Scenario:

safe practical clinical answers - *fast*

How should I diagnose menorrhagia?

- Menorrhagia is diagnosed when both the woman and clinician agree menstrual bleeding is heavy after a history has been taken.
- It is not necessary to measure blood loss to diagnose menorrhagia.

Basis for recommendation

These recommendations are consistent with clinical guidelines on *Heavy menstrual bleeding*, published by the National Institute for Health and Clinical Excellence [National Collaborating Centre for Women's and Children's Health, 2007].

What should I ask about when taking the history?

The history should set out to define the nature of the bleeding; identify potential underlying causes; and to address the woman's ideas, concerns, expectations, and needs.

- Ask the woman her age at menarche and for details about her menstrual cycle — length of cycle, the number of days of menstruation, how long she considers her periods to be heavy, what were her periods like previously, and impact on quality of life.
- Enquire about symptoms that suggest an underlying pathology, particularly 'red flag' symptoms (e.g. persistent intermenstrual or postcoital bleeding).
- Consider the possibility of an underlying systemic disease, such as hypothyroidism or a coagulation disorder (e.g. von Willebrand disease).
- Take a family history, and in particular ask about endometriosis and coagulation disorders that may have a hereditary component.
- Check the woman's smear status.
- Ask about current contraceptive use, contraceptive plans, and future plans for a family.

o It is important to ascertain the woman's need for contraception, as this may impact on the choice of treatment. For more information, see Advice and counselling.

Symptoms suggesting an underlying pathology

- Underlying pathologies that might be found in women with heavy menstrual bleeding include pelvic inflammatory disease, endometriosis, and endometrial carcinoma. For further information, see Causes of menorrhagia.

- Symptoms that may indicate an underlying pathology include:
  - Persistent postcoital bleeding.
  - Persistent intermenstrual bleeding.
  - Dyspareunia.
  - Dysmenorrhoea.
  - Pelvic pain and/or pressure symptoms.
  - Vaginal discharge.

Basis for recommendation

These recommendations are consistent with clinical guidelines on *Heavy menstrual bleeding*, published by the National Institute for Health and Clinical Excellence [National Collaborating Centre for Women's and Children's Health, 2007].

When and how should I examine the woman?

- Consider abdominal and pelvic examination in the following women:
  - Women with symptoms suggestive of underlying abnormalities, before further investigations are arranged.
  - Those in whom initial treatment has proved ineffective.
  - Those for whom the levonorgestrel-releasing intrauterine system is being considered.
- A pelvic examination should include:
  - Vulval examination for evidence of external bleeding and signs of infection (e.g. vaginal discharge).
  - Speculum examination of vagina and cervix. High vaginal, endocervical, and chlamydia swabs should be obtained if infection is suspected.
  - Bimanual palpation to identify uterine or adnexal enlargement or tenderness.
- In addition to abdominal and pelvic examination, look for systemic signs of underlying disease:
  - Endocrine disease: hirsutism, striae, thyroid enlargement or nodularity, or changes in skin pigmentation.
  - Coagulation disorders: bruises or petechiae.
- Women who refuse an examination should be referred directly for investigations as appropriate.
- Women who have fibroids that are palpable abdominally should be offered immediate referral or sent for an ultrasound.

Basis for recommendation

These recommendations are consistent with clinical guidelines on *Heavy menstrual bleeding*, published by the National Institute for Health and Clinical Excellence [National Collaborating Centre for Women's and Children's Health, 2007], and are based on consensus opinion rather than primary evidence.

What investigations should I carry out?

- Menstrual blood loss does not have to be measured accurately, and objective measurement is impractical.
- Take a full blood count in all women to rule out iron deficiency anaemia.
  - Iron deficiency anaemia is a strong indicator of excessive menstrual bleeding (see the CKS topic on Anaemia - iron deficiency).
- Other blood tests and endocrine investigations are not routinely indicated.
  - Thyroid function tests should only be carried out if the woman has other symptoms or signs suggestive of thyroid disease (for more information on hypothyroidism, see the CKS topic on Hypothyroidism).
  - Tests for bleeding disorders (e.g. von Willebrand disease) should be performed if there are suggestive features in the history or on examination. Investigations should be arranged in conjunction with the local haematology department, as many of the tests are not routine. Women who may require screening include:
    - Those who have had heavy menstrual bleeding since menarche, or a history of excessive bleeding after tooth extraction, operations, or childbirth.
    - Those with a family history of a coagulation disorder.
- Consider opportunistic cervical screening, if appropriate, in line with national recommendations.
- Consider arranging for a trans-vaginal pelvic ultrasound to identify structural abnormalities if the woman has symptoms suggesting an underlying cause for heavy menstrual bleeding, or if she:
  - Has a uterus that is palpable abdominally.
  - Has a pelvic mass of uncertain origin on vaginal examination (although also consider urgent referral).
  - Has had treatment that has proved ineffective.
- Urgent referral to a specialist (rather than referral for ultrasound) should always be considered if a suspicious mass is detected.
- Investigations that may be used in secondary care include hysteroscopy and tissue biopsy for endometrial cancer; for further information, see Management in secondary care.

