BLEEDING NUISANCE

Treatment Choices For Heavy Menstrual Periods

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Treatment choices for heavy menstrual periods

CONTENTS

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Information and Preferences in Menorrhagia

This booklet accompanies a video in which a number of patients talk about their experiences of treatment for menorrhagia. The information in the video and booklet is drawn from a systematic review of clinical trials and other scientific research into this condition. For further information about the research evidence on which this is based, see *Effective Health Care* vol. 1, no. 9, The Management of Menorrhagia, Universities of Leeds and York, August 1995 (available from the subscriptions department, Pearson Professional, PO Box 77, Fourth Avenue, Harlow CM19 5BQ. Tel: 01279 623924).

The video was produced and directed by Serena Macbeth of Boxclever Productions.

This booklet was written by Dr Angela Coulter on behalf of the study team. Other members include Dr Nuala Dwyer, Sue Horsley, Dr Margaret Rees, Mark Sculpher, Prof Gordon Stirrat, Dr Simon Wallace.

Introduction

You have consulted your doctor because you are suffering from heavy periods. Don't worry, you are not alone. Many women experience this problem and a lot of them ask their doctors for advice. Heavy periods are one of the most common reasons why GPs refer women to gynaecologists.

Since there are a number of possible treatments for this problem – including drugs as well as surgery – and none is superior in all respects, it is important that doctors take account of women's views before deciding on any one in particular. It may not even be necessary for you to have any treatment. Your preference is very important in choosing the best course of action.

This booklet summarises the benefits and harms of each of the options so you can make an informed choice in consultation with your doctor.

It is hard to avoid using technical terms when discussing this problem, but we have tried to explain medical words as we go along. There is also a list at the end with definitions of the terms you are likely to come across.

The booklet is for use with the video, so we have colour-coded each chapter to correspond to the colours used in each part of the video. This way you can review a particular section by rewinding or 'fast-forwarding' the video and turning to the linked chapter in the booklet. We hope you will find it easy to use.

We have left some space at the end of the booklet for you to jot down your thoughts about the different choices open to you. It may help to make some notes before you go to see the doctor again, to remind yourself about the main points you want to discuss.

Even with a video and a booklet, we cannot hope to answer all the questions you may have. Don't hesitate to ask your doctor about anything that is worrying you.

CHAPTER

1

Menorrhagia and its causes

What are heavy periods?

Heavy periods can be very distressing. They can affect all aspects of your life – your energy levels, your work life, your social life, your sex life and your emotions. If you also suffer from other menstrual symptoms such as pain, bloating, breast tenderness, mood changes and headaches, you can feel miserable at that time of the month. If your menstrual periods are causing you problems, it makes sense to ask your doctor for advice.

Menorrhagia is a medical term meaning heavy *regular* menstrual bleeding. Doctors often use the word menorrhagia to describe the problem of heavy periods, whether or not the periods are regular. It is a term used to describe your symptoms and not a diagnosis. As we shall see, diagnosing the cause of the problem is often quite difficult.

On average women lose about 35ml of blood per menstrual period, but about one in ten women lose more than 80ml. A blood loss of more than 80ml per period is what doctors call menorrhagia. 80 ml is equivalent to less than half a cupful so it is not a huge amount, but it can cause considerable discomfort and embarrassment and may require frequent changes of pads and tampons.

Sometimes women losing this much blood suffer from **anaemia** (shortage of red blood cells usually due to lack of iron). This condition can make you feel very tired and lacking in energy.

Heavy periods are not usually a sign of a serious disease. You are unlucky if you suffer from this problem, but it does not mean your life is at risk. Some women suffer other kinds of menstrual problems: for example, periods that are very irregular or very painful, or bleeding between periods or after sexual intercourse. You should tell your doctor if you are having any of these problems.

Periods can vary greatly in length. Some women bleed for only two or three days per cycle, while others bleed for ten days or more.

Different women also experience different cycle lengths. Although 28

days is the average, the time between the beginning of one period and the beginning of the next can be as little as 15 days or as much as 50 days. Duration of periods and cycle length tend to change as you get older.

Menorrhagia is most common among women aged between 40 and 49, although some women suffer heavy periods when they are younger. Menstrual periods cease after the **menopause** (the 'change of life'), which occurs around the age of 50 in most women, although it can sometimes happen several years earlier or later.

You lose most menstrual blood on the second or third day of a period. Many women have occasional 'flooding', and it is fairly common to pass clots occasionally as well – these do not necessarily mean that your periods are abnormal.

Some women who complain of heavy menstrual bleeding may not actually have higher than average blood loss. Each woman has only her own experience of menstrual bleeding to go by in judging what is 'normal', and it is hard to know whether your periods are heavier than those experienced by other women. If your periods are causing you concern, it is a good idea to discuss this with your doctor.

How can I find out if my periods are abnormal?

Your doctor will probably ask you a number of questions to find out how heavy your periods are. These are some examples of the type of questions asked:

On average, how many days do your periods last? (duration)
More than 8 days would be considered quite long.

On average, how long is it between the first day of a period and the first day of your next period? (cycle length)
A cycle length of less than 18 days means that your periods come more frequently than most other women's.

