Primary Care
Women's Health Society

Abnormal uterine bleeding (AUB)

Taking a history and pathway guidance

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This advice has been produced by PCWHS clinical expert consensus. This guidance is not intended to replace the need to apply your clinical judgement on a case-by-case basis.

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Abnormal uterine bleeding (AUB) is a common concern for women of reproductive age and can have a significant impact on the quality of a woman's life. This guidance advises primary healthcare professionals on how to assess and manage AUB and to offer the right treatments, taking into account the woman's priorities and preferences.

What is abnormal uterine bleeding?

Abnormal uterine bleeding (AUB) is the term used to describe any symptomatic variation from normal menstruation in terms of regularity, frequency, volume, or duration. It is a common and often debilitating condition, affecting women of reproductive age.

One of the most common symptoms of AUB is heavy menstrual bleeding (HMB) that may cause 'flooding' and passage of clots, that may require double protection and affect the patient's quality of life.

AUB ALSO INCLUDES:

- Intermenstrual bleeding (IMB)
- Postcoital bleeding (PCB)
- Oligomenorrhoea
- Dysmenorrhoea

Causes of AUB

The International Federation of Gynecology and Obstetrics (FIGO) classification system can be used to identify the 9 main causes of AUB: PALM-COEIN.

Structural	Non-structural
Polyps	Coagulopathy
Adenomyosis	Ovulatory disorder
Leiomyoma	Endometrial
Malignancy or hyperplasia	Iatrogenic
	Not yet classified

Munro et al. FIGO classification system (PALM-COEIN) for causes of abnormal uterine bleeding in nongravid women of reproductive age. Int J Gynaecol Obstet 2011 Apr;113(1):3–13

History taking

Sensitive and focused history taking is essential to understand the impact of the AUB and help direct the focus of investigations and management options

IMPACT

1. Ask '*What is it that matters to you?*' Establish patient's QOL and impact of the concern

MENSTRUAL HISTORY

2. Date of Last Normal Menstrual Period
3. Cycle length
4. Pattern of bleeding
    a. Duration of bleeding and variability
    b. Is it erratic or predictable?
    c. Is the bleeding heavy?
    d. Are there missed periods?
    e. Is there any bleeding between periods?
    f. Is the bleeding related to sex?
    g. Are the periods painful?
5. When did the pattern of bleeding change?
6. Sexual history
    a. Pregnancy risk
    b. STI risk
    c. Any pain during sex
    d. Any abnormal vaginal discharge
7. Other symptoms
    a. Pelvic pain
    b. Pressure symptoms (inc constipation or urinary frequency)
    c. Weight gain, galactorrhoea, hirsuitism, acne
8. If lifelong concern
    a. Excessive bruising
    b. Frequent nose bleeds
    c. h/o post-partum haemorrhage
9. Any hormone or other medication use, including OTC meds
10. Any endometrial risk factors:
    - Age >45
    - Obesity
    - Polycystic Ovary Syndrome (PCOS)
    - Diabetes
    - Smoking
    - Family history eg ovary/bowel/Lynch syndrome
    - Tamoxifen use
    - Unopposed oestrogen use
    - Late menopause aged > 55

WHAT IS YOUR GUT FEELING?

Follow NICE guideline [NG88] Heavy menstrual bleeding: assessment and management

Pathway

This pathway will focus on the treatment of HMB.

When an abdominal exam is needed

- Do it regardless for reassurance – '*Everyone at least needs a hand on the belly.*'

When pelvic exam required

If history:

- Of pelvic pain
- Of pelvic pressure
- Abnormal finding on abdominal examination

