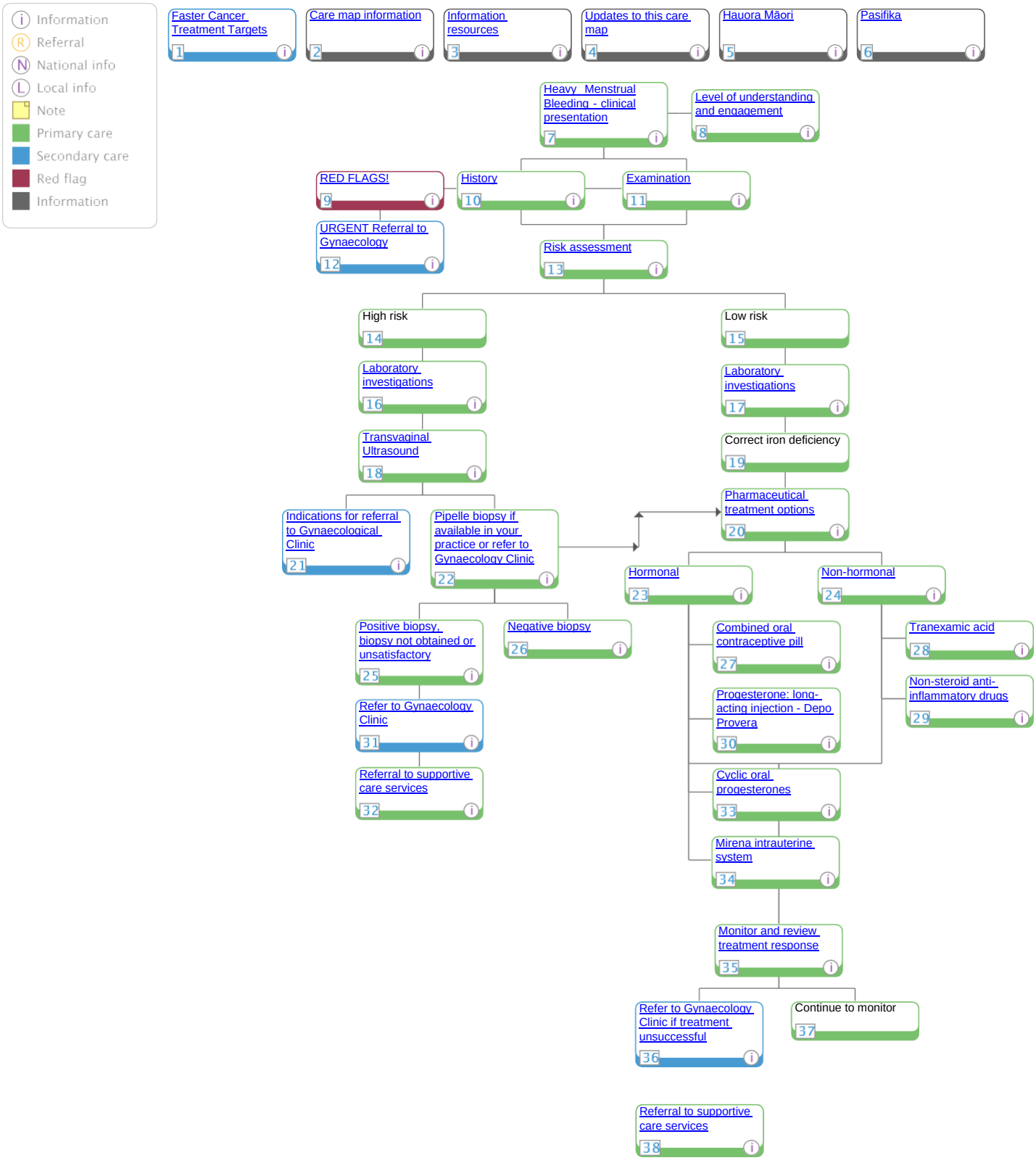
Heavy Menstrual Bleeding (HMB)

Obstetrics and Gynaecology > Gynaecology > Abnormal Vaginal Bleeding



1. Faster Cancer Treatment Targets

Faster Cancer Treatment:

- the Faster Cancer Treatment (FCT) health target builds on the significant improvements that have been made in the quality of cancer services over recent years. It provides a lens across the whole cancer pathway to ensure people have prompt access to excellent cancer services

Targets:

- 85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017

Ministry of Health:

