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Quality statements

**Quality statement 1: Assessment and diagnosis**
The initial assessment of a woman presenting with heavy menstrual bleeding includes a detailed medical history, assessment of impact on quality of life, a physical examination, and exclusion of pregnancy, iron deficiency and anaemia. Further investigations are based on the initial assessment.

**Quality statement 2: Informed choice and shared decision making**
A woman with heavy menstrual bleeding is provided with consumer-focused information about her treatment options and their potential benefits and risks. She is asked about her preferences in order to support shared decision making for her clinical situation.

**Quality statement 3: Initial treatment is pharmaceutical**
A woman with heavy menstrual bleeding is offered pharmaceutical treatment, taking into account evidence-based guidelines, her individual needs and any associated symptoms. Initial treatment is provided to a woman who is undergoing further investigations to exclude malignancy and significant pathology.

**Quality statement 4: Quality ultrasound**
A woman having an ultrasound to investigate the cause of her heavy menstrual bleeding has a pelvic (preferably transvaginal) ultrasound, which assesses endometrial thickness and uterine morphology in days 5–10 of her menstrual cycle.
Quality statement 5: Intra-uterine hormonal devices
When pharmaceutical treatment is being considered, the woman is offered the levonorgestrel intra-uterine system if clinically appropriate, as it is the most effective medical option for managing heavy menstrual bleeding.

Quality statement 6: Specialist referral
A woman with heavy menstrual bleeding is referred for early specialist review when there is a suspicion of malignancy or other significant pathology based on clinical assessment or ultrasound. Referral is also arranged for a woman who has not responded after six months of medical treatment.

Quality statement 7: Uterine-preserving alternatives to hysterectomy
A woman who has heavy menstrual bleeding of benign causes and who is considering surgical management is offered a uterine-preserving procedure, if clinically appropriate. The woman receives information about procedures that may be suitable (such as endometrial ablation or removal of local pathology) and is referred appropriately.

Quality statement 8: Hysterectomy
Hysterectomy for management of heavy menstrual bleeding is discussed when other treatment options are ineffective or are unsuitable, or at the woman’s request. A woman considering a hysterectomy is given balanced information about the risks and benefits of the procedure before making a decision.
Purpose of this document

This Case for Improvement supports the implementation of the Heavy Menstrual Bleeding Clinical Care Standard by highlighting what is known about the evidence, best practice and current practice for managing the condition, and the opportunities to bring these closer together. This document has been developed to inform all those with a role in achieving high-quality care for women with heavy menstrual bleeding, including clinicians, policymakers, health system managers, researchers and consumers. It is based on published evidence where available, and consultation with consumers, clinicians, researchers and health service organisations.

This document describes:
- Why implementing the clinical care standard is important
- What needs to be considered to support implementation at a local level
- The opportunities for broader initiatives and activities to overcome some of the barriers to providing the care recommended in the clinical care standard.

It should be read in conjunction with the Heavy Menstrual Bleeding Clinical Care Standard available at www.safetyandquality.gov.au/ccs.

About the Heavy Menstrual Bleeding Clinical Care Standard

The Heavy Menstrual Bleeding Clinical Care Standard was developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in response to variation in the rates of hysterectomy and endometrial ablation within Australia. The Heavy Menstrual Bleeding Clinical Care Standard and related resources are intended to complement and support existing care and quality improvement activities for women with heavy menstrual bleeding, including state- and territory-based initiatives.

The standard aims to improve women’s healthcare outcomes and contribute to wiser use of health system resources. It differs from a clinical practice guideline; rather than describing all components of care for managing heavy menstrual bleeding, it includes quality statements that address priority areas for improvement.

The scope of the Heavy Menstrual Bleeding Clinical Care Standard includes management from first recognition of clinically significant heavy menstrual bleeding until its resolution either before or at menopause. The standard is relevant to the care provided in primary care settings, as well as in public and private specialist gynaecology clinics and practices, hospitals and radiology clinics.

Heavy menstrual bleeding in the acute setting or related to malignancy, or other abnormal uterine bleeding (such as intermenstrual or post-menopausal bleeding), is not covered by this standard. While the standard is broadly applicable to adolescents with heavy menstrual bleeding, these patients may need earlier specialist review.

For more information on the scope, see the Heavy Menstrual Bleeding Clinical Care Standard.
Key messages

This section summarises the key messages about the implementation of the *Heavy Menstrual Bleeding Clinical Care Standard* for health service organisations and systems, clinicians, and women affected by the condition. These points are discussed in more depth in Sections 2 and 3.

**For health service organisations and systems**

Health system funders, administrators and managers, including hospital CEOs and executives, local area health networks or districts, Primary Health Networks (PHNs) and Aboriginal Community Controlled Health Services, all have an important role in implementing the *Heavy Menstrual Bleeding Clinical Care Standard*.

- The equity, efficiency and effectiveness of health service organisations and systems will be improved through the implementation of the *Heavy Menstrual Bleeding Clinical Care Standard*, which has the potential to reduce demand for hospital services and invasive procedures, such as hysterectomies.
- Variation in the rates of hysterectomy and endometrial ablation described in the *Australian Atlas of Healthcare Variation* suggests an imperative for health service organisations to review the care they provide to women with heavy menstrual bleeding and to understand and address reasons for any variation.
- Health service organisations can monitor the *Heavy Menstrual Bleeding Clinical Care Standard* indicators to identify how well they are achieving the care described in the clinical care standard and to identify areas for improvement; these indicators are available from the Australian Institute of Health and Welfare’s (AIHW) Metadata Online Registry (METeOR) at [http://meteor.aihw.gov.au/content/index.phtml/itemId/666572](http://meteor.aihw.gov.au/content/index.phtml/itemId/666572).
- Involving and empowering consumers and consumer organisations in the establishment of systems and processes for monitoring, evaluating and responding to these indicators is also integral to improving the care and outcomes for women with heavy menstrual bleeding.
- Implementation of the *Heavy Menstrual Bleeding Clinical Care Standard* is consistent with the National Safety and Quality Health Service (NSQHS) Standards for acute health service organisations undergoing assessment. This includes requirements to:
  - Demonstrate evidence-based care, as described in the Clinical Governance for Health Service Organisations Standard (action 1.27)
  - Monitor and respond to unwarranted variation, also described in the Clinical Governance Standard (action 1.28)
  - Support patients to be partners in their care and participate in shared decision making (Partnering with Consumers Standard).
For clinicians

Clinicians, including women's health nurses, practice nurses, nurse practitioners, GPs, family planning doctors, Aboriginal health workers, gynaecologists, sonographers and radiologists, have important roles in improving the diagnosis and management of heavy menstrual bleeding.

