

- and continuity of care in a safe service. London: TSO, 2007.
7. National Collaborating Centre for Women's and Children's Health. *Intrapartum care: care of healthy women and their babies during childbirth*. NICE clinical guideline 55. London: RCOG Press, 2007.
 8. Department of Health. Shribman S. *Making it better: for mother and baby — clinical case for change*. London: TSO, 2007.
 9. Department of Health. *Review of the health inequalities infant mortality PSA target*. London: TSO, 2007.
 10. Royal College of Midwives. *Refocusing the role of the midwife*. Position paper 26. London: RCM, 2006.
 11. Department of Health. *Facing the future: a review of the role of health visitors*. London: TSO, 2007.
 12. Department for Children, Schools and Families. *Children and young people today: evidence to support the development of the Children's Plan*. London: TSO, 2007.
 13. Chew-Graham C, Chamberlain E, Turner K, et al. GPs' and health visitor's views on the diagnosis and management of postnatal depression: a qualitative study. *Br J Gen Pract* 2008; **58**: 169–176.
 14. Locock L, Kai J. Parents' experiences of universal screening for haemoglobin disorders: implications for practice in a new genetics era. *Br J Gen Pract* 2008; **58**: 161–168.
 15. Dormandy E, Gulliford M, Reid EP, et al, and the SHIFT research team. Delay between pregnancy confirmation and sickle cell thalassaemia screening: a population-based cohort study. *Br J Gen Pract* 2008; **58**: 154–159.
 16. Daley A, Winter H, Grimmett C, et al. Feasibility of an exercise intervention in depressed women: a pilot randomised controlled trial. *Br J Gen Pract* 2008; **58**: 178–183.
 17. National Collaborating Centre for Mental Health. *Antenatal and postnatal mental health: clinical management and service guidance*. NICE clinical guideline 45. London: RCOG Press, 2007.
 18. Redshaw M, Rowe R, Hockley C, Brocklehurst P. *Recorded delivery: a national survey of women's experience of maternity care*. Oxford: National Perinatal Epidemiology Unit, 2006.
 19. Renfrew MJ, McFadden A, Dykes F, et al. Addressing the learning deficit in breastfeeding: strategies for change. *Matern Child Nutr* 2006; **2**: 239–244.
 20. National Collaborating Centre for Primary Care. *Postnatal care: routine postnatal care of women and their babies*. NICE clinical guideline 37. London: RCOG Press, 2006.
 21. Dyson L, Renfrew MJ, McFadden A, et al. *Promotion of breastfeeding initiation and duration: evidence into practice briefing*. London: National Institute for Health and Clinical Excellence, 2006.
 22. Department of Health. *Implementation plan for reducing health inequalities in infant mortality: a good practice guide*. London: TSO, 2007.
 23. Healthcare Commission. *Women's experiences of maternity care in the NHS in England. Key findings from a survey of NHS trusts carried out in 2007*. London: Commission for Healthcare Audit and Inspection, 2007.
 24. National Collaborating Centre for Women's and Children's Health. *Antenatal care: routine care for the healthy pregnant women*. NICE clinical guideline 6. London: RCOG Press, 2003.
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Heavy menstrual bleeding: delivering patient-centred care

The last decades of the 20th century saw rising rates of surgery for heavy menstrual bleeding with associated high costs and morbidity.^{1,2} GPs have been implicated as contributing to this as referral rates vary widely between practices and high referral rates are significantly associated with high operative rates.³ GPs have also been criticised for being dismissive of menstrual problems and not addressing patients' concerns.⁴ A NICE guideline has been published recently which could lead to better primary care management of heavy menstrual bleeding and improve patients' quality of life.⁵

