

# **Heavy menstrual bleeding**

## **NICE guideline**

**Draft for consultation, July 2006**

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.

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## Introduction

Heavy menstrual bleeding (HMB) has an adverse effect on the quality of life of many women. It is not a problem associated with significant mortality and consequently, it is thought by some doctors to be unimportant. However, many women seek help from their general practitioners and it is a common reason for referral into secondary care.

In order for women to be successfully treated, it is essential that the underlying problem is understood by both the patient and the doctor. The guideline provides this background information as well as covering epidemiology, physiology, investigation and ultimately, treatment. The aim is to consider the evidence and review it, taking into account, both the patient and the doctor's viewpoint. This is not always easy but it is anticipated that the information contained in the guideline will help patients reach an informed and sensible decision with their doctors. Having read the guideline they will know what questions to ask and the options available to them. As a result of constructive dialogue, we hope that patients will be able to trust the advice given by their practitioner since they will be confident that they have the latest information and are able to use it to inform this decision making process.

Clinical guidelines have been defined as systematically developed statements which assist clinicians and patients in making decisions about appropriate treatment for specific conditions. The guideline has been developed with the aim of providing guidance on heavy menstrual bleeding. The effectiveness of the different treatments as well as their risks and benefits are discussed in relation to their use in the treatment of HMB but the discussion cannot be extrapolated to the use of particular treatments to relieve other symptoms e.g. hysterectomy for cancer or endometriosis. The implications of each treatment in relation to fertility are also clearly stated in order that no woman has a treatment that renders her infertile unless this is her specific wish.

Uterine fibroids are a common cause of heavy menstrual bleeding. The diagnosis and management are discussed in some depth although treatment for symptoms other than heavy menstrual bleeding are not included. The most up to date information is discussed in order that the guideline will reflect current best practice. There are other gynaecological conditions such as adenomyosis or endometriosis where menorrhagia maybe associated with other menstrual symptoms as part of the presenting complaint. These conditions are excluded because heavy menstrual bleeding is not usually the principal presenting complaint and also, endometriosis could be the topic of a separate guideline. It is not possible to cover every condition but some of the advice centred in this guideline will be relevant in some circumstances.

In the early 1990's, it was estimated that at least 60% of women presenting with heavy menstrual bleeding would have a hysterectomy to treat the problem, often as a first line. However, things have changed and the number of hysterectomies is decreasing rapidly. This is a major operation associated with significant complications in a minority of cases and also, it is an emotive procedure, the concept of which is despised by certain sections of society. However, it is also associated with a very high satisfaction rate by those who have had one. The number of hysterectomies, the apparent lack of pathology, and the lack of discussion of alternatives was a major cause for concern by the profession as well as the public. One of the principle aims of our guideline is to consider hysterectomy as well as the other treatment options and determine when they are likely to be the most appropriate for any particular individual.

Alternative effective treatments are available for women who have a normal uterus and no significant pathology such as large uterine fibroids. The consequence of this is that the hysterectomies that are performed, tend to be more complicated than many of those in the past. This has significant implications for the acquisition and maintenance of surgical skills and this area is covered in some depth in the guideline. Surgical competence is an extremely important issue and recommendations are included as to how this might be made apparent to a patient. One possibility suggested is that details

of the surgical practice of individual gynaecologists should be in the public domain.

It is often very difficult for patients to appreciate that not all women are suitable for a particular new 'non-invasive' procedure. Often, the media will discuss new therapies and give patients hope that can in some instances, be inappropriate. This guideline aims to avoid this by including sensible and comprehensible discussions so that women can understand why doctors advise for or against particular treatment. Doctor's decisions are informed by experience as well as their knowledge of the evidence base. It is important that both happen together facilitating an open discussion with the patient to allow the doctor's view to be put into context. If the opinion of the doctor is contrary to that of the patient then a second opinion should be sought. This will mean that patients will get the best possible advice and treatment that will lead to resolution of their HMB.

## **Patient-centred care**

This guideline offers best practice advice on the care of women with heavy menstrual bleeding.

