This booklet for women originally produced in 1998 by the Dorset PACE (Promoting Action On Clinical Effectiveness) Project on Heavy Menstrual Bleeding led by Mr. John Edwards, Consultant Gynaecologist at Poole Hospital.

It has been revised and brought up to date by Mr Julian Pampiglione Consultant Gynaecologist at Royal Bournemouth Hospital and a member of the original project team. There have been a number of significant changes in management highlighted and the recent national NICE Guidelines have been incorporated

The project team would like to thank the women who completed questionnaires and joined discussion groups without whom a full understanding of the issues would not have been possible. Their good humoured comments have inspired the cartoons in this booklet.

The information gathered from those discussions have been included in the booklet and we hope it will help other women and their doctors.

1. HOW TO USE THIS BOOKLET

Many women suffer from heavy bleeding during their periods and seek help from their family doctor (or GP). Heavy periods are one of the most common reasons why GPs refer patients to doctors specialising in the treatment of women (gynaecologists). There are various ways of treating this problem - ranging from prescription drugs to surgery. Different treatments suit different women. It is important that you discuss the options with your doctor, so you can decide which course of action best suits you. This booklet has been designed to:

- give you information about the different treatments available;
- explain the process for checking why you have heavy periods;
- help you choose which treatment you wish to try;
- provide a record of the treatments you do try.

Your doctor can help you complete the records at the end of this booklet. Don't be afraid to ask him or her questions if you don't understand something. It is difficult to avoid using medical terms when discussing this problem and you need to understand what they mean. There is a list of the terms used and explanations at the end of the booklet to help you.

2. BACKGROUND INFORMATION

What is heavy bleeding?

The medical term for heavy, regular menstrual bleeding is menorrhagia (pronounced men-or-ray-ja). Heavy periods can affect all aspects of your life - work, your social life, sex life, your energy and your emotions. It may be associated with other menstrual symptoms, such as pain, bloating, breast tenderness, mood swings or headaches.

Menorrhagia is most common among women aged between 40 and 49, although some women suffer heavy periods when they are younger. Menstrual periods cease after the menopause (the `change of life'), which for most women occurs around 50, although it can happen several years earlier or later.

On average women lose about 35 ml of blood per menstrual period. This is about two and a half tablespoons.

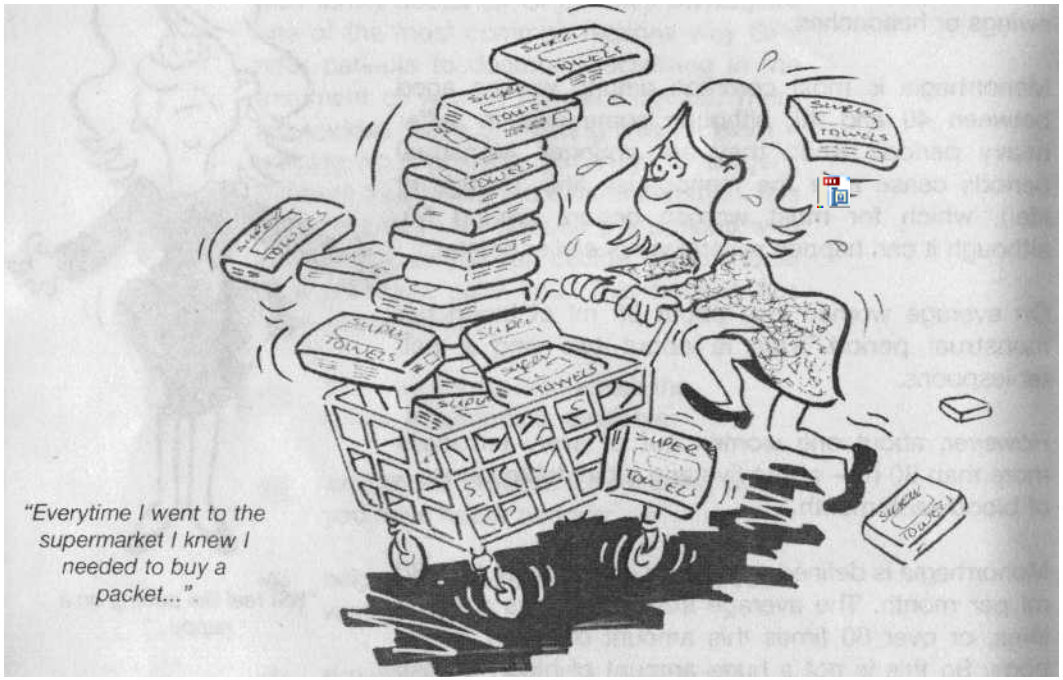
However, about one women out of every ten loses more than 80 ml - about five and a half tablespoons - of blood each month.

