10-minute consultation

Menorrhagia

Sally Hope

A woman comes to see you having been rejected at a blood donor session because of a haemoglobin concentration of 90 g/l. She has happily used a contraceptive diaphragm for the past 20 years. She has two children and has been feeling tired and grumpy.

What issues you should cover

- Ask about flooding, clots, and frequency of changing sanitary wear overnight during periods.
- Are the periods regular? A regular cycle implies ovulation, and non-hormonal treatments should work. Irregular, anovulatory cycles may need hormones.
- Symptoms suggesting other conditions are irregular bleeding, a sudden change in blood loss, intermenstrual bleeding, postcoital bleeding, dyspareunia, pelvic pain, or premenstrual pain.
- Special risk factors that might suggest endometrial cancer are the polycystic ovary syndrome, gross obesity, older nulliparous women, and use of tamoxifen or unopposed oestrogen.
- What contraception is she using? Is she happy with it? The combined contraceptive pill lessens menstrual loss. A copper bearing intrauterine device may increase blood loss.

What you should do

- An abdominal bimanual examination is recommended; do a cervical smear if it is due. Refer to a gynaecologist if the uterus is greater than a 10 week pregnancy or there is any abnormal pelvic mass or tenderness. Otherwise, medical treatments should be effective. Discuss findings and options with the patient.
- Do a full blood count. Menorrhagia is the commonest cause of iron deficiency anaemia in the western world. Many women dislike taking iron tablets because of constipation, diarrhoea, or foul smelling flatulence; some prefer to remain anaemic. Discuss dietary measures to improve iron intake; drinking orange juice with iron tablets, for example, helps absorption.
- Check thyroid and other endocrine function only if the clinical picture suggests the need. Endometrial assessment is not needed initially.
- If the woman has regular ovulatory cycles and prefers a non-hormonal treatment that is taken only during a period, suggest mefenamic acid 500 mg three times daily or tranexamic acid 1 g three times daily on the first day of the period and for other days of heavy flow. Either treatment should be tried for three months. Mefenamic acid may cause gastrointestinal irritation or make asthma worse. It improves dysmenorrhoea, however. Tranexamic acid may cause headaches and nausea and should not be prescribed if the patient has had thromboembolism. Review this treatment at three months and continue it indefinitely if the patient is happy with it. If blood flow is not reduced or there are unacceptable side effects, the

Useful reading

Royal College of Obstetricians and Gynaecologists. *The initial management of menorrhagia—evidence based clinical guidelines*. London: RCOG Press, 1998.

Prentice A. Medical management of menorrhagia. *BMJ* 1999;319:1343-5.

other drug can be tried while the patient waits for referral to a gynaecologist.

- For women wanting hormonal contraception or needing cycle control, offer the combined contraceptive pill, a levonorgestrel releasing intrauterine system, or oral or depot progestogens. A levonorgestrel releasing intrauterine system may produce irregular, continuous bleeding for the first six months but should reduce menstrual blood loss by 80-90% from 6-12 months. The system should last five years. If the patient has a copper or plastic intrauterine contraceptive device she could add tranexamic acid or mefenamic acid; alternatively, offer to replace her device with a levonorgestrel releasing intrauterine system at the end of her next period.
- Ask her to record her next three periods, and see her again after three months, having arranged a repeat haemoglobin test for the week before so the result will be ready for the review consultation.

This is the first in an occasional series of articles on common problems in primary care

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A flowchart of history, examination, and investigations is on the BMJ's website

Medical treatment of menorrhagia, adapted with permission from *The Initial Management of Menorrhagia—Evidence Based Clinical Guidelines* (see box)