Treatment and care should take into account patients' needs and preferences. People with heavy menstrual bleeding should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If patients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines – 'Reference guide to consent for examination or treatment' (2001) (available from [www.dh.gov.uk](http://www.dh.gov.uk)). From April 2007 healthcare professionals will need to follow a code of practice accompanying the Mental Capacity Act (summary available from [www.dca.gov.uk/menincap/bill-summary.htm](http://www.dca.gov.uk/menincap/bill-summary.htm)).

Good communication between healthcare professionals and patients is essential. It should be supported by evidence-based written information tailored to the patient's needs. Treatment and care, and the information patients are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

## **Key priorities for implementation**

### **Definition of HMB**

- For clinical purposes, HMB is defined as excessive menstrual blood loss leading to interference with the physical, emotional, social and material quality-of-life of a woman, and which can occur alone or in combination with other symptoms.

### **Investigations for HMB**

- Ultrasound should be considered the first line diagnostic tool for the identification of structural pathology in HMB.
- An endometrial biopsy should be taken if the woman has persistent intermenstrual bleeding, is aged 45 years and over and has declined or failed adequate medical treatment, and before undertaking surgical or uterine artery embolisation (UAE).

### **Education, information provision, patient choice and lifestyle interventions**

- Patients referred to secondary care with menorrhagia should be provided with an information pack prior to their outpatient appointment.
- Patients should be allowed choice of treatment, but within the clinicians' remit of balancing risk and benefits based on evidence and their competence.



## **Hormonal and non-hormonal medical treatment for HMB**

- When pharmaceutical treatment is felt to be necessary and hormonal treatment is acceptable to a woman with HMB, then the order in which interventions should be considered is:
  - First line, levonorgestrel-releasing intrauterine system (LNG-IUS)
  - Second line, tranexamic acid or non-steroidal anti-inflammatory drugs (NSAIDs) or combined oral contraception (COC)
  - Other treatment options for consideration are: norethisterone (15 mg) daily from days 5 to 26 of the cycle or injected long acting progestogens.
- When pharmaceutical treatment is felt to be necessary and hormonal treatment is not acceptable (for example, if a woman is wishing to conceive) to women with HMB then the order in which treatments should be considered is:
  - First line, tranexamic acid,
  - Second line, NSAIDs.

## **Surgery as first treatment for HMB**

- Hysterectomy should not be used as a first line treatment solely for HMB, unless in the presence of large fibroids, or other symptoms.

## **Non-hysterectomy surgery for HMB**

- In women with HMB alone, with uterus no bigger than a 10-week pregnancy, endometrial ablation methods should be considered preferable to hysterectomy.

## **Hysterectomy**

- The route of hysterectomy to be used should be considered in the following order: first line, vaginal; second line, abdominal; and third line, laparoscopic.

# 1      **Guidance**

The following guidance is based on the best available evidence. The full guideline ([add hyperlink]) gives details of the methods and the evidence used to develop the guidance (see section 5 for details).

## **1.1      *Defining HMB***

- 1.1.1.1      For clinical purposes, HMB is defined as excessive menstrual blood loss leading to interference with the physical, emotional, social and material quality-of-life of a woman, and which can occur alone or in combination with other symptoms.
- 1.1.1.2      HMB should be recognised as having a major impact on a woman's quality of life.
- 1.1.1.3      When deciding care options, clinicians should take into account the range and natural variability in menstrual cycles and blood loss in an individual woman and within normal populations.
- 1.1.1.4      A successful treatment outcome is determined by the woman with HMB.
- 1.1.1.5      Uses of direct or non-direct measurement techniques for menstrual blood loss are not routinely recommended in women presenting with HMB.

## **1.2      *Investigations for HMB***

### **1.2.1      History taking for HMB**

- 1.2.1.1      History taking should cover: the nature of bleeding problem; symptoms suggesting potentially serious pathology; and other factors that will determine treatment options.
- 1.2.1.2      If history taking reveals HMB without the presence of pathology, then there is no need to undertake a physical examination prior to initiating first-line medical treatment.
- 1.2.1.3      If history taking suggests pathology with symptoms such as inter-menstrual or post coital bleeding, pelvic pain and/or pressure symptoms then physical examination and/or appropriate investigations should be undertaken to make a diagnosis.