Menorrhagia is defined as a blood loss of more than 80 ml per month. The average sized adult has about 5 litres, or over 60 times this amount of blood, in the body. So this is not a huge amount of blood to lose but it can cause considerable discomfort and embarrassment and may require frequent changes of sanitary towels and/or tampons.

Although they are inconvenient and uncomfortable, heavy, regular periods are not usually a sign of a serious illness. However other kinds of menstrual problems, such as periods that are very irregular or very painful, or bleeding between periods or after sexual intercourse, may suggest a problem that needs quick attention and you should tell your doctor if you are having any of these symptoms.

"You feel like putting on a nappy.."

How can I tell if my **periods are** heavy?
This may seem a silly question since you have already sought your doctor's help. However most women can only make this judgement on the basis of their own experience. It is not unusual for periods to gradually become heavier as a woman gets older, but the blood loss may still be within the normal range. Some women find that once they know the increased blood loss is not a symptom of a serious illness, they can cope with a heavier period.



"Everytime I went to the supermarket I knew I needed to buy a packet..."

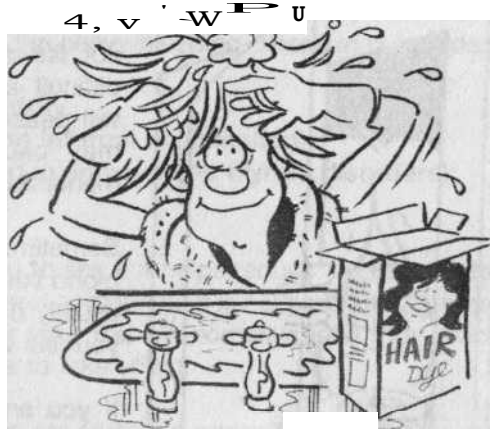
The length of periods can vary greatly. Some women bleed for only two or three days per cycle, while others bleed for ten days or more. You lose most menstrual blood on the second or third day of a period. Many women have occasional 'flooding' and it is fairly common to pass clots occasionally as well. These do not necessarily mean that your periods are abnormal.

Cycle lengths can vary as well. The average is 28 days but the time between the beginning of one period and the beginning of the next can be as little as 15 days or as much as 50 days. The length of periods and the cycle length tend to change as you get older.

The illustration at the back of this booklet may help you to work out how heavy your periods are.

2.1 WHAT CAUSES HEAVY MENSTRUAL BLEEDING?

There are several possible reasons for heavy periods and it is not always easy for the doctor to find out why a woman is having problems. The most likely reason is changes in the blood vessels in the uterus (womb) which makes the blood flow more freely than normal.



"According to my previous doctor I have this problem because I'm a red-head..."

The pattern of bleeding can alter when a woman changes her method of contraception. Oral contraceptive pills usually cause lighter periods, which means that your periods could get heavier if you stop taking the pill.

Sometimes heavy bleeding is caused by large fibroids. These are non-cancerous growths, consisting of bundles of muscle fibres that grow in the muscle wall of the uterus. They cause a problem because they increase the surface area of the lining of the uterus, which is shed each month. Fibroids are very common - about two out of every three women have them - but most will be unaware of them because if they are small they cause no symptoms.

Sometimes heavy bleeding and pain is caused by the lining of the uterus - the endometrium - growing in the wrong place, outside the uterus. This condition is known as endometriosis.

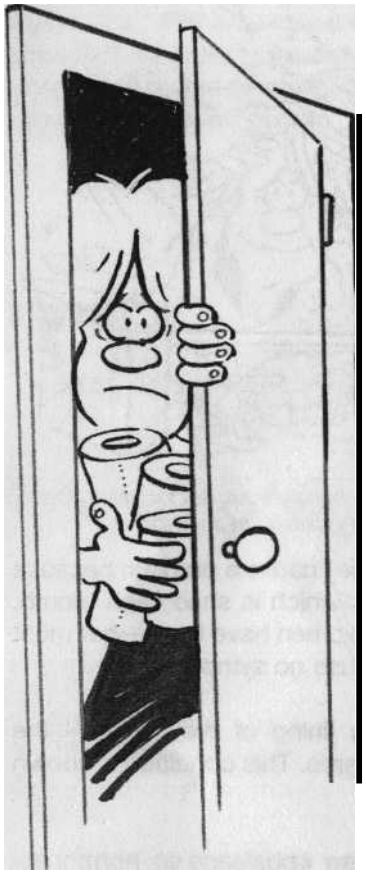
Very occasionally the heavy bleeding may be due to an imbalance in hormones. Hormones trigger ovulation (the release of the eggs from the ovaries). If the hormones are not working properly, ovulation will not occur. This sometimes causes heavy but irregular bleeding. Most women with menorrhagia have normal patterns of ovulation.