- Ministry of Health High Suspicion of Cancer Definitions
- National Tumour Standards - Gynaecology

2. Care map information

In Scope:

- primary care management of heavy and irregular menstrual bleeding

Out of Scope:

- intermenstrual bleeding
- post coital bleeding
- post-menopausal bleeding
- pregnancy related bleeding
- premenstrual syndrome (PMS)
- chronic pelvic pain
- specific management of bleeding problems caused by contraceptive devices
- women on Tamoxifen
- treatment of conditions underlying heavy menstrual bleeding, such as endometriosis and adenomyosis

3. Information resources

Information resources for patients and carers:

- Combined Oral Contraceptive (COC) Pill - Family Planning Association Patient Information
- Patient information pamphlets

Resources for providers:

- Heavy Menstrual Bleeding: Assessment and Management - Clinical Guideline
- Combined Hormonal Contraceptives
- Parenteral Progestogen-Only Contraceptives
- Tranexamic Acid
- Combined oral contraceptive (COC) pill
- Further information about the effects of COC pill
- Progesterones: long-acting injection - Depo Provera

- Further information about prescribing of cyclic oral progestogens

Information resources for clinicians:

- Cancer Society - Gynaecological Cancer Information
- Ministry of Health High Suspicion of Cancer Definitions
- Reducing cancer inequalities in Māori a priority
- Best practices when providing care to Māori patients and their whānau

Read Code:

- K5920

4. Updates to this care map

First published: May 2016

Date of last publication: January 2017.
This care map has been reviewed in line with consideration of evidenced based guidelines with no updates made.

Please see the care map's Provenance for information on references, accreditations from national clinical bodies, contributors, publication schedule, and the editorial methodology.

5. Hauora Māori

Māori are a diverse people and whilst there is no single Māori identity, it is vital practitioners offer culturally appropriate care when working with Māori Whānau. It is important for practitioners to have a baseline understanding of the issues surrounding Māori health.

This knowledge can be actualised by (not in any order of priority):

- acknowledging Te Whare Tapa Wha (Māori model of health) when working with Māori Whānau
- asking Māori clients if they would like their Whānau or significant others to be involved in assessment and treatment
- asking Māori clients about any particular cultural beliefs they or their Whānau have that might impact on assessment and treatment of the particular health issue (Cultural issues)
- consider the importance of Whānaungatanga (making meaningful connections) with their Māori client / Whānau
- knowledge of WhānauOra, Te Ara Whānau Ora and referring to Whānau Ora Navigators where appropriate
- having a historical overview of legislation that has impacted on Māori well-being

For further information:

- Hauora Māori
- Central PHO Māori Health website

6. Pasifika

Pacific Cultural Guidelines (Central PHO) 6MB file

Our Pasifika community:

- is a diverse and dynamic population:
  - more than 22 nations represented in New Zealand
  - each with their own unique culture, language, history, and health status

- share many similarities which we have shared with you here in order to help you work with Pasifika patients more effectively

The main Pacific nations in New Zealand are:

- Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau and Tuvalu

Acknowledging *The FonoFale Model (pasifika model of health)* when working with Pasifika peoples and families.

Acknowledging general pacific guidelines when working with Pasifika peoples and families:

- Cultural protocols and greetings
- Building relationships with your pasifika patients
- Involving family support, involving religion, during assessments and in the hospital
- Home visits
- Contact information

Pasifika Health Service - Better Health for Pasifika Communities:

- the Pasifika Health Service is a service provided free of charge for:
  - all Pasifika people living in Manawatu, Horowhenua, Tararua and Otaki who have long term conditions
  - all Pasifika mothers and children aged 0-5 years
- an appointment can be made by the patient, doctor or nurse
- the Pasifika Health Service contact details are:
  - Palmerston North Office - 06 354 9107
  - Horowhenua Office - 06 367 6433
- Better Health for Pasifika Communities brochure

Additional resources:

- Ala Mo'ui - Pathways to Pacific Health and Wellbeing 2014-2018
- Primary care for pacific people: a pacific health systems approach
- Tupu Ola Moui: The Pacific Health Chart Book 2004
- Pacific Health resources
- List of local Maori/Pacific Health Providers
- Central PHO Pacific Health website

7. Heavy Menstrual Bleeding – clinical presentation

NB: Māori and Pacific Island women have higher incidences of and mortality from endometrial and cervical cancers (Robson and Harris 2007; Harris et al 2012; McLeod et al 2011)