### **1.2.2      Physical examination**

- 1.2.2.1      Physical examination should be undertaken prior to investigations (except haematological investigations).

### **1.2.3      Laboratory tests in HMB**

- 1.2.3.1      A full blood count should be undertaken on women with suspected HMB.
- 1.2.3.2      A serum ferritin test should not routinely be undertaken in women with HMB.
- 1.2.3.3      Female hormone testing for women with HMB should not be performed.
- 1.2.3.4      Thyroid testing in women with HMB should only be undertaken where other symptoms of thyroid disease are present.

- 1.2.3.5 Testing for coagulation disorders should only routinely be undertaken on women with HMB in their teenage years or who have had HMB since menarche, and have other personal or family history suggesting a coagulation disorder.

#### **1.2.4 Investigations for structural and histological abnormalities**

- 1.2.4.1 Ultrasound should be considered the first line diagnostic tool for the identification of structural pathology in HMB.
- 1.2.4.2 Hysteroscopy with biopsy is an accurate method for identification of endometrial and some submucosal pathology, but should be considered only where ultrasound outcomes are inconclusive.
- 1.2.4.3 An endometrial biopsy should be taken if the woman has persistent intermenstrual bleeding, is aged 45 years and over and has declined or failed adequate medical treatment, and before undertaking surgery or UAE.
- 1.2.4.4 Saline infusion sonography should not be undertaken as a first-line investigation of HMB.
- 1.2.4.5 MRI scanning should not be used as a first line diagnostic tool for HMB.
- 1.2.4.6 D&C should not be used as a diagnostic tool for HMB.
- 1.2.4.7 If a woman has fibroids that are intracavitary or a uterine length greater than 12 cm then referral for specialist opinion should be offered.

### **1.3      *Education, information provision, patient choice and lifestyle interventions***

- 1.3.1.1      Patients referred to secondary care with menorrhagia should be provided with an information pack prior to their outpatient appointment.
- 1.3.1.2      Where a potential treatment involves the loss of fertility then counselling and support should be made available to the woman throughout the care pathway.
- 1.3.1.3      A woman with HMB should be given the opportunity to review and veto any treatment decision.
- 1.3.1.4      Patients should be allowed choice of treatment, but within the clinicians' remit of balancing risk and benefits based on evidence and their competence.
- 1.3.1.5      A woman with HMB must have the option of gaining a second medical opinion where a clinician has no knowledge or opinions are at odds.
- 1.3.1.6      A woman with HMB should have adequate time and support in the decision making process, especially where the treatment decision has irreversible results.
- 1.3.1.7      Where a potential treatment involves the loss of fertility then counselling and support should be made available to the woman throughout the care pathway.

## **1.4      *Hormonal and non-hormonal medical treatment for HMB***

1.4.1.1      When pharmaceutical treatment is felt to be necessary and hormonal treatment is acceptable to a woman with HMB, then the order in which interventions should be considered is:

- First line, LNG-IUS<sup>1</sup>
- Second line, tranexamic acid or NSAIDs or COCs<sup>2</sup>
- Other treatment options for consideration are: norethisterone (15 mg) daily from days 5 to 26 of the cycle or injected long acting progestogens.<sup>3</sup>

1.4.1.2      When pharmaceutical treatment is felt to be necessary and hormonal treatment is not acceptable (for example, if a woman is wishing to conceive) to women with HMB then the order in which treatments should be considered is:

- First line, tranexamic acid,
- Second line, NSAIDs.

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<sup>1</sup> World Health Organisation Medical Eligibility Criteria for Contraceptive Use (WHOMECC) criteria apply. These involve the assessment of the individuals' suitability for contraceptives, based on their specific profile of potential benefits and harms. This allows informed decision-making by the woman prior to the start of treatment.<sup>12</sup>

<sup>2</sup> World Health Organisation Medical Eligibility Criteria for Contraceptive Use (WHOMECC) criteria apply. These involve the assessment of the individuals' suitability for contraceptives, based on their specific profile of potential benefits and harms. This allows informed decision-making by the woman prior to the start of treatment.<sup>12</sup>

<sup>3</sup> Healthcare professionals should ensure that informed consent is obtained from the woman whenever any method of injected progestogen is being used outside the terms of the UK Marketing Authorisation. This should be discussed and documented within the notes.