In the past, heavy menstrual bleeding has been defined in terms of volume of menstrual blood loss.⁶ However, volume of loss is not routinely measured in clinical practice and there is a poor correlation between measured loss and women's perceptions of their blood loss.⁷ It was thought that psychological problems could explain the lack of correlation between measured and perceived blood loss, but we now know that the relationship between heavy menstrual bleeding and psychiatric illness is no different to the relationship between psychiatric illness and other physical symptoms.⁸ There are

several alternative explanations. Firstly, for individual women a change in volume of loss may be more significant than absolute volume of loss, for instance in leading to concern that something might be wrong or in challenging menstrual concealment strategies.^{4,9} Secondly, women's ability to contain heavy loss depends on their social circumstances; for example, women in jobs without easy access to toilets may have particular difficulty in managing heavy menstrual loss.¹⁰ Finally, it has been shown that the presence of other menstrual symptoms, such as pain, mood changes, and irregular bleeding all influence the impact of heavy menstrual bleeding.^{9,11}

Clinicians may remain concerned that by focusing on the impact of symptoms rather than attempting to objectively assess volume of menstrual loss they may be missing significant underlying pathology. The NICE guideline provides a thorough summary of the epidemiology of uterine pathology. It highlights that although there is a lack of research in primary care, studies from secondary care show that the association between fibroids and heavy menstrual bleeding is less strong than previously thought. Furthermore, persistent

intermenstrual bleeding is probably a more significant symptom than heavy menstrual bleeding in predicting endometrial cancer and this is very uncommon in women aged less than 45 years.

The NICE guideline provides a useful new definition of heavy menstrual bleeding based on impact on quality of life rather than measured blood loss:

*'Heavy menstrual bleeding should be defined as excessive menstrual blood loss which interferes with the woman's physical, emotional, social, and material quality of life, and which can occur alone or in combination with other symptoms. Any interventions should aim to improve quality of life measures.'*⁵

The implication of this new definition is that clinicians should focus primarily on assessing the impact on daily life, rather than on notions around assessing volume of loss. Focusing on the impact of heavy menstrual bleeding addresses patients' concerns and should lead to more patient-centred care. The NICE guideline dealt only with heavy menstrual bleeding rather than other menstrual symptoms (such as menstrual

pain). However, the full guideline alludes to the importance of other menstrual symptoms and, as discussed above, there is evidence that other symptoms have a powerful influence on the degree of impact of periods on daily life. Concentrating on all menstrual symptoms rather than heavy menstrual bleeding alone should lead to more effective management of menstrual problems through choosing treatments that address menstrual comorbidity (such as non-steroidal anti-inflammatory drugs [NSAIDs] for pain). This shift in emphasis marks an important step forward in the care of heavy menstrual bleeding.

The NICE guideline also highlights other recent developments. There is strong evidence for the effectiveness of the levonorgestrel-releasing intrauterine system, such as Mirena® (Schering–Health), in reducing volume of menstrual bleeding and improving quality of life.¹² Accordingly, the NICE guideline ranks treatments, suggesting that the levonorgestrel-releasing intrauterine system should be considered first, followed by tranexamic acid, NSAIDs, or combined oral contraceptives. The NICE guideline is right to highlight the importance of the levonorgestrel-releasing intrauterine system, which is probably under-used in the UK at present and which is not available in all general practices. A numbered ranking system may add clarity to the guideline and aid construction of algorithms, for instance in local guidelines. However, such a ranking system seems surprising in a condition where choice between treatments is clearly related to a number of complex issues including contraceptive preferences, attitudes to pill-taking compared to insertion of a device, attitudes to hormonal treatments, and presence of other menstrual symptoms. From an evidence perspective it is also a little surprising, given that, as yet, there is no published comparison of quality of life or patient satisfaction between levonorgestrel-releasing intrauterine system versus tranexamic acid.

The role of levonorgestrel-releasing intrauterine system as an alternative to surgery for heavy menstrual bleeding, the emphasis on quality of life, and the recognition of the importance of other menstrual symptoms mean there is a strong imperative to ensure that patients fully understand the different treatment options. It

has been shown that, among women referred to secondary care, provision of information followed by a structured interview to clarify preferences was associated with a lower subsequent rate of surgery and improved satisfaction when compared with those offered information alone or usual care.¹³ In primary care, a decision aid has been shown to improve menorrhagia-specific quality of life and reduce decisional conflict about treatments.¹⁴ The provision and discussion of information regarding treatment options is an important challenge that should be taken up in primary care.

