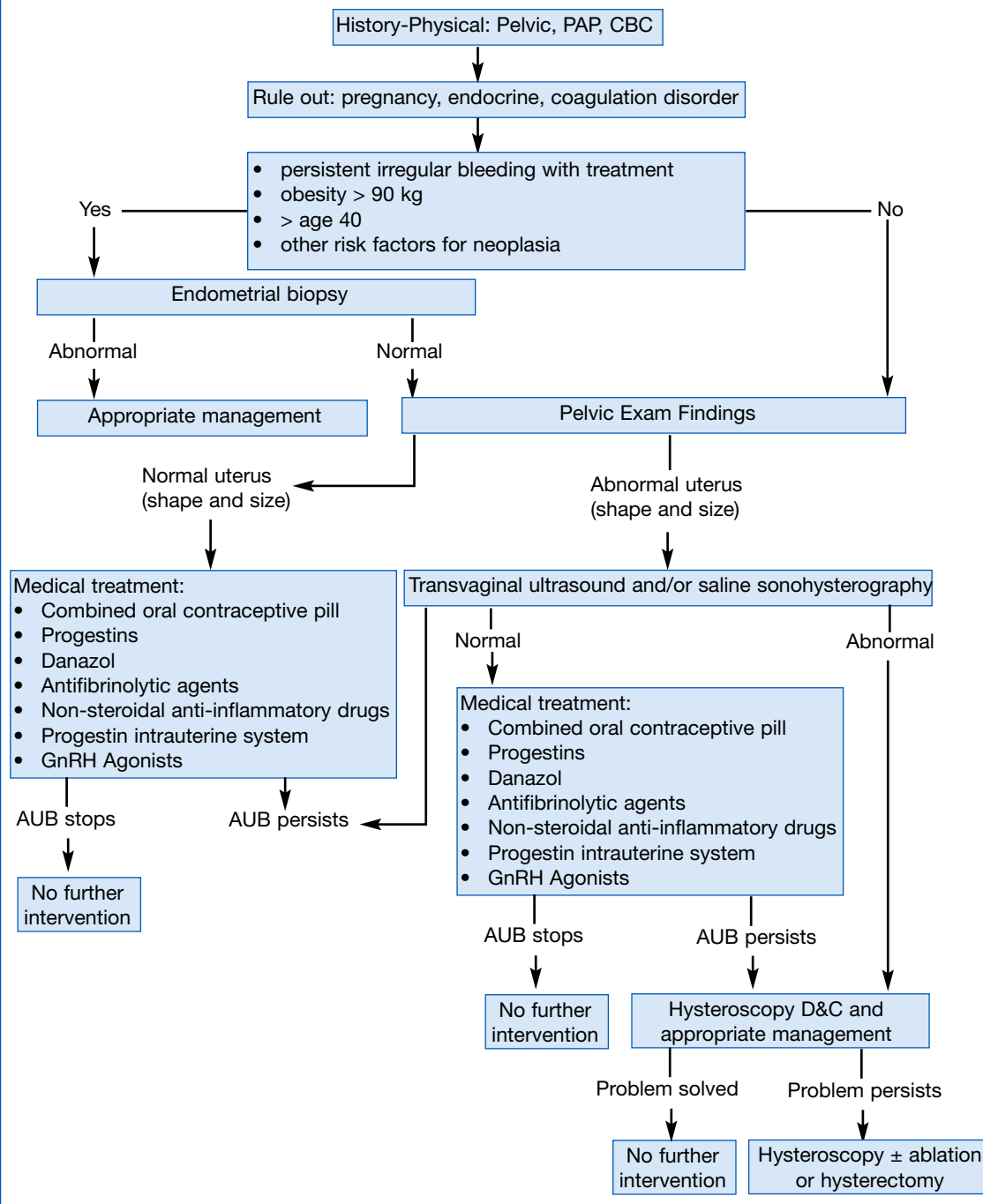


Figure 1. Management of AUB.

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References

1. Vilos G et al: SOGC Clinical Guidelines. Guidelines for the Management of Abnormal Uterine Bleeding. J Obstet Gynaecol Can 2001; 23(8):704-9.
2. Hidalgo M, Bahamondes L, Perrotti M et al: Bleeding Patterns and Clinical Performance of the Levonorgestrel-Releasing System (Mirena) Up to Two Years. Contraception 2002; 65(2):129-32.
3. Lefebvre G, Allaire C, Jeffrey J, et al: SOGC Clinical Guidelines. Hysterectomy. J Obstet Gynaecol Can 2002; 24(1):37-61.