- 1.4.1.3 Use of NSAIDs or tranexamic acid should be stopped if they do not improve symptoms within 3 months.
- 1.4.1.4 Ongoing use of NSAIDs and tranexamic acid can be recommended for as long as they are found to be beneficial by women with HMB.
- 1.4.1.5 When HMB coexists with dysmenorrhoea then NSAIDs should be preferred to tranexamic acid.
- 1.4.1.6 A second medical treatment should be considered when a first-line medical treatment has failed for women with HMB.
- 1.4.1.7 Women should be fully counselled regarding the changes to the bleeding pattern particularly in the first few months post-insertion of an LNG-IUS. Perseverance for at least 6 months is recommended for benefits to be appreciated.
- 1.4.1.8 Oral progestogens given during the luteal phase only should not be used to treat women with HMB.
- 1.4.1.9 Danazol is not recommended for routine use in the treatment of HMB.
- 1.4.1.10 GnRH-a could be considered when all other management options, including surgery or UAE, are contraindicated for the treatment of a woman. If it is to be used for more than 6 months then 'Add-Back' therapy is recommended.<sup>4</sup>
- 1.4.1.11 Etamsylate should not be used in the treatment of HMB.

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<sup>4</sup> Healthcare professionals should ensure that informed consent is obtained from the woman whenever any method of GnRH-a is being used outside the terms of the UK Marketing Authorisation. This should be discussed and documented within the notes.

## **1.5      *Indications for non-hysterectomy surgery***

- 1.5.1.1      Surgery (excluding hysterectomy) should be considered in cases of HMB where bleeding is: having a severe impact on a woman's quality of life, and the woman has completed her family (except in the case of UAE or myomectomy where fertility is potentially retained).
- 1.5.1.2      Women should be made aware of the impact on fertility that surgery will have in all cases.
- 1.5.1.3      Endometrial ablation should be considered in women who have a normal uterus and small uterine fibroids (< 3cm).
- 1.5.1.4      For women with large fibroids in presence of HMB, and other significant symptoms (dysmenorrhoea; pressure symptoms), referral for consideration of surgery or UAE as a first line can be recommended.

## **1.6      *Surgery as first treatment for HMB***

- 1.6.1.1      Endometrial ablation may be offered to women with HMB as an initial treatment in secondary care after full discussion of outcomes and other treatment options.
- 1.6.1.2      Hysterectomy should not be used as a first line treatment solely for HMB, unless in the presence of large fibroids, or other symptoms.

## **1.7      *Non-hysterectomy surgery for HMB***

### **1.7.1      Dilation and curettage**

- 1.7.1.1      D&C should not be used as a therapeutic treatment for HMB.

### **1.7.2      Endometrial ablation/resection**

- 1.7.2.1      Hysteroscopy should be undertaken post-dilation, pre-procedure when undertaking ablation.



- 1.7.2.2 Endometrial ablation should not be undertaken on women wishing to become pregnant at any time in the future.
- 1.7.2.3 Second generation ablation techniques (microwave endometrial ablation [MEA], thermal balloon endometrial ablation [TBEA]) should be considered ahead of first generation techniques (transcervical resection of the endometrium [TCRE], rollerball endometrial ablation [REA]).
- 1.7.2.4 If a TBEA is being undertaken then endometrial thinning is not required.
- 1.7.2.5 If an MEA is being undertaken then scheduling of surgery for post-menstrual phase is an alternative to endometrial thinning.
- 1.7.2.6 In women with HMB alone, with uterus no bigger than a 10-week pregnancy, endometrial ablation methods should be considered preferable to hysterectomy.<sup>5 6</sup>
- 1.7.2.7 Women must be counseled on the need to use effective contraception after endometrial ablation.
- 1.7.2.8 Ablative techniques should be undertaken under local anaesthetic where appropriate.

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<sup>5</sup> Reference should be made to the manufacturers own limits on uterus size.