Do you have flooding with your periods?
Many women with menorrhagia experience flooding in each period, which can lead to stained sheets, clothes and furniture.

Do you pass large clots with your periods?
Women with menorrhagia very often pass large clots on the heaviest days of their period (the size of a walnut). Small clots are quite normal.

Which form of sanitary protection do you use on the heaviest day of your period?
Women with menorrhagia often find that tampons on their own are not enough to contain the blood. Many have to use a combination of pads and tampons on the heaviest day.

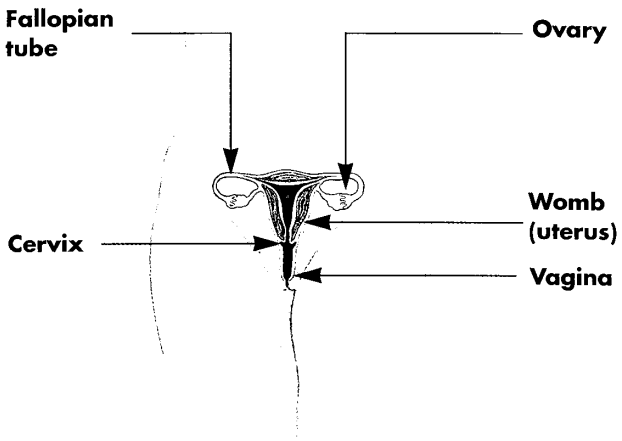
How many pads or tampons do you use on the heaviest day of your period, that is in 24 hours?
It is quite common for women with menorrhagia to get through between 10 and 20 pads or tampons on the heaviest day of their period.

What causes heavy periods?

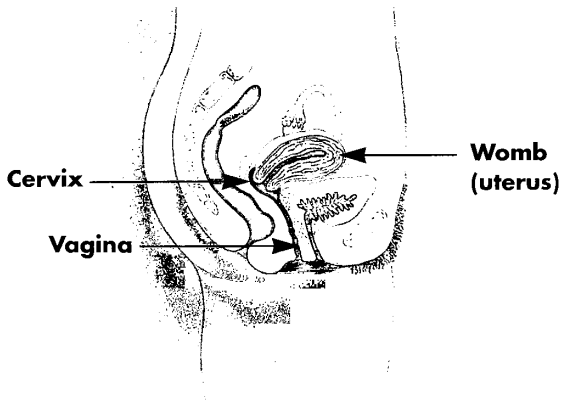
Before deciding about treatment, it is important to try to find out what is causing the problem. It is often difficult for doctors to determine the cause of heavy periods. Women differ in the amount of menstrual blood they lose, and it is not uncommon for the volume of blood loss to change over time. Sometimes your cycle length gets shorter as you get older, making your periods come more frequently. These changes may be quite noticeable, but they are not necessarily anything to worry about.

Doctors disagree on what causes heavy bleeding, but the most likely reason is changes in the blood vessels in the **uterus** (womb), which make blood flow more freely than normal.

THE NORMAL UTERUS



Front view



Side view

A woman's bleeding pattern can alter when she changes her method of contraception. Oral contraceptive pills usually cause lighter periods, which means that your periods are likely to get heavier if you come off the pill. Some types of IUDs (**intrauterine devices** or contraceptive coils) cause periods to become heavier.

Sometimes women with heavy bleeding have **fibroids** (benign growths of fibrous tissue) in their womb. These are *not* 'cancer'. Fibroids are very common – about two in three women probably have them – but most will be unaware of them because small ones cause no problems. Large fibroids can cause pain and they may cause heavy bleeding.

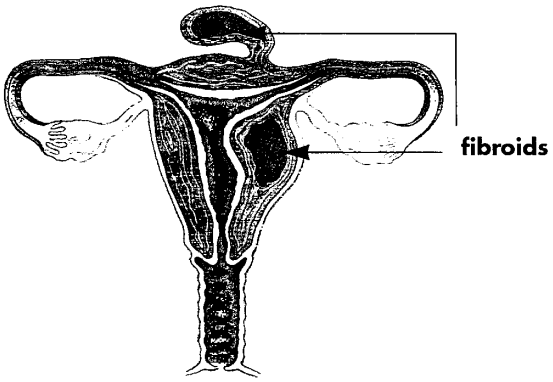
The **endometrium** is the tissue lining the womb. Occasionally, this can grow in the wrong places. **Endometriosis** (growth of endometrial tissue outside the womb) can cause pain and may sometimes be present in women who have heavy periods. Your doctor can tell you about the different treatments available for this problem.

Very occasionally the heavy bleeding may be due to an imbalance in **hormones**. Hormones are chemical substances which trigger **ovulation** (i.e. the release of eggs from the ovaries). If the hormones are not working properly, ovulation will not occur. Sometimes this causes heavy irregular bleeding. Most women with menorrhagia have normal patterns of ovulation.