- Clinicians can help to improve care for women with heavy menstrual bleeding by providing minimally invasive treatments, including long-acting hormonal devices and endometrial ablation, as appropriate.
- Clinical skills training and appropriate referral pathways may help improve women’s access to care.
- Better understanding about the role of less invasive procedures for women with uterine fibroids is needed to support appropriate referral (for example, to interventional radiologists when appropriate).
- Clinicians can identify local implementation goals by monitoring the Heavy Menstrual Bleeding Clinical Care Standard indicators.

For consumers

- Health consumer advocates and consumer representatives on health service committees and boards have a role in advancing the care provided to women with this common condition.
- Many women could benefit from the improved diagnosis and management of heavy menstrual bleeding, with implications for their health, wellbeing and capacity to fulfil their roles in different settings, including in their family, workplace or socially.
- Women with heavy menstrual bleeding should expect to be fully informed about all suitable effective treatments, advised where to access them locally, and supported in sharing decisions about treatment with their healthcare professionals. Treatment options should include less invasive approaches if they are appropriate and reflect the woman’s preferences.
- More information for women with heavy menstrual bleeding is available on the Commission website: www.safetyandquality.gov.au/ccb
Opportunities for collaborative action

Coordinated and collaborative action from a range of stakeholders could support improved care for women with heavy menstrual bleeding. Stakeholders include primary and acute health service organisations, professional colleges and training organisations, women’s health advocacy organisations, and government health departments and agencies. The following are areas for action:

- Development of medical algorithms and pathways of care for heavy menstrual bleeding, encompassing the information in the clinical care standard and current guidelines, could improve assessment, diagnosis and management.
- Development of referral checklists and referral pathways will help to support appropriate referral from primary care and appropriate triage and management.
- Standardised and consumer-appropriate information, decision aids and informed consent forms will help consumers understand their treatment options and support their choices.
- Education, training and skills development are recommended for clinicians in the assessment of heavy menstrual bleeding, as well as in specific treatment modalities such as long-acting hormonal devices and procedural and surgical alternatives to hysterectomy. This is important to ensure women are offered conservative management options for this health condition, if appropriate.
- Establishing systems and mechanisms to support health service organisations and clinicians to monitor indicators for heavy menstrual bleeding and other gynaecological outcomes will assist quality improvement activities.
Section 1: Introduction – a call to action

Evidence suggests that women across Australia are not receiving the same evidence-based care for the common and often debilitating problem of heavy menstrual bleeding. They face delays in diagnosis and, when diagnosed, may not be fully informed about the range of treatment options. As a result, some women may have unnecessary tests and interventions, while others miss out on useful care. This has implications for women’s health and wellbeing, and can impact on many aspects of their lives, including family, work and recreational activities. This situation can also have significant financial implications for women.

The variation in hysterectomy and endometrial ablation rates in the Australian Atlases of Healthcare Variation and international comparisons suggests that the Australian health system is falling short of delivering equitable, evidence-based and efficient care, and points to an opportunity to improve both the quality of care and patient outcomes.

Heavy menstrual bleeding affects 25% of women of reproductive age. It is defined as excessive menstrual blood loss that interferes with a woman’s physical, emotional, social and material quality of life, and can occur alone or in combination with other symptoms.

Who needs to do what differently?

Implementation of the Heavy Menstrual Bleeding Clinical Care Standard requires collaborative action from a range of stakeholders, with the aim of increasing equitable access to appropriate and effective treatment. This Case for Improvement can be seen as the Commission ‘passing the baton’ to others to continue the work that began with the development of the Heavy Menstrual Bleeding Clinical Care Standard.

While this Case for Improvement acknowledges that local issues and needs will inform the development of the most effective strategies and measures for individual health service organisations, the Commission has identified both barriers to care and gaps in existing arrangements, which indicate that there are opportunities for other agencies and stakeholders to support improvements in care through broader system-wide activities.

These activities are equally important to effective implementation, as depicted in Figure 1. They are discussed further in Sections 2 and 3 of this document:

- Section 2: Areas for local action describes how individual health services and clinicians can implement the clinical care standard, using the quality statements and indicators for quality improvement.
- Section 3: Opportunities for collaborative action describes current barriers and suggested initiatives to support implementation and improved care at a system level.
Figure 1: Action to support implementation

**Collaborative action**
Work at a system and leadership level to improve the care for heavy menstrual bleeding

- develop resources, systems and skills
- disseminate and engage

- **Professional organisations and societies**
- **Health departments and agencies**
- **Women’s health advocates**

**Local action**
Use the clinical care standard to improve clinical practice, policies and protocols

- **Health service organisations**
- **Clinicians**
- **Consumer advisory committees**

Monitor the provision of care for quality improvement using the clinical care standard indicators

- **Health service organisations**
- **Clinicians**
Stories for change

Lin and Kathy are cousins. Their stories reveal that there is considerable room to improve the investigation, diagnosis and management of heavy menstrual bleeding – with real benefits for women, health service organisations and health systems. Lin’s story is, in many ways, a worst-case scenario, which draws attention to the impact that heavy menstrual bleeding can have on women’s lives if they do not receive prompt and appropriate care, and to the opportunities to improve care. Kathy’s story illustrates the positive impacts that might be achieved through implementation of the Heavy Menstrual Bleeding Clinical Care Standard.

The stories are informed by the real-life experiences of consumers, clinicians and others; however, they are not the stories of any one individual.

Lin’s story

Lin, 38, had heavy menstrual bleeding since her periods began. As a teenager, it affected her ability to play sport and interfered with her schoolwork. But for many years, she thought this was normal and assumed that all women experienced long, heavy and painful periods. The expense of sanitary products put a considerable strain on her personal budget at times. In her teens and early 20s she asked doctors several times how to manage the pain associated with her heavy periods, but because they didn’t ask specific questions about the volume of her menstrual flow, she remained unaware that her periods were unusually heavy.

It was only when Lin was in her late 20s and began working casually as a chef that a doctor recognised Lin had heavy menstrual bleeding when she regularly had to take time off work. However, she was not given information to help her understand the range of treatment options available. Lin subsequently saw other doctors, all without much change in her condition and at considerable expense and inconvenience. She became frustrated with the medical merry-go-round and felt resigned to living with the problem.