Cancer rarely causes heavy menstrual bleeding and it is very unusual for women with heavy periods to have cancer. However your doctor may decide to do a test just to be on the safe side.

Sometimes doctors can find no obvious cause for heavy bleeding and the condition is then called dysfunctional uterine bleeding or idiopathic (no known cause) menorrhagia.

2. BACKGROUND INFORMATION

2.1 WHAT CAUSES HEAVY MENSTRUAL BLEEDING?



"Last period I used 4 toilet rolls in twelve hours..."

Do I need treatment for heavy periods?

This is really up to you. Heavy menstrual bleeding is not life-threatening, although it can make life very difficult and uncomfortable. Your menstrual periods will cease at the menopause. Large fibroids, which may cause menorrhagia, often shrink after the menopause.

Sometimes, but not always, women losing this much blood suffer from anaemia (shortage of red blood cells usually due to lack of iron). This condition can make you feel very tired and lacking in energy.

If you are not anaemic and not suffering too much pain, you may decide you don't want any treatment at the moment. Some women prefer to put up with the heavy periods until they stop naturally at the menopause.

A lot depends on your age and how far **you** feel that you can cope with the problem.

Discuss this with your doctor but there is usually no reason for advising you to have treatment for heavy periods if you don't want it. Many women decide against treatment once reassured that there is nothing seriously wrong.

If you decide against treatment, you may find that the blood loss becomes lighter after a while. You may find it helps to change your diet or give up smoking. Your doctor can give you advice about how to make such changes in your lifestyle.

If you decide against having treatment for the time being there is no reason why you can't change your mind later.You should not rush into a decision you may regret later. Ask your doctor to give you time to think about it if you are not sure. You can always consult your GP again if you become worried for any reason.

2.2 WHAT YOUR GP CAN OFFER

Investigations

The first thing your doctor is likely to do is to ask you questions and carry out a number of tests to try to find out what is causing the heavy bleeding. These may include:

your medical and contraceptive history;
a physical examination (including an internal examination);
blood tests (to test for **anaemia and in some cases thyroid disorders);**
measuring your weight **and height.**

Your GP may then prescribe medicine for you to see if it helps reduce the flow. There are a number of prescription drugs available and sometimes it is necessary to try more than one before finding which works best for you. You will normally need to try each one for three menstrual cycles to allow it time to take effect.

Information about the various drugs available are given on pages 9 and 10. You can record details of the drug(s) that have been prescribed for you, your notes on how well you think they are working and any concerns you may have on page 20.

Some of the drugs only have to be taken for a few days each month, while others are taken continuously. It is important to follow your doctor's advice on this. You need to make sure you know when to start taking the tablets and when to stop. If your periods are very long or if your cycle is so disrupted that you're not sure which is day one of the period, ask your doctor when to start taking the tablets.

Your GP is likely to refer you to a gynaecology clinic for more specialised tests and treatment if:

you have tried drug treatment and it has not worked satisfactorily for **you;**
if, on the physical examination, your doctor discovers a large fibroid, which is likely to require surgical treatment;

you are **over** 40 years of age and **you have** been suffering from intermenstrual bleeding (bleeding between periods) **or post-coital** bleeding (bleeding after sexual intercourse).

If you are very concerned about your condition and do not wish to try drug treatment to see if this will help, you do have the right to ask your GP to refer you to the gynaecology clinic straight away. However you should listen to your doctor's advice before making your mind up.

2.2 WHAT YOUR GP CAN OFFER

Choosing the right drug

TRANEXAMIC ACID: BRAND NAME - CYKLOKAPRON

How the drug works - Cyklokapron is an anti-fibrinolytic drug which research shows to be most effective in reducing blood loss by about a half. However it does not work for everybody.

The dosage -Two to three 500 mg tablets three to four times daily for three to four days.

Reasons why **you should** not take this drug - It should only be taken after the heavy bleeding has started. Cyklokapron should not be taken if you have suffered from blood clots in your legs.

Possible side effects - These are not common but can include nausea, vomiting and diarrhoea. The side effects usually disappear when the dose is reduced. If you are at all concerned, contact your doctor for further advice.