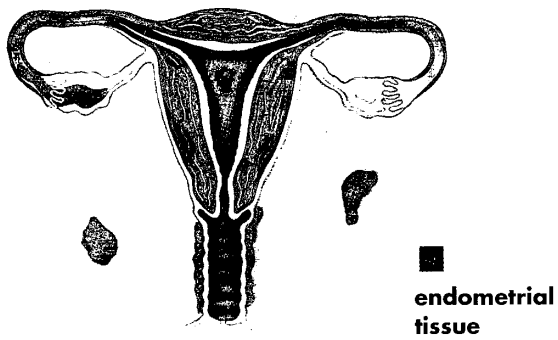
Cancer does not cause heavy menstrual bleeding and it is very rare for women with heavy periods to have cancer. However, your doctor may decide to do a test just to be on the safe side (see page 9).

If they cannot find an obvious cause of the heavy bleeding, doctors call it **dysfunctional uterine bleeding** or **idiopathic** (no known cause) **menorrhagia**.

UTERUS WITH FIBROIDS



ENDOMETRIOSIS



Endometriosis can affect the ovaries, the Fallopian tubes, the outside of the womb, the pelvic cavity, the bladder and the vagina.

Is it essential to have treatment for heavy periods?

Heavy menstrual bleeding is not life-threatening although it can have serious effects on your quality of life. Your menstrual periods will cease anyway at the menopause. Large **fibroids**, which may cause menorrhagia, often shrink after the menopause.

If you are not anaemic and not suffering too much pain, you may decide you don't want any treatment. Some women prefer to put up with the heavy periods until they stop naturally at the menopause.

A lot depends on your age and the extent to which you feel you can cope with the problem. You should discuss this with your doctor, but there is usually no reason for advising you to have treatment for heavy periods if you don't want it. Many women decide against treatment once they are reassured that there is nothing seriously wrong with them.

Even without treatment, some women find that their blood loss gets less heavy after a while. You may find it helps to change your diet or give up smoking. Ask your doctor for advice about how to make these important lifestyle changes.

If you decide against having treatment for the time being, there is no reason why you can't change your mind later. You certainly shouldn't rush into a decision that you may regret. Ask your doctor to give you time to think about it, if you're not sure. You can always consult your GP again if your condition gets worse or if you become worried for any reason.

CHAPTER

2

Investigations

Your doctor may want to do some tests to find out what is causing the heavy bleeding. If you have a clinic appointment, you should attend at the appointed time even if you are having a period, unless you have been told not to.

The tests might include:

- *physical examination* (including an internal examination);
- ***ultrasound*** (a scan, sometimes useful for detecting **fibroids**);
- *blood tests* (to test for **anaemia**);
- ***hysteroscopy:*** If you are over 40 or you have other symptoms such as **intermenstrual bleeding** (bleeding between periods) or **post-coital bleeding** (bleeding after sexual intercourse), you may need to have a special internal examination of your **endometrium** (lining of the womb). This is to see if the cause of the heavy bleeding can be detected and to make sure that there are no signs of abnormalities. The examination is done using a **hysteroscope** (a kind of camera), which allows the gynaecologist to see inside the womb. The hysteroscope will reveal any growths such as **fibroids**, **polyps** or abnormal thickening of the lining of the womb, which might be causing the problems. This test is normally done in the outpatients clinic, usually without anaesthetic.
- ***endometrial biopsy***: A small sample of the lining of the womb may be taken for analysis in the laboratory. This is done to check that there are no cancer-like cells in the womb. There are a number of ways of taking the sample. It is usually done in the outpatient clinic. The doctor inserts a narrow instrument through the vagina to collect the sample. It may be a bit uncomfortable, but it doesn't take long to do.
- ***dilatation and curettage*** (D&C): This is a scrape of the lining of the womb to check for cancerous cells or other abnormalities. D&C is another form of **endometrial biopsy**, but it is done using wider instruments. You need an anaesthetic with this procedure because the **cervix** (neck

of the womb) has to be dilated (stretched) to allow for the insertion of the instruments. It is not usually necessary for younger women (under 40) to have D&C.

- *menstrual blood loss measurement:* It is possible to measure the actual amount of blood lost. This involves collecting all the pads and tampons used and extracting the blood from them. It is usually only done in research studies. Most women will not have their blood loss measured in this way.

CHAPTER

3

The non-surgical or medical options

How effective are the drugs for heavy menstrual bleeding?

Most women who have problems with very heavy menstrual bleeding try a course of drug therapy first to see if it helps reduce the flow. There are a number of drugs available (see boxes on pages 12-15) and sometimes it is necessary to try more than one before finding the one that works best for you. You will need to try each one for a few cycles to allow it time to take effect. You will have to ask your GP for a prescription as these drugs are not available over the counter at the chemist. Choices include:

- *mefenamic acid (Ponstan)* – A fairly simple preparation (rather like aspirin) which causes few side-effects, if taken as prescribed. It has the added advantage of reducing menstrual pain. Trials have shown that mefenamic acid can reduce menstrual blood loss to about two-thirds of what it was before, but it does not work for everybody.
- *tranexamic acid (Cyklokapron)* – This seems to be more effective than mefenamic acid since it can halve the amount of blood lost, but the risk of minor side-effects is slightly higher. Again, this drug does not work for everybody.
- *oral contraceptive pill* – This can help to reduce the heaviness of periods, but should not be taken by women over 35 who smoke. A few women find the pill causes unacceptable side-effects.
- *other drugs* – There are a variety of hormonal drugs which are sometimes used. Danazol (Danol) is very effective but it can have fairly severe side-effects so it is not normally prescribed for long-term use. Norethisterone (Primolut) is often prescribed but it is not very effective for most women with menorrhagia unless high doses are used. Norethisterone can help to make periods more regular. There are a number of other drugs that are sometimes used to treat menorrhagia (see tables overleaf), and your doctor may recommend one of these.

