Abnormal Uterine Bleeding

Work-up and Assessment

Abnormal uterine bleeding (AUB) is common and may arise due to structural pathology (i.e., fibroids, endometrial polyps, adenomyosis, neoplasia) or non-uterine issues (i.e., ovulatory dysfunction, disorders of hemostasis, medications).

DIagnosis

The Fédération International de Gynécologie et d'Obstétrique (FIGO) created the acronym: PALM-COEIN to guide diagnosis: **P**olyp, **A**denomyosis, **L**eiomyoma, **M**alignancy, and **C**oagulopathy, **O**vulatory disorders, **E**ndometrial, **I**atrogenic, and **N**ot otherwise classified).

Clinical Evaluation

- **Patient History:**
  - Evaluate for irregular duration, frequency, and volume of menstrual bleeding.
  - Assess for ovulatory issues (i.e., PCOS).
  - Consider associated symptoms (i.e., pain, fatigue, weight gain, mood changes, sleep, inability to conduct activities of daily living).
  - Reproductive history: onset of menses, pregnancy, miscarriages, menopausal status.

- **Physical Exam:**
  - Pelvic exam: Assess for structural abnormalities (i.e., fibroids, polyps).
  - Cervical exam: Evaluate for cervical lesions or infection.
  - Check for sIgns of anemia, bleeding disorders, and endometrial cancer.

- **Medications:**
  - Hormonal contraceptives, blood thinners, aspirin, hormone replacement therapy, iron supplements, and tamoxifen.

Laboratory Tests

  - Complete blood count (CBC) to check for anemia; coagulation tests, if indicated
  - Thyroid function tests (TSH) to rule out thyroid disorders.
  - Hormone levels: LH, FSH, prolactin, and androgens for any imbalance.

Imaging

- Pelvic Ultrasound: First-line imaging to concern structural abnormalities (i.e., fibroids, polyps).
- Transvaginal ultrasound: For enhanced visualization of the endometrium and ovaries.
- Sonohysterography: Ultrasound using saline infusion for detailed uterine cavity imaging.
- MRI: For further evaluation of indeterminate masses or extensive fibroids.
- Other Diagnostic Tools:
  - Hysteroscopy: Direct visualization with or without biopsy of the uterine cavity.
  - Dilation and Curettage (D&C): Diagnostic and sometimes therapeutic procedure for endometrial sampling.

Sources::
- UpToDate: Abnormal Uterine Bleeding: Management and Diagnosis.
- American College of Obstetricians and Gynecologists. Clinical Practice Guidelines on Abnormal Uterine Bleeding.
- StatPearls. Evaluation of Abnormal Uterine Bleeding in Reproductive-Aged Women.

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TREATMENT

Management Goals for Reproductive-Aged Individuals:
- Correct for or treat any underlying primary etiology.
- Support unimpeded activities of daily living and quality of life.
- Achieve a regular bleeding pattern (or amenorrhea).

Patient-Centered Considerations:
- **History and severity of bleeding** (i.e., nose bleeds, bruising, excessive bleeding after a dental procedure) frequently co-exist with fibroids.
- **Associated symptoms** (i.e., pelvic pain/pressure, dysmenorrhea, infertility, adenomyosis).
- **Contraception and plans for future pregnancy**. If pregnancy is desired, avoid levonorgestrel intrauterine device and depot medroxyprogesterone acetate.
- **Clinical comorbidities.** Consider patient risk for thrombosis; if yes, estrogen-progestin contraceptives are contraindicated.
- **Treatment preferences** (i.e., medical vs. surgical options; short-term versus long-term therapy)
- **Time to menopause.** Considerations may change if the patient is nearing menopause.

Treatment Priorities:
- Address underlying conditions including structural lesions: polyps, cesarean scar tissue, fibroids, and endocrine (i.e., PCOS, hypothyroidism, hyperprolactinemia), and infections)
- When no detected structural anomalies are present, consider hormonal therapies (i.e., estrogen-progestin contraceptives, levonorgestrel-releasing intrauterine device, progestin-only oral or injectable medications, non-contraceptive estrogen-progestin formulations); non-hormonal medications (i.e., tranexamic acid; and nonsteroidal anti-inflammatory drugs)
- For patients with no plans for future pregnancy and an expressed desire to avoid medical therapy or for whom medical therapy was ineffective or resulted in adverse side effects, surgery is an option.

Other Considerations:
- Patients planning for a pregnancy should be advised that estrogen-progestin contraceptives may delay the ability to conceive for several months after discontinuation; tranexamic acid (stimulating blood clotting to control for heavy bleeding) and NSAIDs should be stopped once pregnant. Medroxyprogesterone acetate should be avoided in anyone wishing to conceive in the next two years.
- About 30% of individuals taking oral anticoagulant therapy, particularly warfarin, experience exacerbated AUB; adjusting the dose to a (prothrombin time test) INR range of 2 to 3 tends to resolve heavy bleeding. When there are no structural lesions, progestin-only therapy is recommended.
- New onset iron deficiency anemia in adults over age 50 should be evaluated for other causes, including upper gastrointestinal disorders.

When to Make a Referral:
- Suggest a gynecologic consult for patients with heavy or persistent bleeding despite treatment and/or increased risk of thrombosis; if there is suspicion of malignancy; or, for those needing surgery, including for endometrial sampling or placement of an intrauterine device (as warranted).
- Suggest an endocrine consult to rule out hypothalamic amenorrhea, necessitating a series of laboratory tests to evaluate serum levels of estrogen, thyroid hormones, and prolactin

Sources:
StatPearls. Abnormal Uterine Bleeding.
UpToDate: Abnormal Uterian Bleeding: Management.
Whitaker L. Abnormal Uterine Bleeding.

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