Heavy menstrual bleeding (HMB):

- defined as excessive menstrual blood loss which interferes with the woman's physical, emotional, social and material quality of life [6]
- heavy menstrual bleeding can occur regularly (once a month on a predictable basis) or irregularly
- difficulties exist in defining 'normal' menstrual blood loss and women's perceptions of HMB may vary considerably [5]
- interventions should focus on improving symptoms and quality of life, rather than focusing on menstrual blood loss [5]
- measuring menstrual blood loss (MBL) is not routinely recommended for HMB - patient should use own judgement instead however if monthly blood loss is greater than 80ml, iron deficiency is likely [5]
- in 40 - 60% of cases, no underlying pathology is found, and bleeding is due to hormonal reasons [6]

Patient may present with the following complaints [5,6]:

- 'flooding'
- clothes bloodstained
- painful periods
- anxiety/depression
- moodiness or irritability
- interference with social life, hobbies, or life in general
- anaemia and iron deficiency

Common causes of HMB [6]:

- dysfunctional uterine bleeding (ovulatory and anovulatory bleeding) [6]
- uterine fibroids [6]
- endometriosis and adenomyosis [6]

Read Code:

- K5920

8. Level of understanding and engagement

Apply health literacy principles:

Is English their second language, ask what the patient understands:

- is an interpreter required?
  - call ***Interpreter Services – Language Line*** (Nationwide) 0800 656 656 Monday to Friday, 9am to 6pm, Saturday 9am to 2pm
- build on what the patient already knows
- translate medical terminology into lay language (do they have a support person)
- draw diagrams or write key phrases and messages down and give it to the patient to take with them
- provide educational material
- check the patient's understanding to confirm that they understand the key messages (or confirm with support person if required)
- encourage patient to bring trusted support people to future consultations
- consider other health literacy resources as appropriate:
  - Local community Māori Health Services
  - Best practices when providing care to Māori patients and their whānau
  - Local community Pasifika Health Services
  - LETS PLAN is a resource to help plan your next health care visit. It will help you understand more about your health and treatment for an illness or injury

Barriers to effective care:

Factors that could stop the patient from getting further tests or treatment can include:

- complexity of care pathway not knowing when or where to go next
- cost
- locality and geographical access to health and hospital services (travel)
- no Whānau / family support
- family obligations including dependents
- work responsibilities (can't take time off)

Discuss options of referral to available supportive care services. For more information see the ***'referral to support services'*** box within this pathway.

9. RED FLAGS!

If intermenstrual bleeding or post coital bleeding present, refer to Gynaecology Clinic. The following alarm symptoms and signs may indicate cancer and the need for referral to the Gynaecology Clinic:

- sudden increase in blood loss
- bulky uterus palpable abdominally (size more than a 10 week pregnancy) - order ultrasound prior to referral to Gynaecology Clinic
- pelvic mass [5]
- an unexplained vulval lump or vulval bleeding due to ulceration
- dyspareunia
- pelvic pain, tenderness, or pressure symptoms
- severe anaemia (haemoglobin less than 80g/L)

10. History

Establish that the woman has menstrual bleeding that is, in both her opinion and your own, heavy - take into account the range and natural variability in menstrual cycles and blood loss when diagnosing heavy menstrual bleeding (HMB) [5,6]. Take a thorough history to include:

- the nature of the bleeding
- degree of blood loss (e.g. 'flooding' or passage of clots, frequency of changing sanitary products)
- impact on quality of life
- menstrual cycle details (menstrual diary may be useful), including:
  - length of cycle
  - duration of menstruation (including duration of heavy menstruation)
  - variability of cycle
  - any intermenstrual bleeding
  - presence of additional symptoms suggesting possible underlying pathology, such as:
    - postcoital bleeding
    - sudden increase in blood loss [10]
    - dyspareunia
    - dysmenorrhoea
    - pelvic pain and pressure symptoms
  - inherited bleeding or clotting disorders
- consider alternative reasons for blood loss if anaemia is out of proportion to menstrual loss
- current contraceptive method (including duration of use and compliance - consider the possibility of pregnancy
- medical history, including gynaecological history and presence of co-morbidity
- current medications, concentrating on anticoagulation agents
- cervical screening history
- desire for pregnancy
- impact upon the woman's work, social and personal relationships

11. Examination

Examination:

