



OFFICIAL

OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Menstrual bleeding: Heavy

Scope (Staff): WNHS Obstetrics and Gynaecology Directorate staff

Scope (Area): Gynaecology clinical areas at KEMH and OPH

This document should be read in conjunction with this [Disclaimer](#)

Aim

To provide guidance on the investigation and management of patients presenting to the Women and Newborn Health Service (WNHS) with heavy menstrual bleeding (HMB), in both the acute and outpatient settings.

Definition of heavy menstrual bleeding

The Australian Commission on Safety and Quality in Health Care (ACSQHC) Heavy Menstrual Bleeding Clinical Care Standard (2024) defines heavy menstrual bleeding as 'excessive menstrual blood loss which interferes with the woman's physical, social, emotional, and/or material quality of life, and which can occur alone or in combination with other symptoms'¹.

Background

Heavy menstrual bleeding is a common condition, affecting up to 25% of Australian women of reproductive age. Many women with heavy menstrual bleeding consider their experience normal, and it is estimated that around 50% do not seek medical care despite the substantial and sometimes debilitating impact on their daily life¹.

Whilst these symptoms tend not to be life threatening, they are frequently life altering. Heavy menstrual bleeding is a major cause of iron deficiency anaemia, cognitive impairment, work productivity, family and social life. Evidence suggests iron deficiency, even in early pregnancy, may adversely impact fetal neurodevelopment². Collectively, these circumstances make HMB in the reproductive years an important but often overlooked health issue with insidious impact on world economies.

Therefore, early recognition and prompt treatment are essential¹. Many women with heavy menstrual bleeding consider their experience normal¹, therefore their experience and impact on quality of life (QOL) ultimately determines the degree to which intervention may be required.



HMB Clinical Care Standard

WNHS endorses the Australian Commission on Safety and Quality in Health Care (ACSQHC) Heavy Menstrual Bleeding Clinical Care Standard (2024).

This document includes eight quality statements describing the expected standard for key components of care (update reference). The statements and related indicators are listed below. Details on these statements and other resources can be accessed through (hyperlink to updated reference)

Quality statement - 1 Assessment and diagnosis

The initial assessment of a woman presenting with heavy menstrual bleeding includes a thorough history, assessment of impact on quality of life, a physical examination (where clinically appropriate), and exclusion of pregnancy, iron deficiency and anaemia. Further investigations are based on the initial assessment.

Indicator 1a: Proportion of patients with heavy menstrual bleeding who were tested for iron deficiency and anaemia.

Quality statement 2 - Informed choice and shared decision making

A woman with heavy menstrual bleeding is informed about her treatment options and their potential benefits and risks. She is supported to participate in shared decision making based on her preferences, priorities and clinical situation.

Quality statement 3 - Initiating medical management

A woman presenting with heavy menstrual bleeding is offered medical management, taking into account evidence-based guidelines, her individual needs and preferences and any associated symptoms. Oral treatment is offered at first presentation when clinically appropriate, including when a woman is undergoing further investigation or waiting for other treatment.

Indicator 3a: Proportion of patients with heavy menstrual bleeding who were offered medical management at their first presentation.

Quality statement 4 - Quality ultrasound

When a woman requires an ultrasound to investigate the cause of her heavy menstrual bleeding, she is offered a pelvic (preferably transvaginal) ultrasound, which assesses all pelvic structures, including the uterus and endometrium, and is ideally performed in days 5–10 of her menstrual cycle.

Indicator 4a: Evidence of local arrangements to support appropriate referral for investigative pelvic ultrasounds for heavy menstrual bleeding. **Indicator 4b:** Evidence of local arrangements for conducting investigative pelvic ultrasounds for heavy menstrual bleeding.

Quality statement 5 - Intrauterine hormonal devices

When medical management options are being considered, a woman is offered a 52 mg levonorgestrel-releasing intrauterine device if clinically appropriate, as it is currently the most effective medical option for managing heavy menstrual bleeding.

Indicator 5a: Proportion of patients with heavy menstrual bleeding deemed clinically suitable for a 52 mg levonorgestrel-releasing intrauterine device (IUD), who had one inserted or were referred to another clinician for insertion.

Quality statement 6 - Specialist referral

A woman with heavy menstrual bleeding is referred for early specialist review when there is a suspicion of malignancy or other significant pathology based on clinical assessment or ultrasound. Referral is also offered to a woman who has not responded to medical management.

