



Menorrhagia (Heavy Periods)

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MENORRHAGIA (HEAVY PERIODS)

Heavy periods is a symptom, not a disease in itself. It affects at least 20% of women, and tends to become worse as one gets older, especially after the age of 35. It does not indicate that the menopause (cessation of periods) will occur in the near future, and this problem may persist for 20 years or more without help.

It is diagnosed as a loss of more than 80 ml per cycle, and this can be measured by weighing pads or tampons. There is an increase in blood flow, often with clots, associated often with pain and other pre-menstrual symptoms.

CAUSES

Dysfunctional Uterine Bleeding (DUB)

No specific abnormality is found. There may be an imbalance in the ovarian hormone levels, although the individual hormone levels may be in the normal range. It is thus a diagnosis of exclusion, once all other causes have been investigated.

Perimenopause (The time around the menopause)

As a woman approaches the menopause, ovulation may not occur, although the ovaries are still producing oestrogen. This causes the endometrium (lining of the uterus) to build up. There may be lack of menstruation for 2-3 months. When the oestrogen levels fluctuate downwards, there is a heavy withdrawal bleeding, which may be

extremely massive, with flooding. This condition is termed Metropathia Haemorrhagica.

Fibroids (Leiomyomata)

These are benign hormone dependent tumours of the muscle of the uterus. They are very common and occur in over 50% of women. They are associated with heavy periods, and can vary between pin-head size and football size. Only the larger ones need removal, and when a woman reaches the menopause, they stop growing, unless she is still taking HRT.

Endometrial Polyp

This is tissue which forms on a stalk inside the uterus. The cause is unknown, but it acts like a foreign body, and can cause heavy periods and break-through bleeding.

Endometrial Hyperplasia

This is a thickening of the endometrium, due to an imbalance in the hormones that control the menstrual cycle.

Adenomyosis

This is a condition where the roots of the endometrial glands grow into the muscle of the uterus. It usually also causes dysmenorrhoea and is similar to endometriosis

INVESTIGATIONS

Pelvic Examination

An internal examination is performed to assess the size and shape of the uterus and other pelvic organs. A Pap smear can be taken at the same time Blood test can be requested to rule out anaemia.

Pelvic Ultrasound

To assess the thickness of the endometrium and determine whether there are fibroids present. The ovaries can also be assessed

Hysteroscopy and Curettage

A hysteroscopy and curettage can be performed to make an exact diagnosis and to rule out cancerous changes

NON-SURGICAL TREATMENTS

Non-surgical treatments can offer some relief from period problems, and are of most benefit if a woman is still desirous of pregnancy. It must be realized that the treatments only work while being taken, and would need to be taken until the menopause is reached.

The Pill

The oral contraceptive pill reduces blood loss and pain and regulates the cycle. There can be weight gain, bloating and headaches and should not be taken after the age of 35 if you are still smoking, due to the increased risk of DVT, stroke and heart attack.

Oral Progestogens

These are given for 21 out of 28 days of the cycle, and can reduce periods, but can lead to break-through bleeding, bloating and mood swings. These include Norethisterone (Primolut) and Medroxyprogesterone (Provera) Side-effects can include cardiovascular effects, such as DVT, stroke and heart attack, nervous effects, such as insomnia, fatigue, depression, dizziness and headache. There can also be irregular bleeding, rash, acne and weight gain.

Injectable Progestogens

Medroxyprogesterone (Depo-Provera and Depo-Ralovera) can be given at 3 monthly intervals. In some cases, periods will cease but a large percentage have irregular break-through bleeding which can be difficult to control, and the effect can last up to 18 months. Side-effects include cardiovascular problems, such as DVT, stroke and heart attack, eye problems, irregular bleeding and bone loss.

NSAIDS (Non-steroidal Anti-Inflammatory Drugs)

These include Naproxen (Naprosyn), Ibuprofen (Neurofen) and Mefenamic Acid (Ponstan) They reduce blood loss by about a third and can reduce dysmenorrhoea but affect the bowel, causing indigestion, nausea, diarrhoea and stomach ulcers and bleeding. Allergic reactions can also occur.

Tranexamic Acid (Cyclokapron)

These are taken with menstruation, and can reduce blood loss by about a half. It is taken each month when the period is present, and works by altering the blood clotting mechanisms. Gastro-intestinal discomfort occurs in 30 % and is dose related. Side-effects include nausea, vomiting and diarrhoea.

Danazol

Can reduce blood loss by about two-thirds, and in some cases, the periods will cease. However, there can be serious side-effects, including weight gain, acne, masculinization, including increased hair growth, baldness, deep voice and is usually kept for more serious conditions such as endometriosis.

Mirena Intrauterine Device

This is inserted into the uterus and releases a progestogenic hormone slowly over 5 years. It counteracts the effect of the ovarian hormones and suppresses the

endometrium, reducing the blood flow by about 80%. It is also an effective contraceptive. In about 20% of cases, there is cessation of menstruation after 12 months. It can, however, lead to pain in some women together with break-through bleeding and must be changed after 5 years.

SURGICAL TREATMENTS

Endometrial Ablation

This is a method of controlling menorrhagia by destruction or removal of the endometrium. It is a Day-Surgery procedure. Different methods have been used, but the gold standard is Endometrial Resection, whereby the endometrium (lining of the uterus) is resected using a telescope (hysteroscope) inserted into the uterus, There is a metal loop on the end of the hysteroscope, which can be moved back and forth. When activated, it is used to resect the endometrium.

This method has eliminated the need for hysterectomy in cases of Dysfunctional Uterine Bleeding. It has a 97% success in controlling menorrhagia, and only 3% need further treatment. Other second generation methods, such as Microwave and hot balloons do not penetrate deeply enough, and with these methods, contraception is still needed.

For more information on Endometrial Ablation please visit <http://www.goldcoastgynaecology.com.au/100045.php>

Hysterectomy

Hysterectomy is the removal of the uterus. It is a major procedure, and should only be reserved for cases where there is serious pathology present, such as major fibroids, adenomyosis, endometriosis and malignant conditions. It carries the risk of major complications, both short and long-term.

The types of hysterectomy are :

1. Abdominal Hysterectomy - the uterus is removed through an abdominal incision.
2. Vaginal Hysterectomy – the uterus is removed through the vagina
3. LAVH (Keyhole Surgery) – there is no such thing as Keyhole Surgery. Laparoscopy instruments are placed through three puncture wounds in the abdomen to help the operator perform a Vaginal Hysterectomy. This may be of value in difficult cases

For more details please see our hysterectomy information page at <http://www.goldcoastgynaecology.com.au/100046.php>