<sup>6</sup> It is recommended that the Medicines and Healthcare products Regulatory Agency (MHRA), safety notices on endometrial ablation should be followed (MDA [1998] SN 9812 Devices used for endometrial ablation achieved by thermal means, and MDA [1999] SN 1999(18) Devices used for endometrial ablation).

## **1.8      *Interventions for uterine fibroids***

- 1.8.1.1      Prior to scheduling of UAE or myomectomy, the uterus and fibroid(s) should be assessed by imaging, preferably MRI when available.
- 1.8.1.2      UAE is recommended for women with HMB associated with uterine fibroids and who want to retain their uterus and/or avoid surgery.
- 1.8.1.3      Use of GnRH-a should be stopped as soon as UAE has been scheduled.
- 1.8.1.4      Myomectomy is recommended for women with HMB associated with uterine fibroids and who want to retain their uterus.
- 1.8.1.5      Women should be informed that UAE or myomectomy will potentially allow them to retain their fertility.

## **1.9      *Hysterectomy***

- 1.9.1.1      Hysterectomy should be considered only where:
  - Other treatment options have failed or are inappropriate,
  - Women have completed their families,
  - There is a wish for amenorrhoea,
  - And either women (who have been fully counselled) request it or other forms of further treatment are contraindicated.
- 1.9.1.2      The route of hysterectomy to be used should be considered in the following order: first line, vaginal; second line, abdominal; and third line, laparoscopic.
- 1.9.1.3      Individual patient assessment is essential when deciding route of hysterectomy. Factors that need to be taken into account are:
  - presence of other gynaecological conditions or disease,

- uterine size,
- presence and size of uterine fibroids,
- mobility and descent of uterus,
- size and shape of vagina,
- and history of previous surgery.

- 1.9.1.4 Any counselling should include: psychosexual impact, fertility impact, bladder function, need for further treatment, success rates (by patient), treatment complications, patient expectations, alternative surgery.
- 1.9.1.5 When abdominal hysterectomy is decided upon then both total and sub-total methods should both be discussed with the woman.
- 1.9.1.6 Pre-treatment before hysterectomy and myomectomy with GnRH-a for 3 to 4 months should be considered where uterine fibroids resulting in an enlarged or distorted uterus are present.<sup>7</sup>
- 1.9.1.7 Women should be informed about the increase in complications with hysterectomy when uterine fibroids are present.
- 1.9.1.8 When surgery for fibroid related HMB is felt necessary then myomectomy, UAE and hysterectomy must all be considered, discussed and documented.

## **1.10 Removal of ovaries at time of hysterectomy**

- 1.10.1.1 A full discussion before ovaries are to be removed of the impact on HRT use and other effects should take place.

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<sup>7</sup> Healthcare professionals should ensure that informed consent is obtained from the woman whenever any method of GnRH-a is being used outside the terms of the UK Marketing Authorisation. This should be discussed and documented within the notes.

- 1.10.1.2 Women should be informed of the risk of premature loss of ovarian function even when they are retained.
- 1.10.1.3 Women should be informed about the impact of bilateral oophorectomy on risk of ovarian cancer, breast cancer and uterine pathology.
- 1.10.1.4 Oophorectomy should not be undertaken with hysterectomy for HMB, without full counselling and consent.
- 1.10.1.5 Women found to have a family history of ovarian cancer should be referred for genetic counselling.
- 1.10.1.6 In women aged under 45 years considering hysterectomy for HMB and have other symptoms that may be related to ovarian dysfunction then a trial of medical ovarian suppression for 3 months should be used as a guide to the need for oophorectomy.

## **1.11 Competencies**

### **1.11.1 Training**

- 1.11.1.1 On appointment to a consultant post, clinicians should demonstrate completion of an accredited training programme in an established procedure and this will be assessed on acquisition of competence, prior to undertaking that procedure.
- 1.11.1.2 Operative competence of clinician trainees undertaking procedures to diagnose and treat HMB should be formally assessed by trainers through a structured process such as that defined within training schemes of the Post-graduate Medical Education & Training Board and/or Royal Colleges.
- 1.11.1.3 Training programmes must be available of sufficient length to allow clinicians time to achieve competency in complex procedures (e.g. operations for large fibroids or when sited in an awkward position)

when these are appropriate. These will usually be sited in units with a particular interest and sufficient workload to facilitate this.

