Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Evidence Based Intervention

Hysterectomy for heavy menstrual bleeding

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Version:	V1.0
Approved By:	Strategic Finance and Commissioning Committee
Date of Approval:	9th January 2025
Date of Review:	January 2028 If the review date has exceeded, the published policy remains valid

Policy:

This is a national Evidence Based Intervention policy formally adopted by Hertfordshire and West Essex Integrated Care Board. Please see https://ebi.aomrc.org.uk/

Hysterectomy is the surgical removal of the uterus.

Criteria

Based on NICE guidelines [NG 88] Heavy menstrual bleeding: assessment and management, hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.

It is important that healthcare professionals understand what matters most to each individual and support their 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 individual (who has been fully informed) requests it; the individual no longer wishes to retain their uterus and fertility.

1.13.1.1.1 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.

1.13.1.1.2 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 3 cm 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: tranexamic acid, 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: pharmacological options not already tried (see recommendations 1.5.2 and 1.5.3), surgical options: second-generation endometrial ablation, hysterectomy.

1.5.10 For women with submucosal fibroids, consider hysteroscopic removal.

1.13.1.1.3 Treatments for women with fibroids of 3 cm 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 5.10.

1.5.16 Pretreatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus.

For further information, please see:

NICE Guidance [NG 88] Heavy menstrual bleeding: assessment and management

NHS Conditions, Heavy periods

Rationale for Recommendation

NICE's Guideline Development Group considered the evidence (including 2 reviews, four randomised control trials and one cohort study comparing hysterectomy with other treatments) as well as the views of patients and the public and concluded that hysterectomy should not routinely be offered as first line treatment for heavy menstrual bleeding. The Group placed a high value on the need for education and information provision for individuals with heavy menstrual bleeding.

Complications following hysterectomy are usually rare, but infection occurs commonly. Less common complications include intra-operative haemorrhage; damage to other abdominal organs, such as the urinary tract or bowel; urinary dysfunction –frequent passing of urine and incontinence. Rare complications include thrombosis (DVT and clot on the lung) and very rare complications include death. Complications are more likely when hysterectomy is performed in the presence of fibroids (non-cancerous growths in the uterus). There is a risk of possible loss of ovarian function and its consequences, even if their ovaries are retained during hysterectomy. If oophorectomy (removal of the ovaries) is performed at the time of hysterectomy, menopausal-like symptoms occur.

Patient Information

Information for Patients
There are two surgical procedures which have in the past been used to investigate and treat heavy periods. The first, dilation and curettage, was used to establish the cause of heavy periods, but today, the medical evidence tells us this procedure in inappropriate and should not be routinely carried out. The second procedure, a hysterectomy which removes a woman's womb and therefore ends menstruation completely, can be carried out, but only when specific criteria are met and alternative treatments have been tried first.

What you can do about the condition
Heavy periods are common and can have a significant effect on a woman's everyday life. In about half of women, no underlying reason is found. But, there are several conditions and some treatments that can cause heavy menstrual bleeding, so you should discuss your symptoms with a clinician if you are concerned.

It's important you and your doctor make a shared decision about what's best for you if your heavy periods are becoming a problem. When deciding what's best you should both consider the benefits, the risks, the alternatives and what will happen if you do nothing.

What are the BENEFITS of the intervention?
There are no diagnostic or treatment benefits with dilation and curettage. A hysterectomy for patients with heavy periods should only be considered in certain circumstances.

What are the RISKS?
Complications following dilation and curettage are rare, but can include uterine perforation, infection, damaging your cervix. A hysterectomy is a significant operation and therefore inevitably carries a small risk of blood loss or complications from the anaesthetic. Other risks include infection, or a prolapse in later years. It may also cause the early onset of your menopause and should only be considered if you definitely don't want to have children as your periods will be permanently ended.

What are the ALTERNATIVES?
A doctor will usually use an ultrasound scan or an instrument which takes a small sample of the lining of your womb to see what's causing your heavy periods. There are a number of alternative treatment options including hormone treatment and a coil that provides contraception and are good at reducing blood loss.

What if you do NOTHING?
Doing nothing is not likely to be harmful. However, if heavy periods are having a significant impact on your life, you should seek medical advice to identify the underlying cause and discuss treatment options.

Further information can be found at https://ebi.aomrc.org.uk/interventions/hysterectomy-for-heavy-menstrual-bleeding/ .This weblink was correct as of 27/11/2024.

Coding

```
WHEN Primary_Spell_Procedure IN
('Q071','Q072','Q073','Q074','Q075','Q076','Q078','Q079','Q081','Q082','Q083','Q088','Q089')
AND ( Any_Spell_Diagnosis like '%N92[0124]%'
OR Any_Spell_Diagnosis like '%N950%')
AND Any_Spell_Diagnosis not like '%D25[0129]%'
AND not ( Any_Spell_Diagnosis like '%C52%'
OR Any_Spell_Diagnosis like '%C53[0189]%'
OR Any_Spell_Diagnosis like '%C54[012389]%'
OR Any_Spell_Diagnosis like '%C5[56]%'
OR Any_Spell_Diagnosis like '%C57[01234789]%'
OR Any_Spell_Diagnosis like '%C58%')
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN 'J_hysterec'
```

Exclusions

```
WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)

–Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

References

1. NICE guidance 2018 Heavy menstrual bleeding: assessment and management [Ng88]
2. NHS information: Heavy periods. https://www.nhs.uk/conditions/heavy-periods/#Causes

3. Hurskainen R, Teperi J, Rissanen P, et al. Clinical outcomes and costs with the levonorgestrel-releasing intrauterine system or hysterectomy for treatment of menorrhagia: randomized trial 5-year follow-up. JAMA: the journal of the American Medical Association 2004;291(12):1456–63.
4. Learman LA, Summitt Jr RL, Varner RE, et al. Hysterectomy versus expanded medical treatment for abnormal uterine bleeding: Clinical outcomes in the medicine or surgery trial. Obstetrics and Gynecology 2004;103(5 I):824–33.
5. Zupi E, Zullo F, Marconi D, et al. Hysteroscopic endometrial resection versus laparoscopic supracervical hysterectomy for menorrhagia: a prospective randomized trial. American Journal of Obstetrics and Gynecology 2003;188(1):7–12.
6. Lethaby A, Hickey M, Garry R. Endometrial destruction techniques for heavy menstrual bleeding. Cochrane Database Syst Rev. 2005 Oct 19;(4):CD001501. Review. Update in: Cochrane Database Syst Rev. 2009;(4):CD001501. PubMed PMID: 16235284.
7. Hehenkamp WJ, Volkers NA, Donderwinkel PF, et al. Uterine artery embolization versus hysterectomy in the treatment of symptomatic uterine fibroids (EMMY trial): peri- and postprocedural results from a randomized controlled trial. American Journal of Obstetrics and Gynecology 2005;193(5):1618–29.
8. Pinto I, Chimeno P, Romo A, et al. Uterine fibroids: uterine artery embolization versus abdominal hysterectomy for treatment – a prospective, randomized, and controlled clinical Radiology 2003;226(2):425–31.

Change History:

Version	Date	Reviewer(s)	Revision Description

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