The NICE guideline makes some subtle, but significant, changes in recommendations regarding the assessment of heavy menstrual bleeding, compared with previous guidelines.⁶ In doing so they acknowledge that they are basing their recommendations on guideline development group discussions as more evidence is needed regarding which element of history, examination, and investigations are most relevant for women reporting heavy menstrual bleeding. The guideline states that treatment for heavy menstrual bleeding (except levonorgestrel-releasing intrauterine system) may commence without physical examination if there is no history of intermenstrual bleeding, postcoital bleeding, pelvic pain, or pressure symptoms. A full blood count is still recommended for all women complaining of heavy menstrual bleeding. Treatment failure in women aged 45 years or over is an indication for further investigation, but not necessarily among younger women. Previous guidelines recommended bimanual examination for all women presenting with heavy menstrual bleeding and further investigation in all women with treatment failure. These recommendations potentially mean that some treatments can be commenced without bimanual examination, which may have formed a barrier to treatment in some practices where female practitioners or chaperones were less available. In addition, further investigations will focus on those more likely to have underlying pathology.

Although more rational use of investigations, increased use of the levonorgestrel-releasing intrauterine system, and greater provision of information may all have a positive impact on care, a shift in

emphasis away from measured blood loss and towards quality of life may be even more important in improving the management of heavy menstrual bleeding. This means that, as well as excluding serious disease, we will be assessing and treating the symptoms that really matter to our patients.

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REFERENCES

1. Coulter A, McPherson K, Vessey M. Do British women undergo too many or too few hysterectomies? *Soc Sci Med* 1988; **27**: 987–994.
2. Lethaby A, Farquhar C. Treatments for heavy menstrual bleeding. *BMJ* 2003; **327**: 1243–1244.
3. Grant C, Gallier L, Fahey T, et al. Management of menorrhagia in primary care — impact of referral and hysterectomy: data from the Somerset Morbidity Project. *J Epidemiol Community Health* 2000; **54**(9): 709–713.
4. O'Flynn N, Britten N. Menorrhagia in general practice — disease or illness? *Soc Sci Med* 2000; **50**(5): 651–661.
5. National Institute for Health and Clinical Excellence. *Heavy menstrual bleeding*. Clinical guideline 44. London: NICE, 2007.
6. Royal College of Obstetricians & Gynaecologists. *The initial management of menorrhagia*. Evidence-based clinical guidelines 1. London: RCOG, 1998.
7. Fraser IS, McCarron G, Markham R. A preliminary study of factors influencing perception of menstrual blood loss volume. *Am J Obstet Gynecol* 1984; **149**: 788–793.
8. Shapley M, Jordan K, Croft PR. Increased vaginal bleeding and psychological distress: a longitudinal study of their relationship in the community. *BJOG* 2003; **110**: 548–554.
9. Warner P, Critchley HOD, Lumsden M-A. Menorrhagia II: is the 80ml blood loss criterion useful in the management of complaint of menorrhagia? *Am J Obstet Gynecol* 2004; **190**: 1224–1229.
10. O'Flynn. Menstrual symptoms: the importance of social factors in women's experience. *Br J Gen Pract* 2006; **56**(533): 950–957.
11. Santer M, Wyke S, Warner P. What aspects of periods are most bothersome for women reporting heavy menstrual bleeding? Community survey and qualitative study. *BMC Womens Health* 2007; **7**: 8.
12. Hurskainen R, Teperi J, Rissanen P, et al. Quality of life and cost-effectiveness of levonorgestrel-releasing intrauterine system versus hysterectomy for treatment of menorrhagia: a randomised trial. [comment]. *Lancet* 2001; **357**(9252): 273–277.
13. Kennedy AD, Sculpher MJ, Coulter A, et al. Effects of decision aids for menorrhagia on treatment choices, health outcomes, and costs: a randomized controlled trial. *JAMA* 2002; **288**(21): 2701–2708.
14. Protheroe J, Bower P, Chew-Graham C, et al. Effectiveness of a computerized decision aid in primary care on decision making and quality of life in menorrhagia: results of the MENTIP randomized controlled trial. *Med Decis Making* 2007; **27**(5): 575–584.

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