### **1.11.2 Maintenance**

- 1.11.2.1 Maintenance of surgical or radiological skills requires a robust clinical governance framework, this will include audit of numbers, case mix, outcomes of all treatments both at the individual operator and organisational level. These data should be used to demonstrate good clinical practice.
- 1.11.2.2 Established clinicians should be able to demonstrate that their training, experience and current practice at least equates to the standards laid out for newly trained clinicians.

### **1.11.3 Governance**

- 1.11.3.1 If a clinician lacks competence to undertake a procedure then they should refer to a clinician with the appropriate skill. Organisations should be responsible through service specification based on robust audit data that identify clinicians with the appropriate skills.

## **2 Notes on the scope of the guidance**

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is available from [www.nice.org.uk/page.aspx?o=240825](http://www.nice.org.uk/page.aspx?o=240825).

### How this guideline was developed

NICE commissioned the National Collaborating Centre for Women's and Children's Health to develop this guideline. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations. An independent Guideline Review Panel oversaw the development of the guideline (see appendix B).

There is more information in the booklet: 'The guideline development process: an overview for stakeholders, the public and the NHS' (second edition, published April 2006), which is available from [www.nice.org.uk/guidelinesprocess](http://www.nice.org.uk/guidelinesprocess) or by telephoning 0870 1555 455 (quote reference N\*\*\*\*).

## 3 Implementation

The Healthcare Commission assesses the performance of NHS organisations in meeting core and developmental standards set by the Department of Health in 'Standards for better health', issued in July 2004. Implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that national agreed guidance should be taken into account when NHS organisations are planning and delivering care.

NICE has developed tools to help organisations implement this guidance (listed below). These are available on our website ([www.nice.org.uk/CGXXX](http://www.nice.org.uk/CGXXX)).

- Slides highlighting key messages for local discussion.
- Costing tools
  - Costing report to estimate the national savings and costs associated with implementation.
  - Costing template to estimate the local costs and savings involved.
- Implementation advice on how to put the guidance into practice and national initiatives which support this locally.
- Audit criteria to monitor local practice.

## **4 Research recommendations**

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

### **4.1 *What is the epidemiology of women presenting with HMB in primary care?***

#### **Why this is important**

There are only limited data available on the epidemiological profile of women presenting with HMB in primary care. This is an important issue as the majority of women with HMB will be treated solely within primary care settings. An epidemiological profile of women presenting with HMB would help with understanding the presentation of HMB and the requirements from treatment.

### **4.2 *Investigate routine use of indirect measurements of MBL in primary and secondary care***

Evidence shows that direct measurement of MBL is accurate but complex to undertake in clinical practice, and that subjective assessment of MBL is inaccurate but easy to undertake in clinical practice. An alternative is the use of indirect measures of MBL, such as PBAC. However, evidence on the use of indirect measures is contradictory and no data is available on if they could be used in routine practice. If indirect measures are shown to work then they could be introduced as a simple technique for assessing MBL, and from this the management of HMB could be improved.

### **4.3 *What are the long-term recurrence rates of fibroids after UAE or myomectomy?***

#### **Why this is important**

Both UAE and myomectomy are undertaken to reduce symptoms associated with uterine fibroids by directly removing or reducing the size of the fibroid(s). Data exists on short and medium term recurrence of fibroids, but no data is available on long-term recurrence.

#### **4.4      *What are the effects of hysterectomy and oophorectomy on occurrence of cancer?***

##### **Why this is important**

One of the arguments surrounding the use hysterectomy and oophorectomy is the affect on cancer risks. Epidemiological studies are required to investigated the affect of hysterectomy and oophorectomy on cancer. The results of this research will have fundamental affects on the use of these treatments.

#### **4.5      *Do volume-outcome relationships exist in gynaecological procedures, taking into account patient case-mix, hospital and surgeon factors?***

##### **Why this is important**

No good evidence on any volume-outcome relationships in gynaecological procedures were identified. This is an important question as it will impact on service organisation. If volume-outcome relationships do exist then this would suggest the need for concentration of services.