Indicator 6a: Evidence of protocols or pathways to ensure timely and appropriate referral of patients with heavy menstrual bleeding.

Quality statement 7 - Uterine-preserving alternatives to hysterectomy

A woman who has heavy menstrual bleeding of benign causes and who is considering non-medical management is offered uterine-preserving procedures that may be suitable (such as endometrial ablation, uterine artery embolisation or surgical removal of local pathology). She is supported to make an informed decision and is referred appropriately.

Indicator 7a: Proportion of patients with heavy menstrual bleeding of benign cause(s) who received uterine-preserving procedural alternatives to hysterectomy.

Quality statement 8 - Hysterectomy

Hysterectomy for management of heavy menstrual bleeding is considered when other treatment options are ineffective or are unsuitable, or at the woman's request. A woman considering a hysterectomy is fully informed about the potential benefits and risks of the procedure before making a decision.

Indicator 9a: Hospital rate of hysterectomy per 100 episodes.

WNHS is a Level 5/6 Obstetrics and Gynaecology hospital.

Some of the standards may not necessarily be relevant to patients attending this hospital.

Components of care relevant to this hospital are outlined below.

When to consider gynaecology outpatient clinic referral +/- endometrial sampling

1. Persistent intermenstrual or irregular bleeding
2. Age >40 years plus HMB of recent onset, persistent intermenstrual bleeding (IMB) or change in frequency/duration of bleeding
3. Poor response to initial hormonal treatment or failure of conservative management
4. Severe iron deficiency anaemia
5. Bleeding has significant impact on quality of life (QOL)
6. Risk factors for endometrial hyperplasia e.g., tamoxifen, unopposed oestrogen (obesity, anovulation, polycystic ovarian syndrome (PCOS), diabetes), nulliparity, subfertility
7. Family history suggestive of Lynch syndrome
8. Personal history of breast or gynaecological cancer
9. Abnormal imaging, especially structural anomaly e.g., Leiomyoma, polyps, congenital abnormalities
10. If sampling required, consider suitability for:
 - a. Pipelle endometrial biopsy
 - i. Emergency department or clinic
 - b. Hysteroscopy, dilatation and curettage
 - i. Outpatient: eReferral to Outpatient Hysteroscopy Clinic
 - ii. Inpatient: under general anaesthetic (GA) on emergency or elective list, depending on acuity
11. Patient desire for surgical management

Ensure outpatient pelvic ultrasound (USS) booked (Transvaginal TV USS, day 5-10 of cycle) whilst awaiting appointment.

Medical and surgical management of HMB

Consider:

- Patient preference
- Comorbidities and contraindications
- The presence or absence of pathology e.g., leiomyoma (size, number, location), polyps or adenomyosis
- Impact on QOL

Non-hormonal

Non-steroidal anti-inflammatory drug (NSAIDs)

Mechanism of action	Anti-prostaglandin: inhibition of cyclooxygenase
Dose	Mefenamic acid 500 mg TDS PO Ibuprofen 400 mg TDS PO
Reduction in flow	20-40%
Benefits	Improve dysmenorrhea Use in conjunction with tranexamic acid (TXA) as first line
Contraceptive	No
Issues	Better for regular cycles (won't regulate)
Side effects	Indigestion, diarrhoea, peptic ulcer disease, exacerbation of asthma

Tranexamic acid

Mechanism of action	Anti-fibrinolytic
Dose	1 g QID PO x 5 days during menses
Reduction in flow	40-60%
Benefits	Good first line option Few contraindications
Contraceptive	No
Issues	Better for regular cycles (won't regulate)
Side effects	Minimal: indigestion, diarrhoea, headaches
Concerns	Thrombosis / deep vein thrombosis (DVT): No increase in risk in VTE ³

Hormonal**Levonorgestrel-releasing intrauterine system (LNG-IUS)**

Mechanism of action	Prevention of endometrial proliferation
Dose	Levonorgestrel 52 mg / 8 years (20mcg/24 hours)
Reduction in flow	>80% 3 months >90% 6 months >96% 12 months
Benefits	Most effective medical option 85% patient satisfaction + 30% amenorrhoea at 12 months 5 years, cheap Improvement in dysmenorrhoea
Contraceptive	Yes, LARC, >99.95%
Issues	3-6/12 unscheduled bleeding May not be able to place if cavity distortion Risk infection at time of insertion, expulsion <5% Complications of insertion: perforation, incorrectly positioned Potential requirement for GA
Side effects	Same as oral progestins however actions are local therefore progestogenic side effects limited Avoids 1st pass metabolism
Contraindication / caution	Pregnancy, unexplained vaginal bleeding, active pelvic infection, congenital uterine abnormality or significant distortion of pelvic cavity