- body mass index (BMI) and blood pressure
- abdominal and vaginal examination
- a pelvic examination should include [6]:

- vulval examination for evidence of external bleeding and signs of infection (e.g. vaginal discharge)
- speculum examination of vagina or cervix
- high vaginal, and chlamydia/gonorrhoea swabs should be obtained if infection is suspected
- bimanual palpation to identify uterine and adnexal enlargement or tenderness

- in addition to abdominal and pelvic examination, look for systemic signs of underlying disease, such as [6]:
  - hirsutism, striae, thyroid enlargement or nodularity, or changes in skin pigmentation (indicative of endocrine disease)
  - bruises or petechiae (indicative of coagulation disorders)

12. URGENT Referral to Gynaecology

If there is a high suspicion of underlying cancer, the woman should be seen within two weeks [5,6]. High suspicion of gynaecological cancer is defined to include (but is not restricted to) women with:

- a macroscopic abnormality suspicious of a vulval, vaginal or cervical cancer
- significant symptoms including abnormal vaginal bleeding, discharge or pelvic pain and abnormal clinical examination findings consistent with gynaecological malignancy
- a cervical or vaginal smear suspicious of malignancy
- post menopausal bleeding **and** an endometrial thickness of greater than 5mm (unless with a recent normal endometrial biopsy)
- biopsy-proven atypical endometrial hyperplasia
- a complex ovarian mass, with radiological suspicion of ovarian malignancy, ascites or metastatic disease
- a complex ovarian mass and raised CA125 (an RMI >200)
- a large complex ovarian mass (>8cm)
- evidence of a rapidly growing pelvic mass (uterine or ovarian)

Please complete the ***High Suspicion of Cancer referral form*** in your patient management system.
A copy of the form can also be printed here.

NB: Timely feedback (by way of a phone call and/or followed up with a written report) to the person being referred to specialist services will be appreciated.

13. Risk assessment

High risk groups for endometrial hyperplasia and malignancy include the following:

- age 45 years or over
- age > 35 years and one of the following:
  - raised body mass index (BMI)
  - nulliparity
  - family history of endometrial cancer
  - tamoxifen use
  - unopposed oestrogen treatments
  - polycystic ovary syndrome (PCOS)
  - history of infertility
  - Māori or Pacific Islander

16. Laboratory investigations

Take full blood count (FBC) plus Ferritin:

- iron deficiency anaemia occurs in about two-thirds of women with heavy menstrual bleeding (HMB) [5]

- while iron deficiency anaemia is a strong indicator of HMB and identifies the need for oral iron supplements, a normal haemoglobin does not exclude HMB [5]
- anaemia should be treated if present [6]
- coagulation profile if clinically indicated [6]
- thyroid function tests unnecessary unless other signs and symptoms of thyroid disease
- FSH estimation may be useful if peri-menopausal

17. Laboratory investigations

Take full blood count (FBC) plus Ferritin:

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- FSH estimation may be useful if peri-menopausal

18. Transvaginal Ultrasound

Refer women for an **urgent transvaginal** ultrasound to assess endometrial thickness [3]
A transvaginal scan can:

- reliably assess the thickness and morphology of the endometrium
- is highly sensitive for ovarian abnormalities, fibroids and endometrial thickness

Direct access to transvaginal ultrasound scans:

- is available via MidCentral Health' s Radiology Department
- waiting time of no longer than ten working days
- ***GP/NP to mark on radiology request 'urgent high suspicion of cancer as per Heavy Menstrual Bleeding pathway'***

Community Referred Radiology Providers
Patients residing outside of Palmerston North may be referred to one of the following contracted community referred radiology providers and as per current criteria, receive a funded transvaginal ultrasound scan:

- Horowhenua Health Centre (Horowhenua and Otaki patients)
- Dannevirke Community Hospital (Tararua patients)
- Feilding Health Centre (Feilding patients)

Transabdominal ultrasound is inaccurate for the assessment of endometrial thickness.