### **5          Other versions of this guideline**

#### **5.1      *Full guideline***

The full guideline, 'Heavy menstrual bleeding' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Women's and Children's Health, and is available from [NCC website details to be added], our website ([www.nice.org.uk/CGXXXfullguideline](http://www.nice.org.uk/CGXXXfullguideline)) and the National Library for Health ([www.nlh.nhs.uk](http://www.nlh.nhs.uk)). **[Note: these details will apply to the published full guideline.]**

#### **5.2      *Quick reference guide***

A quick reference guide for healthcare professionals is also available from [www.nice.org/CGXXXquickrefguide](http://www.nice.org/CGXXXquickrefguide)



For printed copies, phone the NHS Response Line on 0870 1555 455 (quote reference number NXXXX). **[Note: these details will apply when the guideline is published.]**

### **5.3       ‘Understanding NICE guidance’**

Information for people with heavy menstrual bleeding and their carers is available from [www.nice.org.uk/CGXXXpublicinfo](http://www.nice.org.uk/CGXXXpublicinfo)

For printed copies, phone the NHS Response Line on 0870 1555 455 (quote reference number NXXXX). **[Note: these details will apply when the guideline is published.]**

## **6           Related NICE guidance**

- Long-acting reversible contraception. *NICE clinical guideline* no. 30 (2003) Available from [www.nice.org/CG030](http://www.nice.org/CG030)
- Referral guidelines for suspected cancer. *NICE clinical guideline* no. 27 (2005) Available from [www.nice.org/CG027](http://www.nice.org/CG027)
- Fluid-filled thermal balloon and microwave endometrial ablation techniques for heavy menstrual bleeding. *NICE technology appraisal guidance* no. 78 (2004) Available from [www.nice.org.uk/TA078](http://www.nice.org.uk/TA078)
- Impedance-controlled bipolar radiofrequency ablation for menorrhagia. *NICE interventional procedure guidance* no. 104 (2004) Available from [www.nice.org/IPG104](http://www.nice.org/IPG104)
- Free fluid thermal endometrial ablation. *NICE interventional procedure guidance* no. 51 (2004) Available from [www.nice.org/IPG051](http://www.nice.org/IPG051)
- Laparoscopic laser myomectomy. *NICE interventional procedure guidance* no. 23 (2003) Available from [www.nice.org/IPG023](http://www.nice.org/IPG023)
- Photodynamic endometrial ablation. *NICE interventional procedure guidance* no. 47 (2004) Available from [www.nice.org/IPG047](http://www.nice.org/IPG047)
- Microwave endometrial ablation. *NICE interventional procedure guidance* no. 7 (2004) Available from [www.nice.org/IPG007](http://www.nice.org/IPG007)

- Balloon thermal endometrial ablation. *NICE interventional procedure guidance* no. 6 (2003) Available from [www.nice.org/IPG006](http://www.nice.org/IPG006)
- Uterine artery embolisation for the treatment of fibroids. *NICE interventional procedure guidance* no. 94 (2004) Available from [www.nice.org/IPG094](http://www.nice.org/IPG094)

NICE is developing the following guidance (details available from [www.nice.org.uk](http://www.nice.org.uk)):

- The clinical effectiveness and cost effectiveness of technologies for the primary prevention of osteoporotic fragility fractures in postmenopausal women. NICE technology appraisal guidance (publication expected: TBC).
- Osteoporosis: assessment of fracture risk and prevention of osteoporotic fracture in individuals at high risk. NICE clinical guideline. (Publication expected: TBC)
- Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women. NICE technology appraisal. (Publication expected: TBC)
- Laparoscopic hysterectomy. NICE interventional procedure guidance. (Publication expected: TBC).
- Hysteroscopic laser myomectomy. NICE interventional procedure guidance. (Publication expected: TBC).

## **7            Updating the guideline**

NICE clinical guidelines are updated as needed so that recommendations take into account important new information. We check for new evidence 2 and 4 years after publication, to decide whether all or part of the guideline should be updated. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations.

## **Appendix A: The Guideline Development Group**

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## **Appendix B: The Guideline Review Panel**

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The Panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

[NICE to add]

## **Appendix C: The algorithms**

Algorithms are being published as a separate file on the website.