In the regional area where she lived, it was difficult and expensive to see a GP. Lin, who had two children, was prescribed the contraceptive pill, which she took on and off without much effect on the volume of bleeding. Over the years, she was referred for more than 20 ultrasounds, but these did not lead to any useful information. She was not advised that these should be done at a certain time of her cycle, and so they were not as useful as they might have been. She continued to need at least one day off work during her period. To avoid explaining this to her employer, she would try to organise her shifts around her cycle, sometimes working for nine days straight as a result. This left her feeling constantly tired, especially after her period.

Lin asked friends and family for advice, and was told a hysterectomy would solve her problems. As she did not want to have any more children, she was interested in this option. One friend told her of a surgeon who was well known for her expertise in this procedure, so Lin asked her GP for a referral. Lin waited several months for an appointment with the gynaecologist, who said she could offer Lin a hysterectomy if that was Lin’s preferred option. Having waited so long for a solution, Lin was not willing to delay treatment she was confident would work. Having the procedure privately was more expensive, but would mean she could avoid going on a hospital waiting list. The operation required time off work and several weeks to recover and she was unable to keep her casual job.

Throughout her care, had Lin been told there were other treatments for heavy menstrual bleeding, she may have opted to avoid surgery altogether, which would have saved her and the health system a considerable sum, as well as helping to keep Lin in employment.
Kathy’s story

Lin’s younger cousin, Kathy, also experienced heavy menstrual bleeding. The condition affected all aspects of her life and influenced the choices she made around work and social activities. Like Lin, Kathy went for many years thinking her condition was normal. In her late 20s, however, Kathy was fortunate to see a GP who was confident in managing heavy menstrual bleeding. In the area where Kathy lived, a collaboration of clinicians and consumers organised by the local Primary Health Network and Aboriginal Community Controlled Health Service had undertaken several initiatives to improve and standardise services for this condition.

When Kathy asked her GP for pain management advice for her heavy periods, the doctor responded by asking focused questions, such as how often she had to change sanitary products and how long her period lasted. The GP also conducted a physical examination. The GP used a standardised heavy menstrual bleeding assessment tool to ensure she took a systematic approach to understand Kathy’s condition. As well as talking with Kathy about the possible causes of heavy menstrual bleeding and their treatment options, she gave Kathy an information pack, which included a decision aid explaining the potential benefits and risks of the different treatments. She suggested Kathy spend time considering these before returning for further discussions. In the meantime, she prescribed an oral treatment to reduce Kathy’s menstrual flow.

Because of Kathy’s family history of bowel and other cancers, her GP wanted to rule out the possibility that a cancer or other underlying health condition was responsible for the heavy menstrual bleeding. Being familiar with the referral protocols in her local area, the GP knew what tests would be required by the local hospital gynaecology clinic. She referred Kathy for a transvaginal ultrasound and blood tests for iron deficiency and anaemia. She explained to Kathy what the ultrasound involved, how important it was to arrange an appointment at the right time in her menstrual cycle and how to work that out.

Once the ultrasound and blood tests confirmed that there were no obvious underlying health concerns to address, the GP and Kathy discussed the pros and cons of the treatment options, and what Kathy thought of these. The GP also discussed the local referral pathways available to Kathy, although she didn’t think that Kathy needed to see a gynaecologist at this point.

When Kathy decided she would like to have a levonorgestrel intra-uterine system inserted (often known by the brand name Mirena), her GP referred her to a colleague in the same practice who regularly undertook this procedure, and who gave Kathy a standardised informed consent form that clearly listed all the potential benefits and risks involved. Her GP had already explained the likely side effects such as spotting, but also that these would settle down within a few months.

Within six months, Kathy’s bleeding had reduced and her quality of life had improved. She was able to balance her work and other commitments better, taking fewer sick days and increasing her efficiency.

The management of Kathy’s heavy menstrual bleeding was not only more effective and speedier than that of her cousin’s, it was also considerably cheaper and more convenient. Kathy had fewer out-of-pocket costs, and the health system saved some thousands of dollars by preventing the need for surgery and hospital admission.
Section 2: Areas for local action

Local action: Improving assessment and diagnosis

Do women receive a detailed history, physical examination, appropriate investigations and referral when needed?

Relevant quality statements:

- Quality statement 1 – Assessment and diagnosis
- Quality statement 4 – Quality ultrasound
- Quality statement 6 – Specialist referral.

Why is this important?

The causes for heavy menstrual bleeding are diverse. In a UK audit of over 8,000 women treated for heavy menstrual bleeding, 32.5% reported having been diagnosed with fibroids, 14% with endometrial polyps, and 8.5% with a hormonal imbalance, while almost half of women (48.4%) reported no cause (see Figure 2). Co-morbid conditions such as endometriosis were also reported in addition to heavy menstrual bleeding.  

Figure 2: Reported diagnosis one year after first outpatient visit (survey of women in Heavy Menstrual Bleeding Audit, UK, 2013, n=8297)

A comprehensive assessment, including a detailed history, examination and appropriate investigations, is important to diagnose heavy menstrual bleeding and differentiate it from other forms of abnormal uterine bleeding, to identify a cause, and to develop an understanding of its impact on the woman’s health, wellbeing and daily activities. Assessment also helps detect endometrial cancer, enables the early identification and treatment of iron deficiency and anaemia, and facilitates referral and triage in public clinics when appropriate.

An appropriately timed transvaginal ultrasound is the first-line imaging for suspected uterine abnormalities and pathology. Performing transvaginal ultrasound on days 5–10 of the menstrual cycle provides the most accurate measurement of endometrial thickness, which is used in risk assessment for endometrial hyperplasia and malignancy and improves the detection of polyps. Magnetic resonance imaging (MRI) may be valuable in a small subset of women but is not a first-line diagnostic tool for heavy menstrual bleeding.

Comprehensive assessment is also necessary for adolescents; when teenagers with heavy menstrual bleeding present to hospital clinics, they often do not have appropriate investigations or history-taking.
What needs to happen?

Review Quality statements 1, 4 and 6 in the *Heavy Menstrual Bleeding Clinical Care Standard* and what the statements mean for health service organisations and clinicians. Can consumers expect to receive the care described in the quality statements?

Consider collecting the relevant indicators (described below). Detailed specifications for the *Heavy Menstrual Bleeding Clinical Care Standard* indicators are available from the AIHW’s MetaData Online Registry: [http://meteor.aihw.gov.au/content/index.phtml/itemId/666572](http://meteor.aihw.gov.au/content/index.phtml/itemId/666572)

Questions for reflection

These questions are based on the quality statements and are a guide only. Other questions may be relevant in different local health settings.