Basis for recommendation

These recommendations are consistent with clinical guidelines on *Heavy menstrual bleeding*, published by the National Institute for Health and Clinical Excellence [National Collaborating Centre for Women's and Children's Health, 2007].

- Although there is evidence from diagnostic studies to support objective measurements to determine menstrual blood loss, this is generally felt to be impractical in most clinical situations and is unlikely to guide clinical management.
  - o Direct objective measurement of menstrual blood loss includes the alkaline haematin technique.
  - o The pictorial blood loss assessment chart is an indirect measure.
- Results from epidemiological studies have found that:
  - o Thyroid disease is not associated with menstrual disorders and therefore should not be routinely tested for.
  - o Coagulation disorders, such as von Willebrand disease, are an identifiable risk
  - o factor in women who have experienced heavy bleeding since the menarche.

What advice and counselling should I give to a woman with menorrhagia?

- Discuss the natural variability and range of menstrual blood loss. For some women, reassurance may be all that is required, and treatment may not be needed.
- If reassurance alone is not appropriate, discuss the different treatment options for heavy menstrual bleeding, covering issues such as:
  - o Effectiveness of treatments.
  - o Acceptability of treatments, including likelihood of adverse effects.
  - o Whether contraception will be required.
  - o Implications of treatment on fertility.
- Give written information such as patient information leaflets, to explain the condition and treatment options, where appropriate.
  - o Patient information covering heavy menstrual bleeding is published by the National Institute for Health and Clinical Excellence (NICE) and can be found at www.nice.org.uk (pdf) [NICE, 2007a].
  - o If asked, advise that no specific lifestyle changes benefit menorrhagia.

• If the woman and clinician cannot agree on the most appropriate treatment option, she should be offered the option of a second opinion.

Basis for recommendation

These recommendations are based on clinical guidelines on *Heavy menstrual bleeding*, published by NICE [National Collaborating Centre for Women's and Children's Health, 2007].

• NICE could find no evidence from controlled trials or other types of study that showed any benefit of lifestyle changes (e.g. diet or exercise). Some studies have identified risk factors (e.g. smoking and obesity), but these are not currently seen as planned interventions, but as general health-promotion issues.

When should I prescribe pharmaceutical treatment in women presenting with menorrhagia?

• Pharmaceutical treatment is recommended first-line for woman with menorrhagia who:
o Have no symptoms suggestive of underlying pathology including postcoital bleeding, intermenstrual bleeding, dyspareunia, dysmenorrhoea, vaginal discharge, and pelvic pain and/or pressure (these symptoms may indicate pelvic inflammatory disease, endometriosis, or endometrial carcinoma). See History.
o Are awaiting the results of investigations.

Basis for recommendation

This recommendation is based on clinical guidelines on *Heavy menstrual bleeding*, published by the National Institute for Health and Clinical Excellence [National Collaborating Centre for Women's and Children's Health, 2007].

• Once major structural or histological abnormalities have been excluded, the cause of menorrhagia is likely to be idiopathic with no obvious underlying pathology. In most cases, this will respond to symptomatic treatment.

Which pharmaceutical treatment should I prescribe in a woman with menorrhagia?

Treatments for menorrhagia should be considered in the following order:

- **The levonorgestrel-releasing intrauterine system (LNG-IUS)** (Mirena®) is the preferred first-choice, provided that long-term contraception with an intrauterine device is acceptable (anticipated minimum use of 12 months).
- **Tranexamic acid, nonsteroidal anti-inflammatory drugs (NSAIDs), or the combined oral contraceptive pill (COC)** should be considered second, if LNG-IUS is unsuitable.

o Tranexamic acid and NSAIDs are suitable if contraception is not desired and are first-choice drugs while investigations or definitive treatment is being organized.