Combined oral contraceptive pill (COCP)

Mechanism of action	Endometrial stabilisation + suppression of ovulation
Dose	20–35 microg ethinylestradiol plus progestogen PO daily
Reduction in flow	50%
Benefits	Cycle regulation/control, can 'tricycle' Reduces dysmenorrhea Reduced risk ovarian/endometrial cancer
Contraceptive	Yes
Side effects	Mood, headache, nausea, fluid retention, breast tenderness
Concerns	Risks venous thromboembolism (VTE), cerebrovascular accident (CVA), cardiovascular disease, liver and gall bladder disease Awareness of contra-indications

Oral progestins

Mechanism of action	Limits endometrial inflammation and endometrial atrophy Prevents menstruation
Dose	Medroxyprogesterone acetate: up to 10 mg TDS days 5-26 (21 days) or continuous Norethisterone acetate: 5 mg TDS days 5-26 (21 days) or continuous Drospirenone (Slinda): 4 mg daily
Reduction in flow	Up to 83%
Benefits	Cycle regulation No oestrogen, beneficial if cardiovascular disease or other risk factors
Contraceptive	MPA/norethisterone- non contraceptive Slinda- contraceptive
Side effects	Depression, acne, headache, weight gain, breast tenderness ² Usually short term use only as a result
Issues	Compliance required Minipill not recommended, amenorrhoea 20%, Abnormal Uterine Bleeding 80%

Etonogestrel implant (Implanon)

Dose	Etonogestrel 68 mg subdermal implant/3 years
Reduction in flow	30% no change 30% amenorrhoea 30% irregular bleeding
Benefits	Convenient, inexpensive Dysmenorrhoea: 77% report improvement Rapid return to fertility on cessation
Contraceptive	Yes, long-acting reversible contraceptive (LARC) >99.95%
Issues	Irregular bleeding: 11.3% of women discontinue use as a result Frequent bleeding 6.7% Prolonged bleeding 17.7%
Side effects	Same as oral progestins
Issues	Deep insertion- difficult removal

Depot medroxyprogesterone (Depo-Provera)

Mechanism of action	Inhibition of FSH from the anterior pituitary, inhibition of ovarian follicle development, ovulation and menstruation
Dose	Depot medroxyprogesterone acetate 150mg/3 months
Reduction in flow	50% amenorrhoea 15% lighter
Benefits	Improvement in dysmenorrhoea
Contraceptive	Yes, LARC, >99.95%
Issues	Heavier or irregular bleeding in 30% Delayed return to fertility up to 18 months
Side effects	Same as oral progestins, often limit ongoing use
Concerns	Reduced E2 therefore reduced bone mineral density long term use # rate 9.1 vs 7.3 per 1000 person-years compared to non-users

GnRH analogues

Mechanism of action	Suppression of gonadotrophins, induction of hypogonadotrophic hypogonadism
Dose	Goserelin acetate 3.6 mg (monthly) or 10.8 mg (3 monthly) subcutaneous implant
Benefits	Reliably induce amenorrhoea Reduction leiomyoma size up to 60%
Concerns	Reduction bone mineral density – consider add back oestrogen. Cost (non-PBS for fibroid indications)
Side effects	Initial flare Menopausal symptoms

Surgical

Second generation endometrial ablation

Mechanism of action	Destruction of endometrium, x3 layers including basalis
Benefits	Satisfaction rates high, range 77–96% (>90%) Reduction in flow up to 91% Amenorrhoea up to 70% (approximately 50%) Day surgery procedure QOL scores for women with HMB significant improvement
Additional benefits	Day procedure Avoid major surgery Rapid onset of action Does not require hormonal pre-treatment Recovery in 1–2 days Not indicated for dysmenorrhoea but 70% will notice a reduction
Issues	Contra-indicated if concern re: endometrial hyperplasia (EH) /malignancy, difficulty in sampling Need for permanent contraception Unsuitable if desire for fertility Surgical procedure, risk of hysteroscopic/minimally invasive surgery, GA etc. Irreversible Resumption of menses: average time 7 years If resume: pain related obstructed menses Re-intervention rate: 5% at 5 years, 10% at 10 years