20. Pharmaceutical treatment options

Pharmacotherapy should be the first-line treatment unless, following a full consultation, it is the patient's preference to receive more definitive surgery. While surgery may be a more definitive and successful longer-term treatment than medication, this must be weighed against the surgical risks and fertility issues [5]. Pharmaceutical treatment should be considered where [5]:

- no structural or histological abnormality is present
- fibroids are less than 3cm in diameter and are not causing distortion of the uterine cavity
- determine whether contraceptive effect is acceptable to the woman before recommending treatment (for example, she may wish to conceive) [5]

If history and investigations indicate that pharmaceutical treatment is appropriate and either hormonal or non-hormonal treatments are acceptable, treatments should be considered in the following order [5]:

- **heavy regular bleeding:**
  - tranexamic acid (TA), non steroidal anti-inflammatory drugs (NSAIDs), or combined oral contraceptives (consider contraindications)
  - levonorgestrel-releasing intrauterine system (LNG-IUS) - provided long-term (at least 12 months) use is anticipated; Special Authority Criteria for Mirena

- **heavy irregular bleeding:**
  - tranexamic acid (TA), non steroidal anti-inflammatory drugs (NSAIDs), or combined oral contraceptives (consider contraindications)
  - oral nor-ethisterone, particularly if peri-menopausal
  - levonorgestrel-releasing intrauterine system (LNG-IUS) - provided long-term (at least 12 months) use is anticipated; Special Authority Criteria for Mirena

If bleeding is very heavy or prolonged, consider stopping it abruptly by giving oral norethisterone at high doses (5mg three times daily) [6].

21. Indications for referral to Gynaecological Clinic

Refer woman to the Gynaecology Clinic if any of the following applies:

- endometrium thickness >15mm
- evidence of endometrial polyps
- ovarian or other pelvic mass [5]
- uterine fibroids >3cm in diameter or distorting the uterine cavity

If there is a high suspicion of underlying cancer, the woman should be seen within two weeks [5,6].

Please complete the ***High Suspicion of Cancer referral form*** in your patient management system.
A copy of the form can also be printed here.

NB: Timely feedback (by way of a phone call and/or followed up with a written report) to the person being referred to specialist services will be appreciated.

22. Pipelle biopsy if available in your practice or refer to Gynaecology Clinic

Carry out pipelle endometrial biopsy if this available within your practice.
NOTE: If biopsy is positive or not obtainable, refer women to Gynaecology Clinic.

23. Hormonal

Hormonal pharmaceutical treatment options include:

- combined oral contraceptive pill
- progestogens: long-acting injection - Depo Provera
- cyclic oral progestogens
- mirena intrauterine system

24. Non-hormonal

Non-hormonal pharmaceutical treatment options include:

- tranexamic acid
- non-steroidal anti-inflammatory drugs

25. Positive biopsy, biopsy not obtained or unsatisfactory

If pipelle biopsy shows any of the following, refer woman to the Gynaecology Clinic:

- endometrial hyperplasia
- atypia
- carcinoma

26. Negative biopsy

May include:

- proliferative or secretory endometrium

27. Combined oral contraceptive pill

Combined oral contraceptive (COC) pill **[5]:**

- given to patients who also wish to use this form of contraception
- useful in those who are anovulatory or oligo-ovulatory
- contraindications include:
  - history or presence of VTE
  - history of migraine with Aura
  - pregnancy
  - over 35 and a smoker
  - current or past breast cancer
  - hypertension
- adverse effects include:
  - breast tenderness
  - nausea
  - headaches
  - mood disturbance
  - fluid retention
- rare adverse effects include:
  - deep vein thrombosis (DVT)
  - stroke
  - heart attack

Further information about the effects of COC pill

28. Tranexamic acid

Tranexamic acid:

- dosage usually 1g, three or four times daily
- use is recommended for as long as it is found to be beneficial by the woman
- be cautious when offering to patients that:
  - are at high risk of thromboembolism
  - are taking the combined oral contraceptive (COC) pill (theoretically, there is an increased risk of thrombosis in these patients)
  - have renal impairment - dose should be reduced (TA should be avoided altogether in more severe cases)
- competitive inhibitor of plasminogen activation (antifibrinolytic agent) [5]
- inhibits factors associated with blood clotting without affecting coagulation within healthy blood vessels (no increase in the overall rate of thrombosis) [5]
- does not appear to affect platelet numbers or aggregation but acts to reduce the breakdown of fibrin in a pre-formed clot [5]
- acceptable first-line treatment in those who wish to conceive - taken at the start of the menstrual cycle only and therefore does not interfere with efforts to conceive or have effects on the embryo [6]
- does not [5]:
  - treat dysmenorrhoea - advice on pain relief may be required
  - regulate cycles - advice and suitable additional treatment should be given if required
- adverse effects (uncommon) include:
  - gastrointestinal problems (e.g. indigestion, diarrhoea) [5,6]
  - headaches [5,6]
  - visual disturbances (occur rarely) [6]
  - thromboembolic events (occur rarely) [6]
- may be taken in combination with non-steroidal anti-inflammatory drugs (NSAIDs) [5]