▪ If dysmenorrhoea is present, NSAIDs may be preferred, as they provide relief of menstrual pain.

▪ CKS recommends that if an NSAID is to be used, mefenamic acid, naproxen, or ibuprofen should be prescribed.

o The COC offers more readily reversible contraception than the LNG-IUS. It also has the benefit of regulating cycles and reducing dysmenorrhoea.

- **Oral norethisterone or long-acting progestogens** should be considered third choice if the other treatments are unsuitable.

o Oral norethisterone should be taken during the follicular and luteal phases (days 5 to 26). It is *not* an effective form of contraception. However, a dose that is effective in decreasing menstrual blood loss is also likely to inhibit ovulation, and so its use is not appropriate in women wishing to conceive.

o Depot medroxyprogesterone acetate (Depo-Provera®) is the recommended long-acting progestogen. It is taken as an intramuscular injection once every 12 weeks.

- Danazol, gestrinone, and etamsylate are not recommended for the treatment of menorrhagia.
- Gonadotropin-releasing hormone analogues (e.g. leuprorelin or buserelin) are not recommended for use in primary care, but are an option in secondary care. For more information, see Management in secondary care.

For more information on prescribing drugs to treat menorrhagia, see Prescribing information sections on Levonorgestrel-releasing intrauterine system, Tranexamic acid, Nonsteroidal anti-inflammatory drugs, Combined oral contraceptives, Oral norethisterone, and Long-acting progestogens.

Basis for recommendation

These recommendations are based on clinical guidelines on *Heavy menstrual bleeding*, published by the National Institute for Health and Clinical Excellence (NICE) [National Collaborating Centre for Women's and Children's Health, 2007].

• The order of treatment recommended by NICE is based on the clinical effectiveness and cost-effectiveness of the available pharmaceutical interventions for menorrhagia. For details of the evidence from controlled trials on menorrhagia treatment, see individual sections of Supporting evidence on:

o Levonorgestrel-releasing intrauterine system

o Tranexamic acid

o Nonsteroidal anti-inflammatory drugs

o Combined oral contraceptives

o Oral norethisterone

o Danazol and etamsylate (not recommended)

What should I do if initial drug treatment is ineffective in a woman with menorrhagia?

• If initial treatment fails to produce an adequate reduction in menstrual bleeding (and treatment was complied with), consider three options:

o Switch to an alternative pharmaceutical treatment. Oral norethisterone or depot medroxyprogesterone are often suitable if initial treatment was ineffective.

o Add on an additional drug. Typically, tranexamic acid can be combined with a nonsteroidal anti-inflammatory drug (NSAID), or an NSAID can be combined with the combined oral contraceptive.

o Refer to a specialist.

Basis for recommendation

These are pragmatic recommendations by the CKS, based on standard clinical practice. They are consistent with the clinical guideline on *Heavy menstrual bleeding*, published by the National Institute for Health and Clinical Excellence (NICE) [National Collaborating Centre for Women's and Children's Health, 2007].

• NICE recommends on the basis of consensus opinion that 'when a first pharmaceutical treatment has proved ineffective, a second pharmaceutical treatment can be considered rather than immediate referral to surgery'.

• NICE does not make any recommendations on combining treatments, nor is there evidence from controlled trials on the effectiveness of combining treatments. Nevertheless, this is often done in practice and anecdotal evidence suggests that it can be beneficial. For further information on which treatments can be combined, see When to combine treatment.

• Further treatment options, including referral, are available from specialist management in secondary care.

How can I rapidly stop heavy bleeding, if necessary?

- Consider stopping heavy menstrual bleeding by prescribing oral norethisterone.
  - Oral norethisterone, 5 mg three times daily, usually stops bleeding in 24–48 hours.
  - If bleeding is exceptionally heavy ('flooding'), 10 mg three times daily may provide better results (get informed consent). This should then be tapered down to 5 mg three times daily for about a week once bleeding has stopped.

Basis for recommendation

These pragmatic recommendations are based on national formularies [BNF 53, 2007], data sheets [ABPI Medicines Compendium, 2006], the available medical literature [Rees, 2003], and expert opinion [Rees, Personal Communication, 2007].

