

# Heavy Menstrual Bleeding

Heavy menstrual bleeding (HMB) is one of the most common reasons women present to general practice. It is defined as menstrual blood loss that interferes with a person's physical, emotional, social or quality-of-life wellbeing, regardless of the measured volume of blood loss. HMB can occur at any reproductive age and may be associated with underlying gynaecological, hormonal or systemic conditions.

## Common features

Heavy menstrual bleeding can present in different ways and does not always correlate with underlying pathology. Common features include:

- Menstrual bleeding lasting longer than 7 days
- Passing large blood clots
- Needing to change pads, tampons or menstrual products very frequently
- Bleeding through clothing or bedding
- Using multiple menstrual products simultaneously
- Symptoms of iron deficiency or anaemia, including:
  - Fatigue
  - Reduced exercise tolerance
  - Dizziness
  - Shortness of breath

## Some women may also experience:

- Significant disruption to work, study, social activities or sleep
- Pelvic pain or dysmenorrhoea
- Intermenstrual or irregular bleeding
- Symptoms related to an underlying condition (e.g. fibroids, adenomyosis, bleeding disorders)

## Common causes

Heavy menstrual bleeding may occur with or without identifiable pathology. Common causes include:

### Structural causes

- Fibroids
- Adenomyosis
- Endometrial polyps
- Endometrial hyperplasia or malignancy (less common)

### Non-structural causes

- Ovulatory dysfunction
- Polyendocrine metabolic ovary syndrome (PMOS)
- Bleeding disorders (e.g. von Willebrand disease)
- Thyroid disease
- Medication-related bleeding (e.g. anticoagulants)
- Endometrial dysfunction

In many women, no specific cause is identified.



**A better every day for every woman.**

## Assessment and diagnosis

Assessment aims to confirm the impact of bleeding, identify potential causes, and exclude serious pathology.

### History

Key areas include:

- Bleeding pattern, duration, and severity
- Impact on daily life
- Presence of pain or pressure symptoms
- Intermenstrual or postcoital bleeding
- Contraceptive use
- Pregnancy risk
- Personal or family history of bleeding disorders
- Symptoms of anaemia
- Reproductive goals and fertility intentions

### Examination

May include:

- Abdominal examination
- Pelvic examination where clinically indicated
- Assessment for signs of anaemia or systemic disease

### Investigations

Common investigations include:

- Full blood count
- Ferritin/iron studies
- Pregnancy test when appropriate
- Thyroid function testing if clinically indicated
- Coagulation studies if a bleeding disorder is suspected
- Cervical screening test if due, or co-test if indicated

Pelvic ultrasound may be useful when:

- The uterus is enlarged
- Fibroids or adenomyosis are suspected
- Symptoms persist despite treatment
- Structural pathology is suspected.

## Management

Management should be individualised based on symptom severity, underlying cause, age, contraceptive needs, and reproductive goals.

### First-line medical management

**Hormonal options:**

- Levonorgestrel-releasing intrauterine device (LNG-IUD)
  - Often the most effective non-surgical treatment
  - Provides contraception
- Combined oral contraceptive pill
- Oral progestogens
- Progestogen-only contraception

**Non-hormonal options:**

- Tranexamic acid during menstruation
- NSAIDs (e.g. mefenamic acid, naproxen)
  - May reduce bleeding and improve dysmenorrhoea

### Iron deficiency management

Iron deficiency should be actively identified and treated. Options include:

- Oral iron supplementation
- Intravenous iron when indicated
- Dietary advice and monitoring

### Surgical management

Referral for specialist assessment may be appropriate when:

- Medical management is ineffective
- Significant structural pathology is present
- Symptoms are severe
- Malignancy requires exclusion

Potential treatments include:

- Hysteroscopic polypectomy
- Myomectomy
- Endometrial ablation (for selected women who have completed childbearing)
- Hysterectomy

## Fertility and reproductive considerations

Heavy menstrual bleeding itself does not usually cause infertility, but some underlying conditions associated with HMB may affect reproductive outcomes. Consider:

- Future pregnancy plans when selecting treatment
- Fertility-preserving options where appropriate
- Early referral if symptoms suggest conditions such as fibroids, adenomyosis, or endometriosis that may impact fertility

## Ongoing care in general practice

Heavy menstrual bleeding is often a chronic condition requiring ongoing review rather than a one-off consultation. Regular follow-up allows:

- Monitoring of treatment effectiveness
- Assessment of iron deficiency and anaemia
- Adjustment of management strategies
- Review of reproductive goals
- Early identification of new or worsening symptoms

Primary care plays a central role in improving quality of life and reducing the long-term consequences of untreated heavy bleeding.

## When to refer to a Gynaecologist

Consider Gynaecologist referral when:

- Symptoms persist despite first-line treatment
- Significant anaemia develops
- Fibroids, adenomyosis or other structural pathology are suspected
- There is intermenstrual, postcoital or postmenopausal bleeding
- Endometrial assessment is required
- Fertility concerns arise
- The diagnosis is uncertain

Urgent assessment may be required if:

- Bleeding is causing haemodynamic instability
- Severe symptomatic anaemia is present
- Malignancy is suspected

*Heavy menstrual bleeding is common, treatable, and often under-recognised. Early assessment, investigation of iron deficiency, and patient-centred management in general practice can significantly improve quality of life and health outcomes.*



**Your referral is  
always welcome.**

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