Further information about Tranexamic acid

29. Non-steroid anti-inflammatory drugs

Non-steroidal anti-inflammatory drugs (NSAIDs):

- reduce prostaglandin synthesis by inhibition of cycloxygenase - prostaglandins affect local tissue reactivity and are implicated in inflammatory response, pain care maps, uterine bleeding, and uterine cramps [5]
- should only be taken regularly from the onset of bleeding, or just before, until heavy loss has abated [5]
- acceptable first-line treatment in those who wish to conceive - taken at the start of the menstrual cycle only and therefore should not interfere with efforts to conceive or have effects on the embryo [6]
- there is some evidence to suggest that naproxen and mefenamic acid (part subsidy) are more effective than ibuprofen [5]
- less effective than either tranexamic acid or levonorgestrel releasing intrauterine system (LNG-IUS) [9]
- preferable to tranexamic acid if dysmenorrhoea is also present [5]
- prescribe the minimal dose needed to improve symptoms [4]
- should not be:
  - combined with other NSAIDs simultaneously [4]
  - used where it is thought that heavy menstrual bleeding (HMB) is caused by bleeding/coagulation disorders [5]
- may be prescribed in combination with tranexamic acid to increase efficacy [5]
- contraindicated if:
  - history of gastrointestinal complications, such as peptic ulcers [5,6]
  - history of bronchospasm, urticaria, angioedema, rhinitis, or severe skin reaction with aspirin or an NSAID [6]
  - history urticaria, angioedema, rhinitis, or severe skin reaction with aspirin or an NSAID

- history of asthma, hypertension, renal impairment, or heart failure
- patient is pregnant [6]
- patient is receiving low-dose aspirin [6]

- potential for adverse effects, including indigestion and diarrhoea [5]

30. Progesterone: long-acting injection – Depo Provera

Progesterone: long-acting injection - Depo Provera:

- consider contraindications
- use of long-acting progesterones for the management of heavy menstrual bleeding (HMB) is controversial and their effect is highly variable
- menstrual irregularity can be made significantly worse
- effect is difficult to reverse
- contraindicated if there is a history of infertility or ovulatory problems
- can occasionally be associated with decreased bone density with long-term use

31. Refer to Gynaecology Clinic

If there is a high suspicion of underlying cancer, the woman should be seen within 2 weeks.

Please complete the ***High Suspicion of Cancer referral form*** in your patient management system.
A copy of the form can also be printed here.

NB: Timely feedback (by way of a phone call and/or followed up with a written report) to the person being referred to specialist services will be appreciated.

32. Referral to supportive care services

He Anga Whakaahuru - Supportive Care Framework [5]
Improving the quality of life for those with cancer, their family and whānau through support, rehabilitation and palliative care - the essential services required to meet a person's physical, social, cultural, emotional, nutritional, informational, psychological, spiritual and practical needs throughout their experience with cancer.

Further information on the Standards and Competencies

Support Services:

1. Community Cancer Nurses Community-based cancer support service is provided to:

- anyone with a possible, probable or definite diagnosis of cancer and are enrolled with a PHO and/or is a resident in the PHO area

Māori Community Cancer Coordinators - community-based Māori cancer support services:

- Te Wakahuia (Palmerston North, Manawatu)Phone: 06 3573400
- Best Care Whakapai Hauora (Palmerston North)06 3536385 Ext 773
- Te Rānanga o Raukawa (Otaki, Horowhenua)Phone: 06 3688679
- Te Kete Hauora (Tararua)Phone: 06 3746860
- referral form

2. Pae Ora Māori Health Service:

- kaupapa Māori community and hospital based navigation service
- referral form and contact details

3. MidCentral CNS Gynaecology Nurse:

- 06 356 9169 Ext 9608

4. Cancer Society:

- for additional support services phone the cancer information nurses on the **Cancer Information Helpline 0800 226 2374**

5. Central Region Cancer Services Directory:

The directory provides a list of cancer support services available across MidCentral, Whanganui and Hawke's Bay including:

- ethnic and cultural
- accommodation
- disability support
- government health services
- medication
- legal advice

6. Social Workers Oncology

- We can support you and your family/whānau as you come to terms with your diagnosis and the impact it may have in your day-to-day life, now and in the future
- for more information and contact details

7. Cancer Psychology Service (Massey): Te Ara Whatumanawa.

We work with people and their whānau/family at all stages of the cancer journey, from diagnosis to treatment and beyond.