- There is no strict definition on what constitutes very heavy bleeding. It ranges from prolonged, heavy menstruation to acute periods of exceptionally heavy bleeding that is difficult to control using sanitary products. In these cases, the woman may desire acute treatment to rapidly stop the bleeding.
- CKS could not find any controlled trials that investigated the use of drugs to stop acute and exceptionally heavy menstrual bleeding, but oral progestogens are usually used for this purpose.
  - The licensed dose of norethisterone to arrest uterine bleeding is 10–15 mg per day [ABPI Medicines Compendium, 2006; BNF 53, 2007]. This should be adequate in most cases; if the higher dose regimen of oral norethisterone (i.e. 30 mg per day) is considered necessary, informed consent should be sought before starting treatment.
  - However, a higher (off-license) dose of norethisterone may be required for rapid cessation of bleeding if the bleeding is exceptionally heavy (flooding) [Rees, Personal Communication, 2007].

When should I refer?

- Refer the woman to a specialist if:
  - There are alarm symptoms suggesting a possible malignancy. Urgent referral is required (within 2 weeks).
  - Heavy bleeding persists that negatively affects the woman's quality of life, despite adequate trials of pharmaceutical treatment. A routine referral should be made, according to local protocols.
  - The woman wishes to consider surgery rather than persist with medical treatment. A routine referral should be made, according to local protocols.

o The woman has iron deficiency anaemia that has failed to respond to treatment, and other causes have been excluded. The timing of referral should reflect clinical judgement.

Alarm symptoms

- Alarm symptoms or signs suggestive of gynaecological cancer, which include:
o Persistent intermenstrual or postcoital bleeding.
o An unexplained vulval lump or vulval bleeding due to ulceration.
o A palpable abdominal mass that is not obviously uterine fibroids.
- If there are clinical features of cervical cancer, an urgent referral should be made without the need for a smear test, and regardless of previous smear results.
- For further information on when to refer to a specialist when a gynaecological cancer is suspected, see the CKS topic on Gynaecological cancer - suspected.

Basis for recommendation

These referral recommendations are based on *Referral Advice: A guide to appropriate referral from general to specialist services* [NICE, 2001], and *Referral guidelines for suspected cancer: quick reference guide* [NICE, 2005a], both published by the National Institute for Health and Clinical Excellence.

- Specialist services are in a position to:
o Confirm, establish, or exclude a diagnosis. Investigations in secondary care include endometrial biopsy, hysteroscopy, and/or pelvic ultrasound.
o Advise women on, and oversee where necessary, drug management.
o Discuss and undertake surgical operations, such as endometrial ablation and hysterectomy.
- For more information on treatments that may be undertaken in secondary care, see Management in secondary care.

What management is available in secondary care?

What investigations can be carried out in secondary care?

- An endometrial biopsy for histological examination should be taken to exclude endometrial cancer or atypical hyperplasia, if appropriate, for example in women:
o With persistent intermenstrual bleeding.
o Aged 45 years and over.
o Whose treatment has failed or is ineffective.

• Hysteroscopy allows direct visualisation of the uterine cavity and the opportunity to take an endometrial biopsy. It is used as a diagnostic tool when ultrasound results are inconclusive, to determine the exact location of a fibroid or the exact nature of an abnormality.
• Dilatation and curettage (D and C) is no longer recommended as a diagnostic tool for heavy menstrual bleeding.

[National Collaborating Centre for Women's and Children's Health, 2007]

What drug treatments are available in secondary care?

• CKS recommends that therapy with gonadotrophin-releasing hormone (GnRH) analogues (e.g. leuprorelin and buserelin) should not be initiated in primary care.
o They produce a profound hypogonadal effect through downregulation, resulting in no ovulation and no menses.
o They may be used under specialist supervision before surgery or when all other treatment options for uterine fibroids, including surgery or uterine artery embolization, are contraindicated. They may also be used to produce temporary endometrial thinning and relief of bleeding before fibroid surgery.
• GnRH analogues are effective at treating menorrhagia. Evidence from two randomized controlled trials has shown:
o They are effective at reducing menstrual blood loss (RR 1.39, 95% CI 1.12 to 1.72).
o They cause amenorrhoea in most women (89%).
• GnRH analogues can cause significant adverse effects that often limit their use. These are principally perimenopausal in nature, including hot flushes, increased sweating, and vaginal dryness (due to oestrogen deficiency).
• GnRH analogues are given by subcutaneous or intramuscular injection, or intranasally, and they are usually used for less than 6 months. If treatment with these drugs is required for more than 6 months or if adverse affects are experienced, 'add-back' treatment with supplemental oestrogens and progestogens is recommended.