- ***intrauterine devices*** – A new kind of medicated contraceptive coil (Mirena) which releases hormones has also been found to be very effective in reducing blood loss. Studies have shown that it can reduce bleeding by as much as 80 per cent.

Some of the drugs only have to be taken for a few days each month, while others are taken continuously. It is important to follow your doctor's advice on this. You need to make sure you know when to start taking the tablets and when to stop. This can be difficult if your periods are very long or if your cycle is so disrupted that you're not sure which is day one of the period. Ask your doctor if in doubt.

The boxes below summarise details of some of the most commonly used drugs. You should only take these if prescribed by your doctor. It is very important to follow your doctor's instructions about how and when to take them.

MEFENAMIC ACID: BRAND NAME – PONSTAN

Action:
Ponstan is a non-steroidal anti-inflammatory drug (NSAID) which can be used in the treatment of heavy periods.

Dose:
Ponstan comes in two strengths and you should ask your doctor for guidance on which dose best suits you. The drug should be started on the first day of excessive bleeding and taken as advised by your doctor.

Ponstan: Two 250mg capsules or tablets three times a day

Ponstan Forte: One 500mg tablet three times a day

Contra-indications:
Ponstan should not be taken if you have inflammatory bowel disease, suffer from stomach ulcers or have poor kidney or liver function.

Side-effects:
These are not common, but can include nausea, indigestion and diarrhoea. Any degree of worsening of asthma may be related to the use of NSAIDs. If you are at all concerned, then contact your doctor for further advice.

Other NSAIDS:
Drugs of the same type which are sometimes prescribed for menorrhagia include ibuprofen and naproxen. They are similar to Ponstan and the contra-indications and possible side-effects are the same. Dosages will be different, though, so you should follow your doctor's instructions about how, and when, to take them.

TRANEXAMIC ACID: BRAND NAME – CYKLOKAPRON

Action:
Cyklokapron is an anti-fibrinolytic drug that can be used in the treatment of heavy periods. It should be taken only after heavy bleeding has started.

Dose:
Two to three 500mg tablets three to four times daily for three to four days.

Contra-indications:
Cyklokapron should not be taken if you have suffered from blood clots in your legs.

Side-effects:
These are not common but can include nausea, vomiting and diarrhoea. These usually disappear when the dose is reduced. If you are at all concerned, contact your doctor for further advice.

CONTRACEPTIVE PILL:
There are several brands of pill. Popular brands include Microgynon, Loestrin 30, Brevinor and Femodene.

Action:
The pill contains the hormones oestrogen and progestogen and works by preventing **ovulation** and reducing the menstrual flow. As well as treating your heavy periods, the pill will also protect you from becoming pregnant.

Dose:
The pill is started on the first day of your period and taken for 21 days. This is usually followed by a seven-day 'pill free period', during which you will have a light withdrawal bleed.

Contra-indications:
The pill should not be taken if you suffer certain types of severe migraine, heart disease, or have had a blood clot in your leg. It should not be taken if you are over 35 and smoke.

Side-effects:
The risks of serious side-effects, such as stroke and blood clots, are greater if you smoke. Minor side effects can include nausea, vomiting, headaches, breast tension, changed body weight, or libido and mood changes.

Note:
There has been much concern recently about the increased risk of blood clots in women taking certain types of pill. If you have any concerns or questions, then you should discuss these with your doctor.

NORETHISTERONE: BRAND NAMES – PRIMOLUT, UTOVLAN

Action:
Primolut contains a progestogen hormone and can be used for the treatment of heavy periods.

Dose:
One 5mg tablet two to three times a day from the 19th to the 26th day of your cycle (counting the first day of menstruation as day 1). Some doctors recommend starting on the 6th day.

Contra-indications:
Should not usually be taken if you had jaundice when you were pregnant.

Side-effects:
These do not generally occur with doses of up to three tablets per day. At higher doses nausea may occur and migraine and epilepsy may be exacerbated.

DANAZOL: BRAND NAME – DANOL

Action:
Danol is a weak androgen (male hormone) which can be used for the treatment of heavy periods.

Dose:
One or more 200mg tablets daily for three months.

Contra-indications:
Should not be taken if you are breast-feeding, or if you have severe heart, liver or kidney disease.

Side-effects:
These can include weight gain, acne, growth of facial hair, hair loss, voice changes.

Note:
This drug is sometimes prescribed for a few weeks before surgery.