Hysterectomy

Mechanism of action	Removal of uterus
Benefits	100% cessation of menses 90% satisfaction Majority laparoscopic 1-2 night admission
Issues	Involves 'major' surgery Risk of surgical and anaesthetic complications Requirement for GA 'Down time' 2-4 weeks Irreversible, loss of fertility

Consider suitability for hormone therapy

See [The Faculty of Sexual and Reproductive Healthcare UKMEC Summary](#)

Management where specific pathology is present:

Endometrial pathology e.g. polyps, submucosal leiomyoma	Hysteroscopy dilatation and curettage (D&C) + MyoSure excision
Leiomyoma	Surgery (hysterectomy/myomectomy)- see relevant Clinical Guidelines : Myomectomy
	Uterine artery embolisation
	MRgFUS (not currently available in Western Australia)
Adenomyosis	Hormone therapy Surgery (hysterectomy)
Endometrial hyperplasia	LNG-IUS vs hysterectomy Histopathology may warrant gynae-oncology referral (if 'atypia')
Malignancy	Gynae-oncology referral
Coagulopathy	Haematology input
Ovulatory dysfunction e.g., anovulatory cycles, PCOS, menarche, perimenopause, thyroid disorder	Hormone therapy
Endometrial Regular, cyclical, heavy bleeding with no identifiable cause. May represent a primary endometrial disorder. Diagnosis of	Diagnosis of exclusion

exclusion. e.g., deficiencies in local production of vasoconstrictors, excessive production of plasminogen activators or increased local production of substances that promote vasodilation such as PGE2	
Iatrogenic e.g. Hormones, anticoagulants, anticonvulsants, dopamine antagonists	Cessation
Not otherwise classified e.g. uterine arteriovenous malformation, isthmocoele	

Emergency management of HMB

1. If meets criteria: activate code blue medical dial '55' + request Consultant or Senior Registrar presence
2. Stabilise patient: Danger, response, airway, breathing, circulation (DRABC); insert 1-2 large bore intravenous catheters (IVC)
3. Intravenous (IV) fluid resuscitation
4. Keep nil by mouth
5. Assess rate and visible cause of bleeding via speculum examination
 - Vaginal/cervical trauma or abnormality, prolapsed leiomyoma/polyp, products of conception (POC)
 - Consider endometrial pipelle sample if suitable
6. Investigations
 - Urinary β HCG
 - Full blood count (FBC), Quantitative β HCG, group and hold and cross match
 - Coagulation profile, ROTEM, von Willebrand's screening if clinically indicated
7. Commence tranexamic acid (TXA) 1g PO QID x 5 days PLUS high dose oral progesterone
 - Consider 1g TXA IV stat PLUS
 - Medroxyprogesterone acetate 10-20mg daily/BD/TDS PO OR
 - Norethisterone 5-10mg daily/BD/TDS PO
8. Consider admission, may require iron or blood transfusion
9. Urgent pelvic USS if suitable
10. Consider indwelling catheter (IDC)

11. If unable to control bleeding may need to consider transfer to theatre for examination under anaesthesia +/- treatment of pathology (e.g., polyp, prolapsed leiomyoma)
12. If evidence of coagulopathy: contact on-call Consultant Haematologist
13. Withhold anticoagulation

Suggested indicators for local monitoring

Refer to [indicators \(external site\)](#) linked to this Clinical Care Standard from the Australian Institute of Health and Welfare: Metadata Online Registry (METeOR).

Abbreviations

CI	Contraindicated
COC	Combined oral contraceptive pill
CVA	Cerebrovascular accident
D&C	Dilatation and curettage
EH	Endometrial hyperplasia
FBC	Full blood count
GA	General anaesthetic
GnRH	Gonadotropin-releasing hormone
HMB	Heavy menstrual bleeding
IDC	Indwelling catheter
IMB	Intermenstrual bleeding
IUD	Intra uterine device
IVC	Intravenous catheters
PCOS	Polycystic ovary syndrome
POC	Products of conception
TV	Transvaginal
QOL	Quality of life
USS	Ultrasound scan
VTE	Venous thromboembolism