- free service
- 06 3505180
- referral form

8. Regional Cancer Treatment Service (RCTS):

Cancer treatment services are provided to patients in Taranaki, Whanganui, Tarawhiti, Hawkes Bay and MidCentral District Health Boards by the Regional Cancer Treatment Service (RCTS):

- for more information go to website

Reference: He Anga Whakaahuru - Supportive Care Framework [5]

33. Cyclic oral progesterones

Cyclic oral progesterones:

Cyclic oral progesterones have a limited role in perimenopausal women with annovulatory bleeding and women with poly-cystic ovary syndrome (PCOS) and annovulatory bleeding. In the latter group they are protective against endometrial hyperplasia and malignancy. Ineffective generally if ovulatory bleeding:

- Primolut 5 - 15mg daily, days 15 - 28 or Provera 10 - 20mg daily, days 15 - 28. If ineffective, then trial days 5 - 26
- adverse effects (usually minor and transient) include:
  - irregular bleeding
  - weight gain
  - bloating and fluid retention

- breast tenderness
- headaches
- mood changes
- depression

Further information about prescribing of cyclic oral progestogens

34. Mirena intrauterine system

Mirena intrauterine system (IUS):*Special Authority Criteria for Mirena*

- intrauterine, long-term progesterone-only method of contraception licensed for up to 5 years of use (consider plans to use this method for at least 12 months) [5]
- is a very effective treatment in those who do not wish to conceive and for whom hormonal therapy is acceptable [5]
- may be used in patients with fibroids, but not the first treatment choice (due to the problems of possible abnormal uterine anatomy or distortion) [5]
- adverse effects are generally minor and transient, and include [5]:
  - premenstrual (PMS) symptoms, such as:
    - breast tenderness
    - mood swings
    - headache
    - acne
    - amenorrhoea (less common) [1]
- spotting, bleeding, and intermenstrual bleeding are normal during the first few (up to 6) months and not a reason for discontinuation [5]
- rarely, uterine perforation during intrauterine device (IUD) insertion may occur [5]
- prior to insertion [4]:
  - a pelvic examination must be performed
  - chlamydia and gonorrhoea screening should be performed - where appropriate, this can be done at the time of insertion
- offers similar relief of symptoms to endometrial ablation techniques after 1 year of treatment
- a recent study also found similar therapeutic results to that of endometrial ablation techniques after 2 years of treatment [8]
- recommended that recall is set up for replacement/removal

35. Monitor and review treatment response

Monitor and review treatment response:

- trial oral treatments for at least 3 months and the levonorgestrel-releasing intrauterine system (LNG-IUS) for 6 months before considering them to be ineffective [5]
- when an initial pharmaceutical treatment has proved ineffective, a second pharmaceutical treatment should be considered rather than immediate referral for surgery [5]

36. Refer to Gynaecology Clinic if treatment unsuccessful

Treatment failure can be an indication of potential endometrial cancer or atypical hyperplasia. Make a routine referral to a gynaecologist if [5,6]:

- there has been inadequate response to drug treatment for menorrhagia
- the patient wishes to explore the possibility of surgical intervention in place of current drug treatment

Make an urgent referral to a gynaecologist/oncologist if there is a suspicion of underlying pathology (e.g. uterine cancer, hyperplasia,

fibroids) due to:

- an abdominally palpable uterus (more than a 10 week pregnancy) [5,6]
- a mass palpable on vaginal examination [5,6]
- persistent intermenstrual bleeding [5,6]
- significant change (e.g. sudden increase) in blood loss [5,6]
- dyspareunia [6]
- pelvic pain, tenderness, or pressure symptoms [6]
- severe anaemia (haemoglobin less than 8g/dL) [5,6]

If there is a high suspicion of underlying cancer, the woman should be seen within 2 weeks [5,6].