ETHAMSYLATE: BRAND NAME – DICYNENE

Action:
A non-hormonal agent which can be used for the treatment of heavy periods.

Dose:
One 500mg tablet four times a day during menstruation.

Contra-indications:
Porphyrias (a rare hereditary condition).

Side-effects:
Occasional headaches or skin rashes which disappear on reduced dosage. A few patients experience nausea which is reduced by taking the drug after food.

GNRH ANALOGUES: BRAND NAME – ZOLADEX

Action:
Zoladex is a synthetic hormone which decreases the level of oestrogen and thus reduces menstrual blood loss.

Dose:
Injection into the abdomen every 28 days.

Contra-indications:
Not to be taken when breast-feeding.

Side-effects:
Hot flushes and night sweats, loss of sex drive, headaches, mood changes, vaginal dryness and change in breast size.

Note:
This drug is sometimes prescribed for a few weeks before surgery.

INTRAUTERINE DEVICE: BRAND NAME – MIRENA

Action:
A T-shaped coil which releases a progestagen on a daily basis, reducing menstrual blood loss. As well as treating
your heavy periods, the coil will also protect you from becoming pregnant.

Dose:
Needs to be replaced after three years.

Contra-indications:
Untreated pelvic infection.

Side-effects:
In the first three months bleeding tends to be irregular, but this usually settles. Breast tenderness, headache and acne may occur initially, but this usually passes.

What about complementary therapies?

Some women like to try alternative remedies such as homeopathy, acupuncture, or herbal medicines. You may find these helpful, but not enough studies have been done to test whether or not they are effective in reducing heavy bleeding.

CHAPTER

4

The surgical options

This chapter describes the various surgical operations that are used to treat menorrhagia, and Chapter 5 outlines what is known about the benefits and risks of each of them.

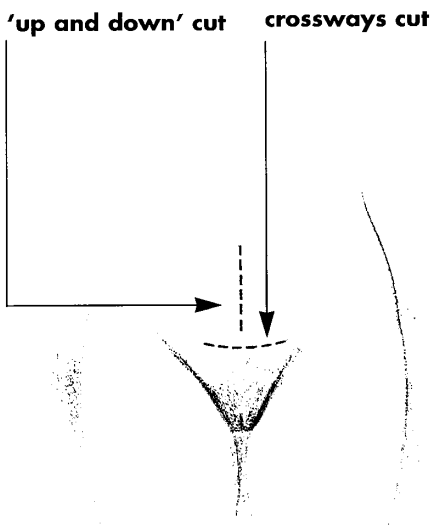
What about surgical treatments?

If you have tried a course of drug therapy and found that it has not solved the problem, you may wish to have an operation. There are a number of choices:

- **hysterectomy**: This is the most common surgical treatment for menorrhagia. It involves removing the whole womb and usually the **cervix** as well. If the cervix is left in place, this is called a **sub-total hysterectomy**. You may be advised to have your ovaries removed at the same time (see page 19). Once the womb has been removed, your menstrual periods will stop completely. This operation also puts an end to fertility – you will not be able to become pregnant after hysterectomy.

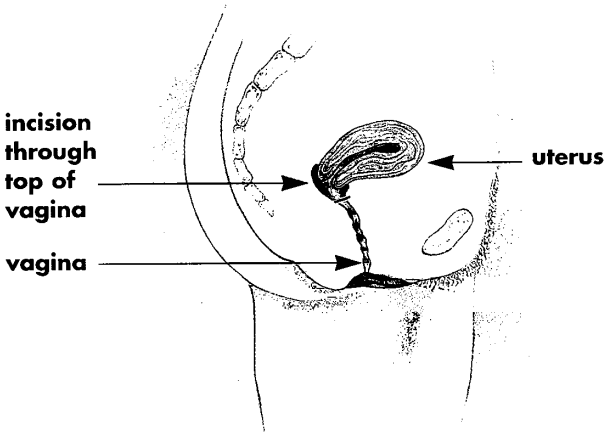
There are three different ways of doing a **hysterectomy**:

1. abdominal hysterectomy – the womb is removed through a cut in the abdomen;



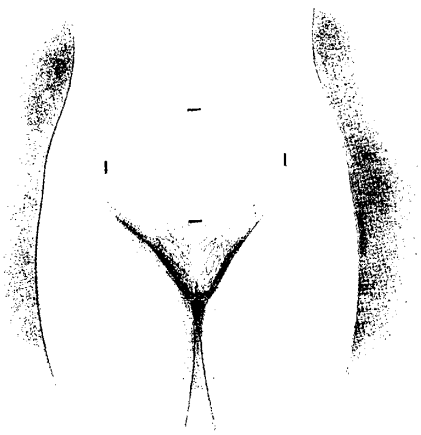
1. Abdominal hysterectomy: 'up and down' or crossways cut of 6-12cm.