References

1. Australian Commission on Safety and Quality in Health Care. Heavy Menstrual Bleeding Clinical Care Standard. Sydney: ACSQHC; 2024.
2. Munro, M.G, Mast, A.E., Powers, J.M., Kouides, P.A., O'Brien, S.H., Richards, T., Lavin, M., and Levy, B.S. (2023). *The relationship between heavy menstrual bleeding, iron deficiency, and iron deficiency anemia*. American Journal of Obstetrics & Gynaecology, 229 (1), 1-9. DOI: [10.1016/j.ajog.2023.01.017](https://doi.org/10.1016/j.ajog.2023.01.017)
3. Shakur, Haleema et al. WOMAN trial: Effect of early tranexamic acid administration on mortality, hysterectomy, and other morbidities in women with post-partum haemorrhage (WOMAN): an international, randomised, double-blind, placebo-controlled trial, The Lancet, 2017. Volume 389, Issue 10084, 2105 – 211.

Bibliography

- American College of Obstetricians and Gynecologists (2013 - reaffirmed 2024). Committee Opinion, No. 557. Management of Acute Abnormal Uterine Bleeding in Nonpregnant Reproductive-Aged Women. 121, 891-6. ISSN: 1074-861X.
- Fraser IS, Critchley HO, Broder M, Munro MG. (2011). *The FIGO recommendations on terminologies and definitions for normal and abnormal uterine bleeding*. Semin Reprod Med, 29 (5), 383-90. DOI: [10.1055/s-0031-1287662](https://doi.org/10.1055/s-0031-1287662)
- Munro MG, Critchley HO, Broder MS, Fraser IS, for the FIGO Working Group on Menstrual Disorders. FIGO classification system (PALM-COEIN) for causes of abnormal uterine bleeding in nongravid women of reproductive age. International Journal of Gynecology & Obstetrics, 2011. 113: 3-13. <https://doi.org/10.1016/j.ijgo.2010.11.011>
- Munro MG, Critchley HO, Fraser IS; FIGO Menstrual Disorders Working Group. The FIGO classification of causes of abnormal uterine bleeding in the reproductive years. Fertil Steril. 2011 Jun;95(7):2204-8, 2208.e1-3. doi: 10.1016/j.fertnstert.2011.03.079. Epub 2011 Apr 15. PMID: 2149680.
- National Institute for Health and Care Excellence. Heavy menstrual bleeding: Assessment and management. Clinical guideline (update). London, UK: NICE, 2016. Search PubMed.

Useful resources

- [Fact sheet for clinicians - Heavy Menstrual Bleeding Clinical Care Standard \(2024\)](#)
- [Presentation - Heavy Menstrual Bleeding Clinical Care Standard - Slide pack for local delivery 2024](#)

Keywords:	Heavy bleeding, menstrual bleeding, hysterectomy, clinical care standard		
Document owner:	Obstetrics and Gynaecology Directorate		
Author / Reviewer:	WNHS Head of Department Gynaecology		
Date first issued:	March 2019(v1)	Version:	3
Reviewed dates:	April 2022(v2); May 2025(v3)	Next review date:	May 2028

Endorsed by:	Gynaecology, Perioperative and Anaesthetics Clinical Practice and Outcomes Committee	Date:	15/05/2025
NSQHS Standards (v2) applicable:	☒  1: Clinical Governance ☒  2: Partnering with Consumers ☐  3: Preventing and Controlling Healthcare Associated Infection ☒  4: Medication Safety	☒  5: Comprehensive Care ☒  6: Communicating for Safety ☐  7: Blood Management ☐  8: Recognising and Responding to Acute Deterioration	
Printed or personally saved electronic copies of this document are considered uncontrolled. Access the current version from WNHS HealthPoint.			

Version history

Version number	Date	Summary
1	Mar 2019	First version
2	Apr 2022	Evidence on this topic was reviewed and overall guidance remains unchanged. Minor changes and formatting have been made.
3	May 2025	Review of content, with updated content added in alignment to updated Clinical Care Standard, including medical and surgical management of HMB with revised references.

This document can be made available in alternative formats on request for a person with a disability.

© North Metropolitan Health Service 2025

Copyright to this material is vested in the State of Western Australia unless otherwise indicated. Apart from any fair dealing for the purposes of private study, research, criticism or review, as permitted under the provisions of the *Copyright Act 1968*, no part may be reproduced or re-used for any purposes whatsoever without written permission of the State of Western Australia.

www.nmhs.health.wa.gov.au