**Health service organisations**

- What current protocols are used for the assessment of heavy menstrual bleeding?
- Are referring clinicians aware of referral requirements for ultrasound or other investigations, including appropriate timing?

**Primary care organisations and clinicians**

- How is heavy menstrual bleeding assessed and diagnosed?
- How often do specialist referrals occur as described in Quality statement 6?
- Do imaging referrals reflect the recommendations in the clinical care standard?
- Are patients who are referred for transvaginal ultrasound informed about optimal timing in their individual circumstances (for example, taking into account women with irregular periods or difficulties accessing services)?

**Ultrasound providers**

- Does scheduling of appointments for transvaginal ultrasound ensure women are informed about optimum timing?
- Do ultrasound reports provide the information needed for accurate gynaecological assessment as described in Quality Statement 4?

**Relevant indicators for ultrasound providers**

- Indicator 4a: Local arrangements for conducting investigative pelvic ultrasound in days 5–10 of the menstrual cycle for patients with heavy menstrual bleeding.
- Indicator 4b: Proportion of patients with heavy menstrual bleeding who have appropriate reporting following an investigative pelvic ultrasound.

**Relevant indicators for primary health care**

- Indicator 1: Proportion of patients with heavy menstrual bleeding who are tested for iron deficiency and anaemia.
- Indicator 6: Local arrangements to ensure timely and appropriate referral to a specialist for patients with heavy menstrual bleeding.
Local action: Informed choice and shared decision making

Do women have the opportunity to make informed treatment choices and share decision-making with their clinician?

Relevant quality statement:
- Quality statement 2 – Informed choice and shared decision making

Why is this important?
Women have different needs and priorities, so may weigh up the potential benefits and risks of the various treatment options differently. Informed choice and shared decision making are important because there are now more options for managing heavy menstrual bleeding than in the past, when hysterectomies were a more common procedure.\textsuperscript{12,13} Not all women are currently provided with evidence-based information about their options in a format they understand or are supported to participate in shared decision making. Nor are all women from culturally diverse and non-English-speaking backgrounds provided with information in appropriate formats.

Research from the UK has shown the benefits for women when they are provided with relevant information and the opportunity to share in decision-making about managing heavy menstrual bleeding. A small randomised controlled trial in England found that women who were given access to a self-directed, interactive computerised decision aid were more likely to develop a better understanding of their condition, to engage with making decisions about their care in subsequent primary care consultations and to perceive improvements in their quality of life in relation to their condition.\textsuperscript{14} Informing women and involving them in treatment choices can assist with patient satisfaction and adherence. Another randomised controlled trial in England found that the use of decision aids with formal efforts to find out women’s preferences for treating heavy menstrual bleeding reduced health service costs and improved patient satisfaction.\textsuperscript{15}

What needs to happen?
Review Quality statement 2 in the Heavy Menstrual Bleeding Clinical Care Standard and what it means for health service organisations and clinicians.
Can consumers expect to receive the care described in the quality statement?
Consider the relevant indicators (described on the next page) and measures of patient reported outcomes.

Additionally, health service organisations should prioritise consumer participation in the implementation of the Heavy Menstrual Bleeding Clinical Care Standard, whether in clinical settings, or in wider education, governance or policy processes.

Consumer representatives on the boards and governance committees of hospitals, PHNs and other relevant organisations should ask questions about hysterectomy rates and encourage collection of relevant indicators at their local health service. Consumer advisory committees, organisations and opinion leaders representing consumers, women’s health advocates and health consumers themselves could also be enlisted.
Questions for reflection

Health service organisations

• How are clinical staff and patients supported to participate in shared decision making?
• How does the organisation support training in shared decision making skills and approaches?
• What processes are in place to ensure the clinical accuracy and consumer-appropriateness of patient information resources?
• Are patient information resources provided in formats accessible to a range of needs, including those of women from culturally diverse and non-English-speaking backgrounds? (For example, print text and graphics, audiovisual)
• Are cultural and religious needs considered in the provision of services and resources?
• How are patient experience and outcomes measured?

Primary care organisations and clinicians

• What information about heavy menstrual bleeding is provided to women? Are cultural factors considered?
• How could standardised decision aids and assessment tools be used to understand individual women’s preferences?16

Decision aids that have been assessed against international standards are available at: decisionaid.ohri.ca

Relevant indicators for clinicians and health service organisations, including primary care

• Indicator 2: Local arrangements for the provision of consumer-focused information about heavy menstrual bleeding.
• Indicator 9: Local arrangements to measure and act upon patient-reported outcomes related to heavy menstrual bleeding.
Local action: Offering the least invasive and most effective treatment for a woman’s needs

Do women receive information about, and access to, the least invasive and most effective treatment for their needs?

Relevant quality statements:

- Quality statement 3: Initial treatment is pharmaceutical
- Quality statement 5: Intra-uterine hormonal devices
- Quality statement 7: Uterine-preserving alternatives to hysterectomy
- Quality statement 8: Hysterectomy.

Why is this important?

Although hysterectomy rates have fallen around the world since the 1980s, the rate remains higher in Australia than in most other comparable countries in the Organisation for Economic Co-operation and Development (OECD). Within Australia, significant variation in hysterectomy rates has been documented. The Second Australian Atlas of Healthcare Variation identified a seven-fold difference between the lowest and highest rates of hysterectomy in local areas, and a 21-fold difference in rates of endometrial ablation. Rates of hysterectomy were markedly higher in inner and outer regional areas than in major cities or remote areas. These data suggest that therapeutic alternatives to hysterectomy are not being consistently used across Australia for women with heavy menstrual bleeding.

Hysterectomy is a definitive treatment for heavy menstrual bleeding that is sometimes the appropriate management choice. However there are a number of less invasive and effective alternatives once malignancies and benign conditions such as polyps and large fibroids have been ruled out. These include pharmaceutical treatments (hormonal and non-hormonal), which are also the treatments of choice for women who wish to preserve fertility. A recent study in the United Kingdom found that pharmaceutical treatment (either the levonorgestrel intra-uterine system or usual medical treatment) for heavy menstrual bleeding, at five-year follow-up, was effective in eliminating the need for surgery in up to 80% of women without serious uterine pathology.