2. vaginal hysterectomy – the womb is removed through the vagina. This technique is not always possible, especially if the womb is very large because of **fibroids**;



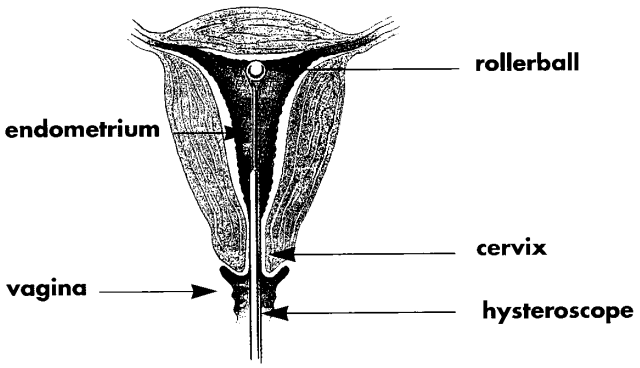
2. Vaginal hysterectomy: incision in top of vagina of 5-6cm.

3. laparoscopic hysterectomy – the surgeon makes several small cuts in the abdomen and uses a mini camera to direct the instruments which are used to remove the womb, usually through the vagina. Not all surgeons use this technique.

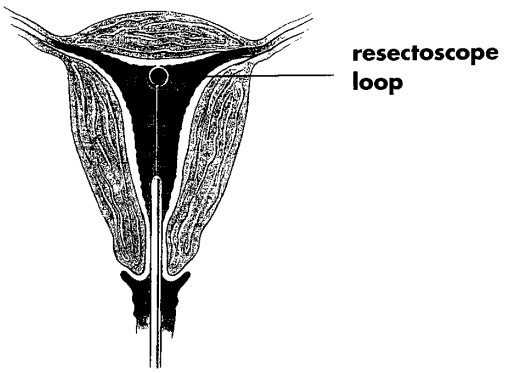


3. Laparoscopically assisted hysterectomy: three to four small incisions of 0.5-1cm.

- **endometrial resection** or **laser ablation** – these newer types of operation involve the removal of the lining of the womb using a **hysteroscope** and **diathermy**

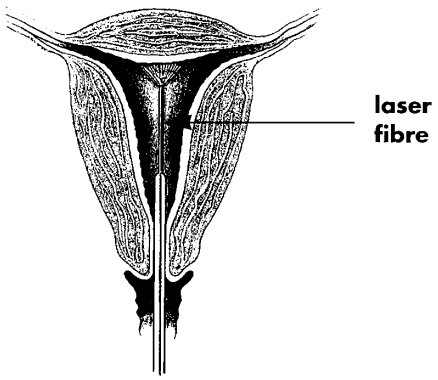


Endometrial resection using the resectoscope with a rollerball attached



Endometrial resection using a resectoscope loop

(applying electrical energy and removing the **endometrium** with a **rollerball** or **resectoscope loop**). Sometimes other techniques are used, including a **laser**. With these procedures the womb remains in place, but menstrual blood loss is usually much lighter. It is technically possible to get pregnant after **endometrial ablation**, but it is not a good idea. Some gynaecologists advise sterilisation to prevent the possibility of pregnancy.



Endometrial ablation using laser

Other operations on the **uterus:**

- **myomectomy**: This operation is only for the treatment of **fibroids**. These are removed and the womb is left in place. It can be more difficult to do than **hysterectomy**. It may help to reduce menstrual blood loss if this is caused by fibroids, but unfortunately fibroids can grow back again if the uterus is left in place. Myomectomy may be a good choice for women who have large fibroids, but don't want to give up their chance of becoming pregnant, but occasionally the operation damages the tubes, thus reducing the chance of pregnancy. It may turn out to be too difficult to remove the fibroids without the womb, so fertility cannot be guaranteed after this operation.

- **dilatation and curettage (D&C)**: This operation used to be done as a treatment for heavy bleeding, but it doesn't usually work. Gynaecologists now believe it is ineffective as a treatment, although it is still used as a diagnostic test (see page 9), to check for abnormalities in the lining of the womb.

CHAPTER

5

The benefits and risks of surgery

Most women who opt for surgery have to choose between **hysterectomy** and **endometrial ablation** (for the sake of simplicity we shall refer to both endometrial resection and laser ablation as endometrial ablation). Each of these operations has different benefits and risks, so it is a good idea to consider carefully which might be best for you.

Abdominal hysterectomy has been around for a long time and millions of women have had this operation, so we know more about its long-term effects than we do about the newer operations. Nobody can say exactly how any of these operations will affect *you*, but research can tell us quite a lot about the likely effects.

The following are some of the issues you need to consider.

What will it do to my periods?

Women who have **hysterectomy** will no longer have any menstrual bleeding or period pains.

Most women who have **endometrial ablation** continue to have periods after the operation, but their blood loss is usually very light. Sometimes bleeding stops altogether, but it may return a few years later and may become heavier over time. Some women continue to have period pains after this operation.

How long will I be in hospital?

Abdominal **hysterectomy** usually involves a four to seven days' stay in hospital, whereas most women undergoing **vaginal** or **laparoscopic hysterectomy** can leave hospital after three and five days.

Many women having **endometrial ablation** go in as 'day cases', which means they don't have to stay in hospital overnight. Others stay in for about one to three nights.

Should I have my ovaries removed at the same time?