38. Referral to supportive care services

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Reference: He Anga Whakaahuru - Supportive Care Framework [5]

Abnormal Vaginal Bleeding Pathways (Post Coital and Intermenstrual Bleeding, Post Menopausal Bleeding, Heavy Menstrual Bleeding)

Provenance Certificate

Overview | Editorial methodology | References | Contributors | Disclaimers

Overview

This document describes the provenance of the Sub-region Districts (MidCentral, Whanganui and Hawke's Bay District Health Boards) Post Coital and Intermenstrual Bleeding Pathway.

The purpose of implementing cancer pathways in our Districts is to:

- Reduce barriers so that all people with cancer are able to access the same quality care within the same timeframes, irrespective of their ethnicity, gender, locality or socio-economic status
- Achieve the faster cancer treatment (FCT) health target – 85% of patient receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90% by June 2017
- Implement the national tumour standards of service provision, developed as part of the FCT programme, to support the delivery of standardised quality care for all people with cancer
- Improve equity along the cancer pathway
- Clarify expectations across providers
- Improve communications and follow up care for cancer patients

To cite this pathway, use the following format:

Obstetrics and Gynaecology/Gynaecology/Abnormal Vaginal Bleeding/

Editorial methodology

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References

This care map has been developed according to the Map of Medicine editorial methodology. The content of this care map is based on high-quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience. This sub-region version of the evidence-based, practice-informed care map has been peer-reviewed by stakeholder groups and the CCP Programme Clinical Lead.

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The classification employed by Map of Medicine is as follows:

[G] guideline

[M] meta-analysis

[S] systematic review

[A] randomised controlled trial

[B] nonrandomised prospective study

[C] retrospective study

[Q] cost- or decision-analysis

[P] performance measure or policy document

[E] practice-based information (expert opinion)

Contributors

MidCentral DHB's Collaborative Clinical Pathway editors and facilitators worked with clinical stakeholders such as front-line clinicians and pharmacists to gather practice-based knowledge for its care maps.

The following individuals have contributed to this subregion care map:

- Digby Ngan Kee, Gynaecologist MidCentral DHB
- Gillian Forsyth, CNS Gynaecology, MidCentral DHB
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- Stephanie Fletcher, Project Manager, Central Cancer Network, MidCentral DHB
- Katherine Gibbs, Project Manager, MidCentral DHB
- Catherine Kelsey, CNS Gynaecology, Hawke's Bay DHB
- Elaine White, Consultant, Obstetrics and Gynaecology, Hawke's Bay DHB
- Keven Nevil, Consultant, Obstetrics and Gynaecology Whanganui DHB (Secondary Care Clinical Lead)
- Ruth Carter, General Practitioner, Whanganui Regional Health Network (Primary Care Clinical Lead)
- Ray Jackson, Project Director, Collaborative Clinical Pathways (Facilitator)
- Kim Vardon, Project Assistant, Collaborative Clinical Pathways (Editor)

The following individuals have contributed to this MidCentral care map:

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Disclaimers

Clinical Board Central PHO, MidCentral DHB

It is not the function of the Clinical Board Central PHO, MidCentral DHB to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care.

Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.

Abnormal Menstrual Bleeding Pathways (Post Menopausal Bleeding, Heavy Menstrual Bleeding) Provenance Certificate

Overview | Editorial | Reference | Contributors | Disclaimers

Overview

This document describes the provenance of MidCentral District Health Board's Abnormal Menstrual Bleeding pathways.

This localised pathway was last updated in March 2016.

One feature of the "Better, Sooner, More Convenient" (BSMC) Business Case, accepted by the Ministry of Health in 2010, was the development of 33 collaborative clinical pathways (CCP).

The purpose of implementing the CCP Programme in our DHB is to:

- Help meet the Better Sooner More Convenient Business Case aspirational targets, particularly the following:
    - Reduce presentations to the Emergency Department (ED) by30%
    - Reduce avoidable hospital admissions to Medical Wards and Assessment Treatment and Rehabilitation for over-65-year-olds by 20%
    - Reduce poly-pharmacy in the over-65-year-olds by 10%
- Implement a tool to assist in planning and development of health services across the district, using evidence-based clinical pathways.
- Provide front line clinicians and other key stakeholders with a rapidly accessible check of best practice;
- Enhance partnership processes between primary and secondary health care services across the DHB.

To cite this pathway, use the following format:

Map of Medicine. Medicine. MidCentral District View. Palmerston North: Map of Medicine; 2014 (Issue 1).

Editorial methodology

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- Jess Long, Project Director, Collaborative Clinical Pathways, Health Care Development, MidCentral DHB (Facilitator)
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