

Focus

Less invasive options on hand for menorrhagia

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Although there have been few major advances in gynaecological practice in the last few years there have been some developments, particularly in the investigation and management of abnormal uterine bleeding. This, of course, is one of the most common complaints women present with to their GP and is one of the most common reasons for referral to a gynaecologist.

The *National Guidelines for the Management of Menorrhagia* suggest use of the Pipelle device to sample the endometrium. This can be useful for reassurance in the woman who is having regular but heavy periods or the woman younger than 40 years and not definitely in need of formal endometrial assessment. However, Pipelle biopsy is not always easy, as the cervical os can be difficult to negotiate and the procedure can be quite uncomfortable for the woman.

Pipelle biopsy also has its limitations – it only samples approximately 4 per cent of the endometrium and in postmenopausal women its accuracy for diagnosing endometrial cancer has been shown to be as low as 67 per cent. A GP who feels confident in the use of the Pipelle, especially in conjunction with ultrasound assessment may use it in certain circumstances, but, if in doubt, gynaecological referral with a view to hysteroscopic assessment of the endometrium would be wise.

In most places, hysteroscopy and D&C under general anaesthetic is still the gold standard for endometrial assessment. D&C alone is rarely used now for assessment (and even more rarely for treatment of excessive bleeding as better assessment can be made by managing bleeding hormonally and investigating when it has been controlled). With modern fibre-optic equipment, an excellent view of the endometrial cavity can usually be obtained. I can recall one case where a woman had had a D&C for menorrhagia and when there was no improvement went on to formal hysteroscopic assessment where she was found to

KEY POINTS

- Abnormal uterine bleeding is one of women's most common presenting complaints and cause for gynaecological referral
- Pipelle biopsy is useful for cases needing reassurance but has limitations
- Hysteroscopy and D&C under general anaesthetic are still the gold standard for endometrial assessment in most places
- Smaller diameter equipment and flexible hysteroscopes are making outpatient hysteroscopy increasingly available
- The availability in New Zealand of the Mirena IUCD has allowed significant developments in the management of dysfunctional bleeding and menorrhagia. Overseas evidence suggests its use should significantly reduce the number of surgical procedures such as endometrial ablations and

have an impressive crop of endometrial polyps! These were removed and a significant clinical improvement obtained.

hysterectomies

Submucosal fibroids can also be treated by endoscopic resection. In another case an Indian woman in her early thirties presented with severe menorrhagia (causing significant anaemia) as well as primary infertility. At hysteroscopy, the endometrial cavity was found to be packed with pedunculated submucosal fibroids. Following endoscopic excision of these, her bleeding pattern normalised and she was able to conceive (and has since delivered a healthy and long-awaited infant!).

With the advent of smaller diameter equipment and even flexible hysteroscopes, outpatient hysteroscopy is increasingly available and should eventually result in far fewer women having to undergo general anaesthesia.

Ultrasound equipment and techniques have improved markedly in the last few years.

The use of the transvaginal ultrasound probe allows much better assessment of the pelvic organs than is possible with transabdominal scanning. Though some women may not find it an acceptable technique it does not require a full bladder which is a major cause of discomfort and distress to some. Assessment of the thickness of the endometrial lining can be used in the investigation of postmenopausal bleeding but can be more difficult to interpret if the woman is on HRT.

Endometrial polyps and submucosal fibroids can be detected but with less accuracy. Some sonographers are now using a technique called sonohysteroscopy, in which a small amount of saline is infused into the endometrial cavity, improving the distinction of these pathologies.

The most significant recent change in the management of dysfunctional bleeding and menorrhagia is the availability of the Mirena IUCD. This has now been available in New Zealand for about two years. The device contains a depot of levonorgestrel, which is released at the rate of approximately 20g per 24 hours over a five-year period. The menstrual loss is decreased by up to 90 per cent and dysmenorrhoea may also improve. Progestogenic side effects are not common as very little hormone gets into the systemic circulation.

The main problems that women have with the Mirena (which may lead to its early removal) relate to the common problem of spotting, especially within the first three months after insertion and also to the amenorrhoea which develops in approximately 17 per cent of women and can give rise to anxiety about pregnancy.

The same precautions apply for insertion of a Mirena as apply for an ordinary IUCD, such as previous PID, ectopic pregnancy. As the Mirena is a little wider than other IUCDs it is technically a little more difficult to insert, but this can usually be done as an office procedure by an experienced GP or gynaecologist.

Obviously it is important to investigate any abnormal bleeding prior to its insertion (though insertion can be combined with investigations such as hysteroscopy).

The cost of the Mirena (\$245 +GST) limits its use to some degree but several of the medical insurance companies and some of the public hospitals are now covering this cost. This makes sense from a cost/benefit analysis, as the use of the Mirena should reduce the number of surgical procedures such as endometrial ablations and hysterectomies. In a Finnish study, 64.3 per cent of women with menorrhagia who were on a waiting list for a hysterectomy cancelled the procedure following insertion of a Mirena device.

From the point of view of patient risk the insertion of a Mirena is safer than undergoing a surgical procedure and should always be considered before choosing more invasive options. It is the most effective medical treatment currently available, although it is still a bit early to know whether it will be as useful and well accepted with New Zealand women as it has been in other countries where it has been in use much longer. My clinical experience so far suggests women here may not be as tolerant of the irregular bleeding patterns as our European counterparts!

At the same time the Mirena is being introduced, there have been some technical developments in surgical procedures. Endometrial ablation with a thermal balloon (which appears to be much safer than the resection or rollerball techniques and may be done without general anaesthesia) is being tested in several centres. The cost of the equipment required will limit the spread of this technique, initially at least. Laparoscopically assisted vaginal hysterectomy (LAVH) is still far from the norm but is slowly increasing in numbers - there is great popular enthusiasm for so called "key-hole surgery".

In conclusion, the investigation and management of abnormal uterine bleeding is quietly undergoing changes which should benefit the women of New Zealand now and in the future.

Further reading:

Spencer and Whitehead. Endometrial assessment re-visited. *BJOG* 1999, Vol. 106, pp623-632.

Lahteenmaki et al. Gynaecology Forum Vol. 2, No. 1, 1997 Open randomised study of use of levonorgestrel releasing intrauterine system as alternative to hysterectomy. *BMJ* 1998;16: 1122-6

Mirena Product Monograph

Coleman, McCowen and Farquar. The Levonorgestrel-Releasing Intrauterine Device; A Wider Role Than Contraception. *Aust. NZ J Obstet Gynaecol* 1997; 37 (2) 195 National Guidelines for the Management of Menorrhagia