[National Collaborating Centre for Women's and Children's Health, 2007]

What surgical treatments are available in secondary care?

• Surgical treatments are almost always used as second-line options in the treatment of menorrhagia, despite the long-term effectiveness (and irreversible nature) of surgery. A systematic review found that surgery improved control of bleeding compared with pharmaceutical treatments after 5 years (OR 1.99, 95% CI 0.84 to 4.73). However, this

does not take into account the reversibility of pharmaceutical treatments and other risks with surgery.

- Surgery should be reserved for:
  - Use on the woman's request (following full counselling on the advantages and disadvantages).
  - Difficult-to-treat cases where pharmaceutical treatment has failed to be sufficiently effective or is contraindicated.

[National Collaborating Centre for Women's and Children's Health, 2007]

Endometrial ablation

- Endometrial ablation involves destroying the endometrium (lining) and the superficial myometrium (muscle) of the uterus. The process also prevents the woman from having children in the future. The technique was first developed in the mid-1990s, and has since evolved.
  - First generation techniques consisted of transcervical resection with an electrosurgical loop to destroy tissue or the use of a heated rollerball. These require highly-trained surgeons and are now recommended only where hysteroscopic myomectomy is needed.
  - Second generation techniques were developed to be simpler to use, and are now recommended as standard. These include methods using thermal balloons, microwaves, radiowaves, and cryotherapy.
- There is good evidence from controlled trials that endometrial ablation techniques lead to clinically significant improvements in menstrual blood loss as well as improvements in quality of life. Endometrial ablation is generally preferred to hysterectomy in most women, as it is a less drastic option. It is recommended by the National Institute for Health and Clinical Excellence, provided:
  - Bleeding is having a severe negative impact on the woman's quality of life.
  - Pharmaceutical treatment has been tried but was ineffective, or was not suitable, and a surgical solution is appropriate.
  - The woman does not want to conceive in the future (although contraception may still be needed).
  - The uterus is normal or has fibroids less than 3 cm in diameter, or is no bigger than a 10 week pregnancy.

[National Collaborating Centre for Women's and Children's Health, 2007]

Hysterectomy

- Hysterectomy is the surgical removal of the uterus and may also involve removal of the cervix, fallopian tubes, and/or ovaries (oophorectomy). It is a major surgical procedure with a risk of serious complications. It requires weeks of physical recovery post-operatively and may have psychological complications.
- Hysterectomy was considered the only viable surgical treatment until the mid-1990s; however, since then, other effective techniques have become available. This is reflected in the numbers of hysterectomies performed in the UK: 24,355 in 1993 compared with 10,559 in 2002 (most of this reduction will have been due to alternative surgical treatments and improved pharmaceutical treatments for menorrhagia).
- In general, other less invasive techniques are preferred to hysterectomy for the surgical treatment of menorrhagia, as it is beneficial for most women to retain their uterus. The National Institute for Health and Clinical Excellence recommends that, after a thorough discussion with the woman about the benefits and disadvantages of hysterectomy, it should be considered when:
  - o The woman requests it.
  - o Other treatment options have failed, are contraindicated, or are declined by the woman.
  - o There is a wish for amenorrhoea, and the woman no longer wishes to retain her uterus or fertility.
- Removal of the ovaries (oophorectomy) at the same time as hysterectomy is not recommended unless:
  - o There is a family history of breast or ovarian cancer (refer for genetic counselling first).
  - o There are symptoms related to ovarian dysfunction such as premenstrual syndrome (a trial of pharmaceutical ovarian suppression should be used first).
  - o The woman expressly requests it (after appropriate counselling).

[National Collaborating Centre for Women's and Children's Health, 2007]

Uterine artery embolization and myomectomy

- Uterine artery embolization and myomectomy are both techniques primarily aimed at reducing the size of, or removing, uterine fibroids, but both have benefits in reducing menstrual blood loss. Previously, hysterectomy was seen as the only viable surgical option for these women.
  - o Uterine artery embolization involves blocking the uterine arteries by injection of particles from a catheter inserted into the femoral artery, causing fibroids to shrink.
  - o Myomectomy is the surgical removal of fibroids through laparotomy, laparoscopically, or hysteroscopically. Its main disadvantage is that uterine fibroids can grow back, requiring further surgery.

