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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.12 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.1 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.1 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.2 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.1 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.12 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.12 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.3,11 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.’

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
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


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152
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