ABNORMAL UTERINE BLEEDING (AUB)

INTRODUCTION

- AUB is a term that describes any form of menstrual irregularity including heavy menstrual bleeding (HMB)
- AUB differs from normal menstruation in its regularity, frequency, duration, or volume
- AUB effects 14-25% of women of reproductive age and accounts for around 12% of all referrals to gynaecology services.

AETIOLOGY OF AUB

The International Federation of Gynaecology and Obstetrics (FIGO) Executive Board have recommended a classification system to describe the causes of AUB in non-pregnant women of reproductive age. The causes of AUB can be remembered using this pneumonic: PALM-COEIN

STRUCTURAL	NON-STRUCTURAL CAUSES
Polyp – cervical or endometrial	**C**oagulopathy e.g. VWD, warfarin
Adenomyosis	**O**vulatory dysfunction e.g. PCOS, POF
Leiomyoma (fibroids)	**E**ndometrial e.g. endometritis
Malignancy & Hyperplasia	**I**atrogenic e.g. contraception
	Not yet classified e.g. endometriosis

ASSESMENT AND INVESTIGATIONS

1. **HISTORY** – gynae history inc; contraception, pelvic pain or pressure, risk factors for coagulopathy, symptoms of anaemia and impact on quality of life. Specifically ask about menstruation in terms of:
   Frequency of menses (days) absent (amenorrhoea), frequent <24 days, infrequent > 38 days
   Regularity (cycle length) ⟹ regular or irregular
   Duration (bleeding days per menstruation) ⟹ prolonged if > 8 days
   Volume (monthly blood loss) ⟹ Heavy or light (subjective)

RED FLAGS: PMB, weight loss, change in bowel habit > 50 yrs, irregular bleeding > 40 yrs

2. **EXAMINATION** – PA and PV examination, smear if due, STI screening and pregnancy test if indicated. If suspicious lesion on cervix refer to colposcopy as 2WW
3. **INVESTIGATIONS**– **FBC** to rule out anaemia and **USS** if indicated to rule out pathology (see below)

DIAGNOSIS

If **STRUCTURAL** cause suspected see next page for guidance on HMB

If **NON-STRUCTURAL** cause suspected:

- Coagulopathy – if HMB since menarche and/or FH of coagulopathy arrange investigations to diagnose and then manage as per HMB (may need haematology input)
- Ovulatory dysfunction – do hormone profile and manage underlying cause (see guideline on PCOS)
- Endometritis – do swabs and treat with antibiotics as indicated
- Iatrogenic – if on contraception manage as per FSRH guideline on "Problematic bleeding on hormonal contraception"
- Not yet classified – treat underlying cause

NOTE: THERE IS OFTEN MORE THEN ONE CAUSE OF AUB

ASSESSMENT AND MANAGEMENT OF HMB

INVESTIGATIONS

- History and examination as above
- **FBC** for all women with HMB. TFT's and hormone profile NOT needed routinely unless clinically indicated
- Test for coagulopathy (e.g. VWD) if HMB since menarche and/or family history of coagulopathy
- If appropriate consider pregnancy test, STI screening, smear if due

Consider starting pharmacological treatment with tranexamic acid and NSAIDs whilst investigations awaited

ultrasound or hysteroscopy?

ULTRASOUND PELVIS INDICATED

Large fibroids suspected

- if uterus is palpable abdominally
- history or examination suggests a pelvic mass
- examination is inconclusive or difficult, for example in women who are obese

Women with suspected adenomyosis

- significant dysmenorrhoea
- A bulky, tender uterus on examination that suggests adenomyosis

OUTPATIENT HYSTEROSCOPY INDICATED

Suspected submucosal fibroids, polyps or endometrial pathology

- women with persistent IMB
- >45 years old
- Risk factors for endometrial cancer e.g. PCOS, diabetes, tamoxifen, obesity

Offer outpatient hysteroscopy +/- biopsy
do not do blind endometrial biopsy – offer only in context of diagnostic hysteroscopy

MANAGEMENT

If no identified pathology or fibroids less than 3 cm or suspected or diagnosed adenomyosis:
First line:

- **LNG-IUS –** suitable if no distortion of uterine cavity. Counsel women on expected changes in bleeding pattern, particularly over the first 6 months and that it is advisable to wait for at least 6 cycles to see the benefits of treatment.

Second Line: (If LNG-IUS not suitable or planning pregnancy)

- **non-hormonal methods;** tranexamic acid (and NSAIDs (co-existing dysmenorrhoea)
- **Hormonal methods:**
  - Contraceptives: CHC, POP, Depo-provera or nexplanon
  - Non-contraceptives: cyclical oral progestogens e.g. NET 5mg TDS day 5-25 of cycle or medroxyprogesterone acetate 5-10mg PO OD from day 16-21 of cycle

WHEN TO REFER TO HOSPITAL GYNAECOLOGY?

1. **If above treatment unsuccessful after 3-6 months –** refer to hospital gynaecology to consider hysteroscopic resection, endometrial ablation or hysterectomy
2. **Fibroids > 3cm** – offer tranexamic acid and/or NSAIDs, CHC, oral progestogens in interim Inform patients pharmacological treatment have limited efficacy if fibroids >3cm and refer for consideration of GnRH analogues, uterine artery embolization, endometrial ablation, myomectomy, hysterectomy.

APPENDICES:

AUB TERMINOLOGY

HEAVY MENSTRUAL BLEEDING (HMB)	Excessive menstrual blood loss leading to an interference with the physical, emotional, social and material quality of life of a woman
INTERMENSTRUAL BLEEDING (IMB)	Uterine bleeding that occurs between clearly defined cyclical menses
POSTCOITAL BLEEDING (PCB)	non-menstrual bleeding occurring immediately or shortly after sex
CHRONIC AUB	AUB that has been present for the preceding 6 months
NB: terms such as menorrhagia, menometrorrhagia, metrorrhagia and dysfunctional uterine bleeding should no longer be used as they are poorly understood and can be misinterpreted.	

MENSTRUAL HISTORY TERMINOLOGY

Parameters	Terminology	
Frequency of menses (days)	Absent	Amenorrhoea – primary or secondary
	Infrequent	>38 days
	Frequent	<24 days
Regularity (cycle length)	Irregular	Variation 10 days Cycle length is the number of days from the first day of one menstrual cycle to the first day of the next
Duration (days of bleeding in a single menstrual period)	Prolonged	> 8 days
Volume (monthly blood loss)	Heavy or light	Subjectively defined

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