- The National Institute for Health and Clinical Excellence recommends that [National Collaborating Centre for Women's and Children's Health, 2007]:

o Uterine artery embolization, myomectomy, or hysterectomy, should be considered when the woman has large fibroids and heavy menstrual bleeding with other accompanying symptoms, such as dysmenorrhoea or pressure symptoms; or the woman has large fibroids that are causing bleeding that is having a severe impact on the woman's quality of life.

o Myomectomy should be considered for women who want to retain their uterus.

o Uterine artery embolization is recommended for women who want to retain their uterus and avoid invasive surgery.

Prescriptions

Levonorgestrel-releasing intrauterine system: first choice

Age from 13 to 60 years

Levonorgestrel 20mcg/24hrs intra-uterine system (Mirena®)
Levonorgestrel 20micrograms/24hours intrauterine system For insertion into the uterine cavity. Supply 1 device.
Age: from 13 years to 60 years NHS cost: £83.16 Licensed use: yes
Patient information: You may experience irregular bleeding for about 6 months after insertion of the device. Seek medical advice if this persists

Tranexamic acid: second choice

Age from 12 years onwards

Tranexamic acid 1g three times a day during periods
Tranexamic acid 500mg tablets Take two tablets three times a day for up to 4 days after your period has begun. (If bleeding is very heavy, increase up to three tablets four times a day.) Supply 120 tablets.
Age: from 12 years onwards NHS cost: £20.58 Licensed use: yes

Nonsteroidal anti-inflammatory drugs: second choice

Age from 12 years onwards

Mefenamic acid tablets: 500mg three times a day during periods
Mefenamic acid 500mg tablets Take one tablet three times a day during your period. Supply 50 tablets.
Age: from 12 years onwards NHS cost: £3.24 Licensed use: yes

Naproxen 250mg every 6 to 8 hours during periods
Naproxen 250mg tablets Take one or two tablets initially, then take one tablet every 6 to 8 hours during your period. Maximum of 5 tablets in 24 hours. Supply 56 tablets.
Age: from 12 years onwards NHS cost: £3.80 Licensed use: no - off-label indication

Ibuprofen 400mg three times a day during periods
Ibuprofen 400mg tablets Take one tablet three times a day during your period. Supply 42 tablets.
Age: from 12 years onwards NHS cost: £1.63 OTC cost: £2.90 Licensed use: no - off-label indication

Combined oral contraceptive pill: second choice

Age from 13 to 50 years

Microgynon 30: levonorgestrel 150mcg+ethinylestradiol 30mcg
Microgynon 30 tablets Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions. Supply 63 tablets.
Age: from 13 years to 50 years NHS cost: £2.99 Licensed use: yes
Patient information: This pill is for your heavy menstrual bleeding, but is also a contraceptive. If you are relying on it for contraception, it is essential to follow the instructions carefully. Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek advice from a health professional.

Microgynon 30 ED: levonorgestrel150mcg+ethinylestradiol30mcg

Microgynon 30 ED tablets Take one tablet once a day. See package insert for full instructions. Supply 84 tablets.
Age: from 13 years to 50 years NHS cost: £2.69 Licensed use: yes
Patient information: This pill is for your heavy menstrual bleeding, but is also a contraceptive. If you are relying on it for contraception, it is essential to follow the instructions carefully. Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek advice from a health professional.

Ovranette: levonorgestrel 150mcg + ethinylestradiol 30mcg
Ovranette tablets Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions. Supply 63 tablets.
Age: from 13 years to 50 years NHS cost: £2.29 Licensed use: yes
Patient information: This pill is for your heavy menstrual bleeding, but is also a contraceptive. If you are relying on it for contraception, it is essential to follow the instructions carefully. Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek advice from a health professional.

Levest: levonorgestrel 150mcg + ethinylestradiol 30mcg
Levest 150/30 tablets Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions. Supply 63 tablets.
Age: from 13 years to 50 years NHS cost: £2.64 Licensed use: yes
Patient information: This pill is for your heavy menstrual bleeding, but is also a contraceptive. If you are relying on it for contraception, it is essential to follow the instructions carefully. Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek advice from a health professional.