In a 1998 Finnish study, two-thirds of women using the levonorgestrel intra-uterine system cancelled a hysterectomy, compared with 14% in a control group. International comparisons indicate that Australia has a low use of intra-uterine devices (for any indication) compared with France, Austria and the United States. However, intra-uterine hormonal devices are not suitable for everyone and not all women may wish to have this treatment.

Endometrial ablation is a less invasive surgical option for heavy menstrual bleeding when fibroids and polyps are not present, and there is no wish for future fertility. It involves removal of the endometrium (the lining of the uterus), but not the uterus itself, usually in a day procedure. Minimally invasive procedures for removing fibroids and polyps include hysteroscopic resection and uterine artery embolisation for fibroids, when appropriate to the woman’s clinical situation.
What needs to happen?

Review Quality statements 3, 5, 7 and 8 in the Heavy Menstrual Bleeding Clinical Care Standard and what the statements mean for health service organisations and clinicians. Can consumers expect to receive the care described?

Consider collecting the relevant indicators (described below).

Questions for reflection

Primary care clinicians, gynaecologists and other women’s health specialists

- How are women informed about the risks and benefits of surgical procedures, including hysterectomy? (While a hysterectomy may be the most appropriate option for some women or a woman’s expressed preference, it is important that all women understand the risks and benefits of a hysterectomy and the factors to weigh up before proceeding).
- What options are offered to women with heavy menstrual bleeding?
- What are the referral options locally for women seeking less invasive procedures, taking into account current guideline recommendations?
- What opportunities exist for skills development and training?

Health service organisations

- What guidelines do clinicians use and have access to?
- What arrangements are in place for providing women with:
  - the levonorgestrel intra-uterine system, either onsite or through referral if there is no suitably trained clinician within the service?
  - access to less invasive procedural alternatives to hysterectomy, including endometrial ablation and uterine artery embolisation (for fibroids)?
- Are skills development and training available to clinicians? For example, are GPs in rural and remote areas able to access training support?

Relevant indicators for primary care providers and other clinicians

- Indicator 3: Proportion of patients with heavy menstrual bleeding who are offered pharmaceutical treatment.
- Indicator 5a: Local arrangements for referral of patients with heavy menstrual bleeding for insertion of a levonorgestrel-releasing intra-uterine system.
- Indicator 5b: Proportion of patients with heavy menstrual bleeding who are deemed clinically suitable for a levonorgestrel-releasing intra-uterine system and have one inserted or are referred for insertion.

Relevant indicators for public and private hospitals

- Indicator 7: Proportion of patients with heavy menstrual bleeding of benign cause(s) who are offered uterine-preserving alternatives to hysterectomy.
- Indicator 8: Hospital rate of hysterectomy per 100 episodes.
Local action: Responding to healthcare variation

What might explain patterns of healthcare variation for hysterectomy and endometrial ablation?

Why is this important?
Implementing the Heavy Menstrual Bleeding Clinical Care Standard may help to address disparities and inequities in the diagnosis and management of heavy menstrual bleeding. The types of interventions that women receive may be influenced by where they live and access to services, rather than their clinical need or personal preferences.

Variation in hysterectomy rates suggests an imperative for health service organisations and clinicians who provide services in certain geographic areas or to certain populations – such as women with lower incomes – to support the implementation of the Heavy Menstrual Bleeding Clinical Care Standard.

Regardless of where they live or their social and economic situations, women with heavy menstrual bleeding should have the opportunity to choose from the range of effective therapeutic options. Audits of the management of heavy menstrual bleeding in the UK suggest that women from deprived backgrounds and certain cultural groups face barriers to treatment. Higher rates of hysterectomy in some Australian regional areas compared with major cities may reflect differences in accessibility to less invasive treatments and in the needs and preferences of women. For example, women in rural areas may be less willing to trial other therapies, especially if they need to travel long distances to access ongoing specialist care. Rates of hysterectomy in the Atlas tended to increase with socioeconomic disadvantage, although the reverse was seen in remote areas, so the significance of this finding is not clear. It may mean that women in remote areas are less likely to seek health care for heavy menstrual bleeding.

The hysterectomy rate for Aboriginal and Torres Strait Islander women (262 per 100,000 women) was about 10% lower than the rate for other Australian women (291 per 100,000 women). This discrepancy may be a sign of late recognition and undertreatment of gynaecological conditions more broadly for Aboriginal and Torres Strait Islander women, rather than a difference in the prevalence of uterine conditions. Aboriginal and Torres Strait Islander women have a higher incidence of, and mortality from, gynaecological cancers, and lower rates of cervical screening than non-Indigenous women, which suggests that lack of access to appropriate care may contribute to low rates of treatment for gynaecological procedures overall.
Questions for reflection

Clinicians and health service organisations can use the online interactive Australian Atlas of Healthcare Variation to reflect on rates of hysterectomy and endometrial ablation in their areas and to consider the possible reasons for variations in care.

- How does care in my local area compare to other areas?
- How could the variation be explained and addressed?

In the NSQHS Standards (second edition), action 1.28 explains the requirements for health service organisations to monitor and respond to variation.

What is the rate in your area?

The Interactive Atlas provides rates of hysterectomy and other measures by Statistical Area Level 3 (SA3) and by Local Hospital Network (known as Local Health Districts, Local Health Networks and other terms depending on the state or territory). It is available at www.safetyandquality.gov.au/atlas
Number of hospitalisations for endometrial ablation per 100,000 women aged 15 years and over

20.5x AS HIGH
in the highest rate area compared to the lowest rate area

Notes:
Rates are age standardised to the Australian female population in 2001.
Rates are based on the number of hospitalisations in public and private hospitals (numerator) and women in the geographic area (denominator).
Analysis is based on the patient’s area of usual residence, not the place of hospitalisation.
For further detail about the methods used, please refer to the Technical Supplement.
Section 3: Opportunities for collaborative action – starting the conversation

The Commission has identified some barriers to best-practice care, gaps in existing arrangements, and opportunities for other agencies and stakeholders to support improvement beyond the actions of individual health service organisations and clinicians (see Box 1). This section does not make prescriptive recommendations for advancing the implementation of the *Heavy Menstrual Bleeding Clinical Care Standard*. Instead, it identifies opportunities for collaborative action from a range of stakeholders in four related domains of change:

- Dissemination and engagement
- Resources and systems development
- Professional education and skills development
- Further research and evaluation.

Underlying these domains is the need for tailored communications strategies, including online and media-related activities.

