MENORRHAGIA

There are a variety of treatment options for abnormal uterine bleeding.

Palliation is always a reasonable option. In most cases a patient can take vitamins and Iron to treat anemia related to chronic, excessive blood loss on the menses. Use of non-steroidal anti-inflammatory drugs is appropriate for secondary dysmenorrhea and may sometimes lessen amount of blood lost.

Beyond palliation, both medical and surgical options are available for heavy menstrual periods.

Medical management of menorrhagia has variations. Mixed-dose oral contraceptives are compared and contrasted with progesterone-only contraception. Mixed oral contraceptives with estrogen and progesterone will likely decrease total number of days of flow, decrease secondary dysmenorrhea, and decrease the volume of blood lost on periods. There is significant data attesting to the safety of low-dose oral contraceptives and to their applicability to patients with heavy periods (menorrhagia) and severe cramping (secondary dysmenorrheal).

Lysteda can be given at a dose of 1.3 grams, three times per day for up to five days per menstrual cycle is started at onset of bleeding. About a forty percent reduction in total volume of flow is usually achieved with its use. Significant quality of life improvement is also observed paralleling the decrease in blood flow.

Use of progesterone-only contraception (e.g. Depo-Provera or mini-pill) will likely decrease total number of days of bleeding and decrease secondary dysmenorrhea; however, bleeding can be irregular and patients can experience water retention and bloating as a consequence of progesterone-only contraception. Because there is no estrogen, there is no stabilization of the endometrium and irregular bleeding results. This, bleeding can be unpredictable and problematic.

The use of the progesterone-impregnated IUD is also a therapeutic alternative. Women using Mirena often have fewer days of bleeding, decreased volume of blood lost on the periods, and decrease in secondary dysmenorrhea compared with oral contraceptive and Lysteda users[1]. The IUD has superb safety record and is readily available. Particularly for women seeking aa long-term solution to heavy periods, Mirena is an ideal medical treatment option.

Surgical management of menorrhagia is another option.

Endometrial ablation is a commonly used, first step for many women. The ThermaChoice III endometrial ablation device claims to result in secondary amenorrhea approximately 31% of the time. Of the remaining 69% of patients the vast majority have less bleeding and less secondary dysmenorrhea after ThermaChoice III ablation than they had prior to the procedure. This may well be a starting point for a patient with severe menorrhagia and secondary dysmenorrhea who is resolute in her desire for no future childbearing. Candidates for endometrial ablation must be sterile at the time of the procedure or have concomitant sterilization procedure at the time of the ablation.

More definitive surgical options include laparoscopic supracervical hysterectomy and hysterectomy. Laparoscopic supracervical hysterectomy has the advantage of maintaining the pelvic supports-- cardinal ligaments and uterosacral ligaments are not severed, the vagina is not

entered, and the cervix remains in place. The corpus is removed and tubes and ovaries are conserved. The hormones are unchanged through this surgery. The uterus is stated to be an end-organ and responds only to the hormones created by the ovaries, and has no role in producing hormones on its own. The patient with supracervical hysterectomy would likely experience complete total secondary amenorrhea as well as marked decrease or elimination of her secondary dysmenorrhea. This surgery would not alter the patient's long-term risk of developing cervical cancer.

Complete laparoscopic hysterectomy and vaginal hysterectomy are alternatives as well. In both of these surgeries, the cervix and the entire corpus are removed. This surgery will result in complete secondary amenorrhea as well as cessation of her dysmenorrhea. Patients' long-term risk of endometrial cancer is eliminated.

Reasons for remorse following a definitive sterilization are discussed. Divorce, death of a child, and change in life circumstances are often viewed as the reasons why patients have the most remorse over definitive sterilization with removal of either the corpus or the entire uterus.

Patient is invited to go to the DWC Website to gain additional information on her condition and the treatments we offer. She is also recommended to go to WebMD, UpToDate or similar, lay accessible, websites for more information.

References

1. Gupta J, Middleton L, Pattison H, Gray R, Daniels J. Levonorgestrel intrauterine system versus medical therapy for menorrhagia. N Engl J Med 2013;236:128-137.