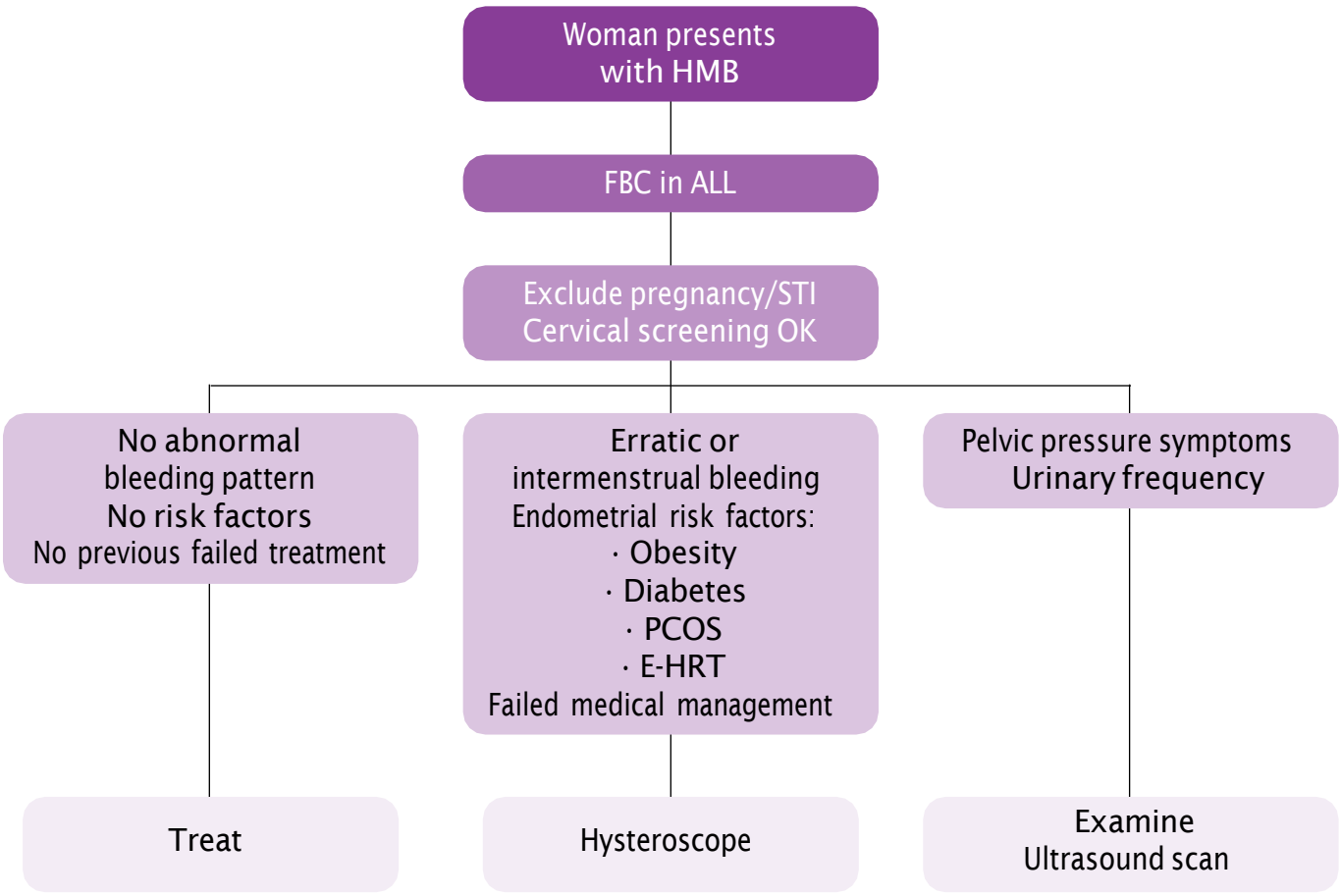
Investigation pathway

FBC in ALL

Exclude:

- Pregnancy
- STIs - consider STI screen
- Check cervical screening history

- Consider screening for clotting deficiency if lifelong problem or h/o excessive bruising/ postpartum haemorrhage – Discuss with haematology.
- A transvaginal ultrasound scan (TVUS) is the preferred method to rule out structural abnormalities (eg fibroids, adenomyosis). If unacceptable, organise a transabdominal ultrasound.
- Hysteroscopy is recommended when endometrial cavity pathology (eg endometrial polyps, submucous leiomyomas) or endometrial pathology (eg endometrial hyperplasia, cancer) is suspected.



When to be concerned

Women with:

- persistent inter-menstrual bleeding
- persistent erratic bleeding
- obesity
- diabetes
- anovulatory cycles of perimenopause or PCOS
- late menopause
- inadvertently prescribed oestrogen only HRT
- using tamoxifen
- FH of breast, colon or endometrial cancer (eg Lynch syndrome)

Women in whom previous treatment has been unsuccessful.

HMB treatment options

A range of medical and surgical management options are available, and the choice of treatment is guided by the underlying cause of AUB alongside the patient's age, parity, co-morbidities, need for uterine and fertility preservation, and personal preference.

Hormonal	Non-hormonal	Surgery
Levonorgestrel-releasing intrauterine device (52mg LNG-IUD)	Tranexamic acid	2nd generation endometrial ablation
Combined Hormonal Contraception (CHC)	NSAIDs (eg ibuprofen)	Hysterectomy: Refer to evidence-based intervention policy
Long-cycle or long-acting progestogens		

Refer

Fast track women with:

- Post Menopausal Bleeding
- Pelvic mass not suggestive of fibroid uterus
- Abnormal cervical appearances refer for colposcopy

When to consider early referral:

- Endometrial risk factors
- Failed medical management.