**Box 1: Barriers and opportunities**

- There are currently no Australian nationally endorsed clinical practice guidelines for heavy menstrual bleeding.
- There are few mechanisms for monitoring quality of care at a system level. Although there are well-established datasets for maternity outcomes, these do not exist for gynaecology.
- Inconsistency in current radiology and radiography practice arrangements for scheduling of appointments and reporting for transvaginal ultrasound may be leading to repeat ultrasounds, delays in diagnosis and unnecessary use of health system resources.
- There is a need to improve access to clinical training and education:
  - In primary care, for insertion of the levonorgestrel intra-uterine system
  - In specialist gynaecological practice, for endometrial ablation (to the extent that variation may be related to a lack of training opportunities).
- The development of evidence-based referral pathways is a priority. Local knowledge of where to refer from primary care for insertion of intra-uterine devices (IUDs) or minimally invasive surgical procedures could support improved care.
- There is a need to develop a more detailed understanding of women’s experiences of treatment for this common condition. Evaluation and research associated with the implementation of the *Heavy Menstrual Bleeding Clinical Care Standard* could help to fill some of these knowledge gaps and support improvements to clinical care, services and women’s outcomes.
Who needs to be involved?

It is unlikely that the outcomes and experiences of women with heavy menstrual bleeding will be improved by individual measures in isolation, as ‘the whole panoply of services’ determines the quality of care for women with this condition. Improving care and outcomes for women with heavy menstrual bleeding requires collaborative action across many spheres, including:

- Federal, state and territory governments and agencies
- Health services and systems, including primary healthcare organisations such as PHNs and Aboriginal Community Controlled Health Services, Local Hospital Networks, and public and private hospitals
- Individuals and organisations involved in health and medical education and professional development, including specialist medical colleges, nursing organisations and family planning organisations
- Consumer health and women’s health advocates and organisations
- Health and medical organisations with a focus on relevant areas and groups, such as organisations working in rural, regional and remote health, and Aboriginal and Torres Strait Islander health.

A full list of relevant stakeholders is provided in Box 2.

Communication strategies

Across the domains of change described is the need for communication strategies that include organisational and professional channels, general and specialist media, social media, opinion leaders and online networks. Raising public and professional awareness could support implementation of the clinical care standard and contribute to improved care and outcomes for women with heavy menstrual bleeding.

Communications strategies could be developed for different contexts, at local, state and territory, and national levels. Communications activities will be most effective if they are done in partnerships with relevant groups and organisations, and tailored to the different audiences referred to in this Case for Improvement. Stakeholders may wish to draw upon the key communications messages developed by the Commission for the launch of the Heavy Menstrual Bleeding Clinical Care Standard (see the Appendix).

Activities to roll out the Heavy Menstrual Bleeding Clinical Care Standard should be developed with awareness of the NSQHS Standards as well as wider work to improve women’s health, as there may be opportunities to draw inspiration from, or model these wider activities.
Collaborative action: Dissemination and engagement

Dissemination of the *Heavy Menstrual Bleeding Clinical Care Standard* and engagement activities could be undertaken at local, state/territory and national levels. The Commission encourages stakeholders to develop partnerships and collaborative arrangements to progress its wider dissemination, and to support its implementation across systems of care.

These implementation activities could form part of a wider agenda to improve women’s health. Commission stakeholders have raised concerns about a relative neglect of women’s health issues in health and medical professional practice, education and training. There are opportunities for colleges such as the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) to work with other organisations and specialty groups to improve such care.

**Box 2: Potential partner organisations and other key stakeholders**

- Primary Health Networks
- Aboriginal Community Controlled Health Services
- The Royal Australian College of General Practitioners (RACGP) and GPs
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and gynaecologists and obstetricians
- The Australian College of Rural and Remote Medicine (ACRRM)
- The Rural Doctors Association of Australia (and its state and territory entities)
- Nursing organisations and nurses, including the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), CRANApplus, the Australian College of Nursing, the Australian Women’s Health Nurse Association and the Australian College of Nurse Practitioners
- The Royal Australian and New Zealand College of Radiologists (RANZCR) and radiologists
- The Australasian Society for Ultrasound in Medicine (ASUM) and sonographers
- Peak groups such as the National Rural Health Alliance (NRHA), the National Aboriginal Community Controlled Health Organisation (NACCHO), and the Australian Health Care Reform Alliance (AHCRA)
- Pharmacy organisations and pharmacists
- The Medical Software Industry Association
- Organisations representing public and private hospitals
- Women’s health organisations such as the Jean Hailes Foundation and Women’s Healthcare Australasia
- Private health insurers
- NPS MedicineWise activities including its Choosing Wisely campaign
- Researchers and research organisations with an identified interest in related topics
- Relevant consumer groups including health consumer bodies such as the Consumers Health Forum of Australia, women’s organisations, women’s health organisations, and wider consumer groups, such as CHOICE
- Unions and employers with a high proportion of female members and employees.
Scenario 1: Collaborative action at the local area level

A PHN in a regional area with high hysterectomy rates takes a leadership role in bringing together stakeholders to examine local issues affecting women’s access to care and treatment for heavy menstrual bleeding. The PHN organises a workshop for women’s health and consumer health representatives, clinicians, primary health care providers including the local Aboriginal Community Controlled Health Service, and public and private hospitals. The workshop allows participants to develop an action plan for local implementation of the *Heavy Menstrual Bleeding Clinical Care Standard*, which includes providing continuing professional development for local clinicians in self-identified areas of need related to the standard.

Using the clinical care standard indicators, the PHN reviews the local arrangements for providing consumer information and referral arrangements for IUD insertion and specialist follow-up, and identifies areas for improvement. They identify a number of GPs in the area with expertise or additional training in women’s health who could support colleagues with advice or accept referrals. This could reduce pressure on referrals to outpatient gynaecological services. The PHN develops referral pathways and provides information in consultation with the local hospitals.

Together the PHN and local hospitals fund the development and distribution of information resources for clinicians and women. The resources are developed from information from the Commission (see Appendix) and are disseminated by media campaigns tailored to specific audiences, including specialist medical publications and the general media. Online communication channels, including social media, are used to support women to become more informed about the diagnosis and treatment of heavy menstrual bleeding. Local patient representatives and consumer advocacy groups play a key role in driving shared decision-making policies. Evaluation of these activities, using the clinical care standard indicators and monitoring local variation, is built into the implementation plan. This helps to identify opportunities for local service development and to monitor the impact of activities.