If you decide to have a **hysterectomy**, the gynaecologist may recommend **oophorectomy** (removal of your ovaries) at the same time. You should think carefully before agreeing to this.

About one in 100 women in the population develops ovarian cancer, but this risk is more likely if other women in your family have had the disease (e.g. your mother or sister). It may be a good idea to remove your ovaries if you are in a high-risk group, for example if there is a history of ovarian cancer in your family. But if your ovaries are removed, you will have an immediate menopause because your body will cease producing certain hormones.

'Surgical menopause', caused by removing the ovaries in an operation, can sometimes lead to severe menopausal symptoms, such as sleeplessness, hot flushes, palpitations, headaches and sexual difficulties. Doctors prescribe **hormone replacement therapy** (HRT) to avoid these problems. They usually advise taking HRT for a long time (five to ten years or longer) to avoid the risk of developing **osteoporosis** (thinning of the bones), or heart disease.

What can happen after the operation?

Minor complications after surgery are more common after **abdominal hysterectomy** than after vaginal or laparoscopic hysterectomy or **endometrial ablation**, but most women recover from these reasonably quickly. These problems are not a threat to your health, but they may account for the longer time taken to recover from hysterectomy.

Nearly half the women who have **abdominal hysterectomy** experience minor post-operative problems of some kind, including fever, bleeding or infections of the wound, bladder or pelvis. These sorts of problems are less common after **vaginal** or **laparoscopic: hysterectomy** and quite uncommon after **endometrial ablation**.

In a recent study, eight out of ten women who had **abdominal hysterectomy** were still experiencing some pain one week after the operation, as compared to only two out of ten who had **endometrial ablation**. Most women who have **vaginal** or **laparoscopic hysterectomy** experience some pain after the operation, but this usually lasts no more than about three days. The pain is usually effectively controlled by painkillers.

What are the risks of dying as a result of the operation?

All surgical operations carry a small risk of death. Studies of **endometrial ablation** and **laparoscopic hysterectomy** have been too small to give reliable estimates of the risk of death after these operations.

Between one and two in every 1000 women who have **hysterectomy** die as a result of the operation, but the risk is lower (about one in every 2000) in women aged under 50. This means that out of 2000 pre-menopausal women having hysterectomy for menorrhagia, 1999 will safely survive the operation.

How long before I can return to normal activities?

On average it takes about eight to eleven weeks to recover from **abdominal hysterectomy** and about three to seven weeks for vaginal or **laparoscopic hysterectomy**. Women having **endometrial ablation** can usually resume their normal activities two to three weeks after surgery.

Will I have to carry on having cervical smear tests?

You will need to have regular cervical smear tests after **endometrial ablation**, as your **cervix** remains in place. These are usually done once every three to five years.

Cervical smear tests are not normally necessary after hysterectomy, since the whole **uterus** and usually the **cervix** is removed. If you have a **sub-total hysterectomy**, where the **cervix** is left in place, you should continue to have regular smear tests.

How will I feel after the operation?

Most women say they feel much better, more energetic and less depressed after **hysterectomy** or **endometrial ablation**. Studies to compare women's experiences of the two operations have found that satisfaction is even higher after **hysterectomy** than after **endometrial ablation**. This may be because women who have had hysterectomy are pleased that they no longer have menstrual periods.

What effect will it have on my sex life?

In a recent study, about one in four women who had **hysterectomy** or **endometrial ablation** said that their sex life had improved after the operation and roughly the same number said that sex was less enjoyable than before. The rest of the women said the operation had made no difference to their enjoyment of sex. There was no difference between the two operations in this respect. Unfortunately, there is no easy way of telling which way surgery might affect you.

Can I get pregnant after the operation?

You should not have **hysterectomy** or **endometrial ablation** if you are planning to get pregnant. Pregnancy is

not possible after hysterectomy because your womb has been removed. This means you will no longer need to bother with contraception.

It is technically possible to get pregnant after **endometrial ablation**, but it is not a good idea. Many gynaecologists recommend sterilisation at the same time as **endometrial ablation** to remove the risk of pregnancy. Obviously this is not necessary if you have already been sterilised.

Are there likely to be any long-term effects on my health?

Endometrial ablation was introduced only a few years ago, so we do not know enough about the long-term effects of this operation on women's health. We know more about the long-term effects of **hysterectomy**. Some women suffer bladder problems after hysterectomy. However, sometimes women who had these problems before the operation find they improve after hysterectomy. If you have problems with passing water frequently or lack of control of your bladder, you should discuss this with your doctor.

Hysterectomy takes away the risk of diseases of the **uterus**, including cancer. If you have your ovaries removed at the same time, your risk of developing ovarian cancer is also reduced. You cannot get pregnant, so the risks associated with pregnancy are also eliminated.

If your ovaries are left in place, there is a small risk that they may be affected by **hysterectomy**. If your ovaries are not working properly, they could stop producing hormones, which will trigger an early menopause. These hormones help to protect you from heart disease and **osteoporosis**, the bone-thinning disease. Some studies have found that women who have hysterectomy may be slightly more likely to develop these problems than women who have not had the operation.