Rigevidon: levonorgestrel 150mcg+ethinylestradiol 30mcg

Rigevidon tablets
Take one tablet once a day for 21 days. Start the next packet after a 7-day break.
See package insert for full instructions.
Supply 63 tablets.

Age: from 13 years to 50 years
NHS cost: £1.89
Licensed use: yes

Patient information: This pill is for your heavy menstrual bleeding, but is also a contraceptive. If you are relying on it for contraception, it is essential to follow the instructions carefully. Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek advice from a health professional.

Brevinor: norethisterone 500mcg + ethinylestradiol 35mcg

Brevinor 500microgram/35microgram tablets
Take one tablet once a day for 21 days. Start the next packet after a 7-day break.
See package insert for full instructions.
Supply 63 tablets.

Age: from 13 years to 50 years
NHS cost: £1.99
Licensed use: no - off-label indication

Patient information: This pill is for your heavy menstrual bleeding, but is also a contraceptive. If you are relying on it for contraception, it is essential to follow the instructions carefully. Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek advice from a health professional.

Ovysmen: norethisterone 500mcg + ethinylestradiol 35mcg

Ovysmen 500microgram/35microgram tablets
Take one tablet once a day for 21 days. Start the next packet after a 7-day break.
See package insert for full instructions.
Supply 63 tablets.

Age: from 13 years to 50 years
NHS cost: £1.58
Licensed use: yes

Patient information: This pill is for your heavy menstrual bleeding, but is also a contraceptive. If you are relying on it for contraception, it is essential to follow the instructions carefully. Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek advice from a health professional.

Loestrin 30: norethisterone 1.5mg + ethinylestradiol 35mcg
Loestrin 30 tablets Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions. Supply 63 tablets.
Age: from 13 years to 50 years NHS cost: £3.90 Licensed use: no - off-label indication
Patient information: This pill is for your heavy menstrual bleeding, but is also a contraceptive. If you are relying on it for contraception, it is essential to follow the instructions carefully. Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek advice from a health professional

Norimin: norethisterone 1mg + ethinylestradiol 35mcg
Norimin 1mg/35microgram tablets Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions. Supply 63 tablets.
Age: from 13 years to 50 years NHS cost: £2.28 Licensed use: no - off-label indication
Patient information: This pill is for your heavy menstrual bleeding, but is also a contraceptive. If you are relying on it for contraception, it is essential to follow the instructions carefully. Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek advice from a health professional.

Cilest: norgestimate 250mcg + ethinylestradiol 35mcg
Cilest 250microgram / 35microgram tablets Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions. Supply 63 tablets.
Age: from 13 years to 50 years NHS cost: £5.97 Licensed use: yes

Patient information: This pill is for your heavy menstrual bleeding, but is also a contraceptive. If you are relying on it for contraception, it is essential to follow the instructions carefully. Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek advice from a health professional.

Oral norethisterone: third choice

Age from 13 years onwards

Oral norethisterone 15mg a day (follicular and luteal phase)
Norethisterone 5mg tablets Take one tablet three times a day for 3 weeks, starting 5 days after the start of your period. Supply 189 tablets.
Age: from 13 years onwards NHS cost: £24.51 Licensed use: off-label duration

Depot medroxyprogesterone: third choice

Age from 13 to 60 years

Medroxyprogesterone acetate 150mg syringe (Depo-Provera®)
Medroxyprogesterone 150mg/1ml suspension for injection pre-filled syringes Give 150mg (1ml) by deep intramuscular injection. Supply 1 1ml prefilled syringe.
Age: from 13 years to 60 years NHS cost: £5.01 Licensed use: yes
Patient information: You may experience altered bleeding patterns whilst you are using this injection.

Oral norethisterone: for rapid cessation of flooding

Age from 13 years onwards

Oral norethisterone 15mg a day (standard dose for flooding)
Norethisterone 5mg tablets Take one tablet 3 times a day for 1 week. Supply 21 tablets.

Age: from 13 years onwards
NHS cost: £2.72
Licensed use: yes

Oral norethisterone 30mg a day (high dose for severe flooding)
Norethisterone 5mg tablets Take two tablets 3 times a day until bleeding stops, then take one tablet three times a day for a further week. Supply 60 tablets.
Age: from 13 years onwards NHS cost: £7.78 Licensed use: no - off-label dose