Collaborative action: Developing and strengthening resources and systems

The development of resources related to heavy menstrual bleeding is critical for supporting implementation of the clinical care standard, given the identified need to improve awareness and information available to women, clinicians, health service organisations and systems. The following resources, which could be developed at local, state and territory, or national levels, are needed:

- An endorsed medical algorithm or pathway of care based on current evidence for appropriate diagnosis and treatment and encompassing the care described in the clinical care standard
- Heavy menstrual bleeding assessment tools based on the above algorithm
- Standardised consumer information and decision aids
- Referral checklists* to ensure comprehensive referral
- Current information about local referral pathways
- Comprehensive informed consent forms providing standardised information.

It is expected that developing these resources will help to identify areas of care that need improvement. For example, it would be useful for GPs to have access to referral pathways that indicate those clinicians working in primary care or family planning clinics who are qualified to insert long-acting hormonal devices, as well as gynaecologists and interventional radiologists who perform less invasive procedures such as endometrial ablation and uterine artery embolisation.

These pathways could be developed by PHNs or HealthPathways, with involvement from a range of clinicians. This collaborative development may provide an opportunity for gynaecologists and other consultants to provide information and education to referring GPs and other practitioners, and for public gynaecology clinics to streamline referral practices to improve triage. See Scenario 2 for another example of collaboration.

### Scenario 2: National leadership

A national research group with expertise in developing and evaluating care pathways and consumer resources responds to the release of the *Heavy Menstrual Bleeding Clinical Care Standard* by establishing a project to develop a range of related resources. These include:

- An endorsed algorithm of care to support the appropriate diagnosis and treatment of women according to their age, presenting symptoms, investigations and clinical context, consistent with the clinical care standard and evidence-based guidelines
- Decision aids targeted to the needs of different groups of women
- Standardised informed consent forms.

The researchers identify and address local barriers to the use of decision aids in clinical practice, and to the implementation of evidence-based practice, including defensive medical practice and financial disincentives. They also identify and harness potential enablers of evidence-based practice. The research group works in partnership with relevant consumer groups, specialist colleges and other stakeholders in developing, evaluating and disseminating these materials. The use of these materials helps health system managers to identify gaps in service delivery and referral pathways, and to facilitate the development of health services and systems at national, state and territory, and local levels. The development, release and dissemination of these resources are supported throughout this process by media and online campaigns that are run by various stakeholders (including the researchers’ institution, consumer groups and medical groups). These campaigns draw upon key communications messages developed by the Commission (see the Appendix).
Collaborative action: Professional education and skills development

Implementation activities should be undertaken with relevant partners seeking to improve related health and medical education, and continuing professional development, including skills in shared decision making. Stakeholders have identified a need to increase the skills of GPs and other specialists, including obstetricians, gynaecologists, sonographers and radiologists, in certain aspects of care described below.

Skills in the provision of long-acting hormonal devices

The Commission recommends that relevant professional colleges include intra-uterine device insertion within their advanced training programs and review the incentives and opportunities for clinicians to participate in continuing professional development training programs, in order to increase the number of clinicians skilled in the safe and appropriate use of the levonorgestrel intra-uterine system.

The establishment or expansion of designated intra-uterine device clinics at family planning clinics and outreach clinics attached to public hospital outpatient departments may also assist with increasing women's access to services, as well as increasing training opportunities for primary care clinicians.

Stakeholders identified other reasons that long-acting hormonal devices are not provided as frequently as they might be, including:

- Financial barriers to GP training in hospital and family planning services (remuneration and time constraints), as well as insufficient opportunities for them to incorporate training into practice
- Concerns about remuneration, time constraints and patient demand for services
- Under-utilisation of nurses – while appropriately trained nurse practitioners can bill through Medicare for inserting a levonorgestrel intra-uterine system, this does not apply to registered nurses who could also be offered expanded training to perform these procedures
- Concerns about equipment, facilities and access to nursing assistance
- A misperception that these procedures require a higher grade of indemnity insurance – this is not the case with most professional indemnity providers.

A collaborative approach between colleges and professional organisations could identify ways to overcome these barriers.

Improving skills through multidisciplinary collaboration

There are many avenues for developing clinicians’ skills in managing heavy menstrual bleeding by drawing on multidisciplinary expertise and networks. This has been successful in England, where face-to-face educational visits to GPs (academic detailing) has led to improvements in care provided to women experiencing this condition.

The development of communities of practice and mentoring networks may assist practitioners to maintain their skills in such procedures with confidence; this may particularly benefit clinicians in regional, rural or isolated areas. One option may be to develop opportunities for GPs to upskill in consultation with gynaecologists.

Professional training organisations might also respond to an identified lack of independent, non-commercial training opportunities for endometrial ablation, and investigate opportunities to play a greater role in providing credentialed training in this area.

Organisations such as RANZCOG may be well placed to support implementation of the standard by developing a heavy menstrual bleeding training module and algorithm that could be available from the College website. Incentives such as continuing professional development points could encourage participation by fellows and other interested clinicians.
Collaborative action: Further research

Further research would assist with a range of related implementation activities. Little information is currently available about the care provided to women with heavy menstrual bleeding in Australia and the capacity of services to provide surgical and non-surgical interventions including radiological interventions. In the UK, successive audits of heavy menstrual bleeding have provided a wealth of information that has been used to understand women’s needs and improve services. A similar approach could be taken here.\textsuperscript{6,22,27}

It would be useful to develop a better understanding of:

- Women’s experiences of heavy menstrual bleeding
- The patient journey of care in Australia and organisational capacity in the public and private sectors
- The economic costs of managing heavy menstrual bleeding, including out-of-pocket costs to women
- The factors affecting women’s treatment choices and their experiences of treatment\textsuperscript{17}
- Consumer-focused outcomes of treatment options
- The impact of shared decision making upon women’s experiences and outcomes\textsuperscript{23}, as well as on health service utilisation and costs, and the clinical settings in which decision aids are most effective and cost effective.\textsuperscript{18}
- The issues affecting access to care for Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse backgrounds, and women from more deprived areas.\textsuperscript{6}

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References


Appendix: Communication messages – developed by the Commission

The Commission prepared these key messages for use in its communications and resources about heavy menstrual bleeding and the Heavy Menstrual Bleeding Clinical Care Standard. They are provided here to assist others to develop communication strategies and messages.

Overall and summary messages

• The Heavy Menstrual Bleeding Clinical Care Standard is the first nationally agreed standard of care for women experiencing heavy menstrual bleeding; it aims to improve women’s health across Australia for what can be a debilitating and under-recognised condition.