The risk of developing heart disease or **osteoporosis** is even greater if you have your ovaries removed as well. You can reduce the risk by taking a long-term course of **hormone replacement therapy** (HRT).

Will I need more operations?

Hysterectomy is a once-for-all cure for menstrual problems, but about one in five women who have had **endometrial ablation** need another operation later on, either a repeat ablation or a hysterectomy. There is no way of predicting which women will need more than one operation.

OUTCOMES OF THE OPERATIONS

	abdominal hysterectomy	*vaginal hysterectomy*	*laparoscopic hysterectomy*	*endometrial ablation*
menstrual periods	none	none	none	light
days in hospital	4–7 days	3–5 days	3–5 days	1–3 days
pain	10 days	3 days	3 days	3 days
return to normal activities	8–11 weeks	3–7 weeks	3–7 weeks	2–3 weeks
contraception necessary?	no	no	no	yes
cervical smear necessary?	no	no	no	yes
further treatment required?	no	no	no	1 in 5 patients

Choosing the best treatment for you may be difficult, and you might prefer to let the doctor make the final decision. There is still a lot that is not known about the effects of different treatments, and it is hard to predict how each of them might affect you.

How can I prepare for the consultation with the gynaecologist?

You may find it helpful to keep a diary of your menstrual periods. You could note down when they start, how long they last, number of days of very heavy bleeding, how many pads and/or tampons you have to use, and so on.

It is also a good idea to think about which treatments might suit you best. You could work through the questions in the personal treatment plan (page 24) and jot down your answers. None of this commits you to anything, but it is sometimes helpful to get your ideas sorted out before discussing them with your doctor. If you decide to have surgery, you will have to sign a consent form, so it is sensible to make sure you are well informed beforehand about the operation and its likely consequences.

Personal Treatment Plan

How can I decide which is the best treatment for me?

Your views are very important in making this decision, so it may help to jot down your thoughts as you watch the video and go through this booklet. We have left some blank spaces for you to do this. The following questions may help to sort out your ideas.

How seriously do your periods affect your daily life? What is the worst thing about them?

Do you know what's causing your heavy periods? Do you need more advice on this?

Have you tried a course of drug therapy? Which drug did you have? Did it help? Did you experience any side-effects? Would you like to try a different drug?

How important is it to retain your fertility? Might you want to become pregnant in the future?

Would you prefer to have an operation? If so, which one do you think might suit you best? Why? You might like to take another look at Chapter 5 before answering the question.

Use this space to jot down anything else that is relevant to your feelings about treatment for heavy periods.

Glossary

anaemia: low blood count due to iron deficiency or some other cause

anticoagulant: a drug that prevents blood from clotting

cervix: neck of the womb

diathermy: technique for removing the lining of the womb using electrical energy and a rollerball or cutting loop

dilatation and curettage (D&C)**:** a scrape of the lining of the womb

dysfunctional uterine bleeding: menorrhagia with no obvious cause

endometrial ablation or resection: removal of the lining of the uterus using a resectoscope loop, rollerball or laser

endometrial biopsy: a small sample of endometrium taken for analysis in the laboratory

endometriosis: growth of endometrial tissue outside the uterus

endometrium: lining of the uterus (womb)

Fallopian tubes: tubes that carry the egg cells from the ovary to the womb

fibroid: benign growth of fibrous tissue in the uterus, NOT cancer

hormones: chemical substances produced in one part of the body which pass into the bloodstream and affect the functioning of other parts of the body

hormone replacement therapy (HRT)**:** female hormones taken as tablets, patches or gel, or an implant under the skin

hysterectomy: removal of the uterus through the abdomen or the vagina

hysteroscope: a mini camera for examining the inside of the womb

hysteroscopy: an examination of the inside of the womb using a mini camera

idiopathic menorrhagia: menorrhagia with no obvious cause

intermenstrual bleeding: bleeding between periods

intrauterine device (IUD)**:** a coil inserted into the uterus

laparoscopic hysterectomy: hysterectomy done with special instruments while viewing with a mini camera inserted through a small 'keyhole' in the abdomen

laser: instrument used with a hysteroscope to remove the lining of the womb in endometrial ablation

menopause: the 'change of life'

menorrhagia: excessive regular menstrual blood loss; blood loss of more than 80ml per menstrual period

myomectomy: surgical removal of fibroids

oophorectomy: surgical removal of ovary; bilateral oophorectomy is the removal of both ovaries

osteoporosis: thinning of the bones, making them more likely to fracture

ovulation: release of eggs from the ovaries

polyp: small benign growth or tumour

post-coital bleeding: bleeding after sexual intercourse

resectoscope loop: instrument used with a hysteroscope to remove the lining of the womb in endometrial resection or ablation

rollerball: instrument used with a hysteroscope to remove the lining of the womb in endometrial resection or ablation

sub-total hysterectomy: the womb is removed but the cervix remains in place

ultrasound: a scanner to check for abnormalities in the body

uterus: womb

For further information and details of support groups, contact:

Women's Health
52 Featherstone Street
London EC1Y 8RT
Tel: 0171 251 6580

King's Fund

IPMEN

Information and Preferences in Menorrhagia