NHS
Coventry and Warwickshire
Integrated Care Board

Hysterectomy for Menorrhagia Policy

Reference Number:	This will be applied to all new ICB-wide PPSs by the Governance and Corporate Affairs Team and will be retained throughout its life span.
Version:	Version 1.0
Name of responsible Committee and date approved or recommended to Integrated Care Board Board:	Audit Committee
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Department:	Corporate Office

VERSION HISTORY

Date	Version	Changes made to previous version	Consulting and Endorsing Stakeholders, Committees / Meetings / Forums etc.

Treatment	Hysterectomy for Menorrhagia
Indication	Heavy Menstrual Bleeding (HMB)
Background	It is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices. Hysterectomy should be considered **ONLY** when: other treatment options have failed, are contradicted; there is a wish for amenorrhoea (no periods); the woman (who has been counselled) requests it; the woman no longer wishes to retain her uterus and fertility.

Treatment:	**NICE Guideline NG88**
	
	1.5 Management of HMB
	
	1.5.1 When agreeing treatment options for HMB with women, take into account:
	• the woman's preferences;
	• any comorbidities;
	• the presence or absence of fibroids (including size, number and location), polyps, endometrial pathology or adenomyosis;
	• other symptoms such as pressure and pain.
	
	Treatments for women with no identified pathology, fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis
	
	1.5.2 Consider an LNG-IUS (levonorgestrel-releasing intrauterine system) as the first treatment for HMB in women with:
	• no identified pathology; OR
	• fibroids less than 3cm in diameter, which are not causing distortion of the uterine cavity; OR
	• suspected or diagnosed adenomyosis.
	
	1.5.3 If a woman with HMB declines an LNG-IUS or it is not suitable, consider the following pharmacological treatments:
	• non-hormonal:
	  o tranexamic acid
	  o NSAIDs (non-steroidal anti-inflammatory drugs), hormonal: combined hormonal contraception, cyclical oral progestogens.
	
	1.5.4 Be aware that progestogen-only contraception may suppress menstruation, which could be beneficial to women with HMB.
	
	1.5.5 If treatment is unsuccessful, the woman declines pharmacological treatment, or symptoms are severe, consider referral to specialist care for:
	• investigations to diagnose the cause of HMB, if needed, taking into account any investigations the woman has already had; AND
	• alternative treatment choices, including:
	  o pharmacological options not already tried (see recommendations 1.5.2 and 1.5.3)
	  o surgical options:
	  ▪ second-generation endometrial ablation
	  ▪ hysterectomy.
	
	1.5.6 For women with submucosal fibroids, consider hysteroscopic removal.
	
	Treatments for women with fibroids of 3cm or more in diameter
	
	1.5.7 Consider referring women to specialist care to undertake additional investigations and discuss treatment options for fibroids of 3 cm or more in diameter.
	
	1.5.8 If pharmacological treatment is needed while investigations and definitive treatment are being organised, offer tranexamic acid and/or NSAIDs.

	1.5.9 Advise women to continue using NSAIDs and/or tranexamic acid for as long as they are found to be beneficial.
	
	1.5.10 For women with fibroids of 3 cm or more in diameter, take into account the size, location and number of fibroids, and the severity of the symptoms and consider the following treatments:
	• pharmacological:
	  ○ non-hormonal:
	  ▪ tranexamic acid
	  ▪ NSAIDs
	  ○ hormonal:
	  ▪ LNG-IUS
	  ▪ combined hormonal contraception
	  ▪ cyclical oral progestogens
	  ○ uterine artery embolization
	  ○ surgical:
	  ▪ myomectomy
	  ▪ hysterectomy.
	
	1.5.12 Be aware that the effectiveness of pharmacological treatments for HMB may be limited in women with fibroids that are substantially greater than 3 cm in diameter.
	
	1.5.13 Prior to scheduling of uterine artery embolisation or myomectomy, the woman's uterus and fibroid(s) should be assessed by ultrasound. If further information about fibroid position, size, number and vascularity is needed, MRI should be considered. [2007]
	
	1.5.14 Consider second-generation endometrial ablation as a treatment option for women with HMB and fibroids of 3 cm or more in diameter who meet the criteria specified in the manufacturers' instructions.
	
	1.5.15 If treatment is unsuccessful:
	• consider further investigations to reassess the cause of HMB, taking into account the results of previous investigations; AND
	• offer alternative treatment with a choice of the options described in recommendation 1.5.10.
	
	1.5.16 Pre-treatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus.
	
	Prior approval from the Integrated Care Board will be required before any treatment proceeds in secondary care unless an alternative contract arrangement has been agreed with the ICB that does not necessitate the requirement of prior approval before treatment.

Diagnostic and Procedure Codes	Q072, Q074, Q075, Q078, Q079, Q081, Q082, Q083, Q088, Q089
Equality Impact	https://www.england.nhs.uk/evidence-based-interventions/