• Heavy menstrual bleeding is a common problem affecting about 25% of women of childbearing age. While many women seek medical help because of severe pain, others do not seek help despite significant impact on their social, emotional and physical wellbeing.

• While surgical removal of the uterus (or hysterectomy) is sometimes appropriate, there is a range of other treatment options available – including pharmaceutical treatments and ‘minimally invasive’ gynaecological procedures – which are supported by evidence and clinical guidelines.

• However, evidence also suggests many women in Australia are not aware of these less invasive treatments or are not offered them. The Commission’s Australian Atlas of Healthcare Variation shows women in many parts of Australia are much more likely to have their uterus surgically removed than to have a less invasive treatment. There is also a lot of regional variation in treatment rates.

• It is important that all women with heavy menstrual bleeding are offered the full range of treatment options and are supported to participate in decision making about their condition.

Consumer messages

• Heavy menstrual bleeding is a common problem affecting 25% of women of reproductive age. It can occur alone or in combination with other symptoms.

• Periods are a very personal experience and women who have always had heavy periods may consider that this is normal. Talking to a clinician can help women to identify if their pattern of menstruation is within the normal range.

• The impact on women’s social, emotional and physical quality of life is an important factor to be discussed when considering treatment.

• Women with heavy menstrual bleeding have a high risk of iron deficiency and anaemia.

• Around 50% of women referred to specialists for heavy menstrual bleeding experience severe pain but many women experience significant disruption to their quality of life from bleeding alone.

• Approximately 10% of women have at least four days of heavy bleeding per period. This equates to 48 days of the year that such women experience significant difficulty in carrying out their normal activities because of flooding through clothes, being confined to bed, being unable to leave home, or similar issues.

• Most women with heavy menstrual bleeding can be treated effectively by a general practitioner (GP). However, sometimes specialist referral is recommended. For example, an ultrasound might identify fibroids or polyps, which are common types of non-cancerous growths that may benefit from specialist review.
• If the bleeding is caused by fibroids or polyps (non-cancerous growths), there are procedures to remove or destroy these without removing the uterus. The risks and benefits will differ for each woman, so it is important that the full range of treatment options is discussed with a doctor. The discussions should include any impact on future fertility.

• Evidence shows that women tend to choose less invasive treatment options when they are informed about them and asked about their preferences as part of shared decision making.

• In the past, hysterectomy was one of the few options for women with heavy menstrual bleeding, but there are now several less invasive treatment options that women should be offered.

• Treatment options for heavy menstrual bleeding include medicines (both non-hormonal and hormonal treatments such as the pill or a hormonal IUD) and surgical options that keep the uterus intact such as endometrial ablation (removal of the inner lining of the uterus, most commonly using a thermal device) and removal of polyps or fibroids.

• Australia has higher rates of hysterectomy than the UK and New Zealand. In addition, women in some parts of Australia are up to seven times more likely to have a hysterectomy than in others.

• These differences suggest that the full range of treatment options is not being used across the country, and that women are not aware of, or informed, about these treatments.

• There are different reasons for heavy menstrual bleeding, so a detailed history and assessment is an important first step in identifying treatment options.

• The best treatment will differ for each woman and will depend on the cause of her condition, other medical problems, and whether she wishes to become pregnant in the future.

• If a gynaecological ultrasound is required, it must be conducted at the correct time in the menstrual cycle. If it is not, women will either need a second ultrasound or medical decisions may be made based on inaccurate imaging.

• Women who are having a gynaecological ultrasound for menstrual problems are advised to talk to their referring doctor to find out exactly when they should have the scan. It is important to schedule their scan accordingly to avoid the need for repeat specialist appointments.

• It is important that women are informed about all their treatment options and asked about their preferences so that they can make the most appropriate decisions about their own care.
Clinician messages

- Heavy menstrual bleeding is the most common reason for hysterectomies for benign gynaecological conditions.
- In 2014–15 there were 27,586 hospitalisations for hysterectomy in women aged 15 years and over without a diagnosis of gynaecological cancer.\(^2\)
- Australia has higher rates of hysterectomy than the UK and New Zealand.\(^3\) In addition, women in some parts of Australia are up to seven times more likely to have a hysterectomy than in others.\(^2\)
- Women in regional areas have higher age-standardised rates of hysterectomy overall than women living in major metropolitan cities, as can be seen on the Australian Commission on Safety and Quality in Health Care’s interactive Australian Atlas of Healthcare Variation.\(^2\)
- These differences suggest that the full range of treatment options for heavy menstrual bleeding is not being offered to women across the country.
- The Commission has developed the **Heavy Menstrual Bleeding Clinical Care Standard** to support high-quality, safe and appropriate care for women with this condition.
- The **Heavy Menstrual Bleeding Clinical Care Standard** aims to increase the number of women who are offered recommended care by their clinicians and who are given the opportunity to make an informed choice from the full range of suitable treatment options.
- Many women with heavy menstrual bleeding have their condition managed successfully with good general practice care. Some women will need referral to a specialist if there is a suspicion of malignancy or other pelvic pathology, or if the bleeding may be related to another condition such as a bleeding disorder.
- If a woman requires further investigations, clinicians are encouraged to offer immediate short-term treatment to relieve symptoms while she awaits her next appointment.
- Best-practice management of heavy menstrual bleeding includes comprehensive assessment, knowing when to refer, and offering less invasive pharmaceutical and procedural alternatives to hysterectomy whenever these are suitable for the individual woman.
- Less invasive procedural interventions include endometrial ablation (surgical removal of the lining of the uterus), and the removal or destruction of fibroids or polyps using surgical or radiological techniques.
- Women tend to choose less invasive treatment options when they are informed about them and are asked about their preferences.\(^3\)
- The clinical care standard promotes informed choice and shared decision making, which are crucial to appropriate treatment of heavy menstrual bleeding.
- Transvaginal ultrasound is recommended when imaging is required, but currently it appears that many women are undergoing second ultrasounds because of quality issues. Ensuring that gynaecological ultrasounds are optimally timed and reported in line with quality practice standards will reduce the need to repeat this relatively invasive procedure, as well as reducing the resulting costs and delays.
- If imaging is required, it must be conducted at the optimal time in the menstrual cycle. If it is not, women will either need to have a second ultrasound or medical decisions may be made based on inaccurate imaging.
- Indicators have been developed alongside this clinical care standard to support ongoing quality improvement activities by the health service organisations and Primary Health Networks that choose to use them.