MEFENAMIC ACID: BRAND NAME - PONSTAN

How the drug works - Ponstan is a non-steroidal anti-inflammatory drug (NSAID) which can be used in the treatment of heavy periods. Drug trials have shown that it can reduce menstrual blood loss by about a third, although it does not work for everybody. It has the added advantage of reducing severe menstrual pain.

The dosage - Ponstan comes in two strengths and your doctor will advise you which dose suits you best. The drug should be started on the first day of excessive bleeding and taken as advised by your doctor.

Ponstan: Two 250mg capsules three times a day
Ponstan Forte: One 500 mg tablet three times a day

Reasons why you should not take this drug - Ponstan should not be taken if you have inflammatory bowel disease, suffer from stomach ulcers or if you have kidney or liver problems. It should be taken with caution if you suffer from asthma.

Possible side effects - These are not common, but can include nausea, indigestion and diarrhoea. If you suffer from asthma and this worsens when you start to use an NSAID, your doctor can advise you further.

Ibuprofen and naproxen are similar types of drugs, which are sometimes prescribed for menorrhagia. The contra-indications and possible side effects are the same. Dosages will be different however, so you should follow your doctor's instructions about how and when, to take them. NB You should avoid taking additional antiinflammatory medication, such as Ibuprofen, which can be purchased over the counter, at the same time.

2.2 WHAT YOUR GP CAN OFFER

CONTRACEPTIVE PILL

How the drug **works -** There are several brands of pill. Popular brands include Microgynon, Loestrin 30, Brevinor and Femodene. The pill contains the hormones oestrogen and progesterone and works by preventing ovulation and reducing the menstrual flow. As well as treating your heavy periods, the pill will also prevent you from becoming pregnant.

The **dosage -** The pill is started on the first day of your period and taken for 21 days. This is usually followed by a seven-day `pill free period', during which you will have a light withdrawal bleed.

Reasons why **you should** not take this drug - The pill should not be taken if you suffer certain types of severe migraine, heart disease, or have had a blood clot in your leg. It should not be taken if you are over 35 and smoke. There has been much concern recently about the increased risk of blood clots in women taking certain types of pill. If you have any concerns or questions, you should discuss them with your doctor.

Possible side effects - The risks of serious side-effects, such as stroke and blood clots, are greater if you smoke. Minor side effects can include nausea, vomiting, headaches, breast tension, changed body weight, or libido and mood changes.

INTRAUTERINE DEVICE: BRAND NAME MIRENA

How the drug works - This is a new medicated contraceptive coil which releases the hormone, progesterone, on a daily basis and studies have shown that it can reduce bleeding by as much as 80 per cent.

The dosage - This can remain in the womb for five years after which time it can be replaced.

Reasons why **you should not take** this **drug -** Untreated pelvic infection.

Possible side effects - In the first three months bleeding tends to be irregular, but this usually settles. Breast tenderness, headache and acne may occur initially, but this usually passes after a couple of months.

*Traditionally, Norethisterone (brand names - Primolut or Utovlan) has been prescribed as treatment for heavy periods. Recent research has shown that while it can help make periods more regular, it is not very effective in reducing heavy regular bleeding for most women, unless it is **prescribed** in very high **doses.***

2.3 WHAT HAPPENS AT THE GYNAECOLOGY CLINIC

Investigations

At the gynaecology clinic you are likely to have further tests carried out. If you have a clinic appointment you should attend at the appointed time even if you are having a period, unless you have been told not to. The tests might include:

a further physical examination (including an internal examination);

further blood tests;

an ultrasound scan which is sometimes used to detect fibroids;

* a hysteroscopy: a hysteroscope is a miniature camera which is introduced via the vagina and allows the gynaecologist to examine the endometrium (lining of the uterus). It shows any growths, such as fibroids, polyps or abnormal thickening of the lining of the womb, which might be causing the problems. This test would normally by done in a special outpatients' clinic without an anaesthetic, but you may be asked to attend the hospital for a day case operation;

an endometrial biopsy: a small sample of the lining of the uterus may be taken for analysis in the laboratory, using a narrow instrument which is inserted through the neck of the womb. This is done to check that there are no cancer-like cells in the womb. The procedure may be done at the same time as a hysteroscopy, so the camera can guide where the sample is being taken. It may be slightly uncomfortable but it doesn't take long. (In the past, the usual way of taking such endometrial biopsies was by dilatation and curettage (D&C) using a wider instrument, like a small spoon. This technique would not normally be used now, since the more sophisticated equipment has become available.)

"One doctor said it's"

2.3 WHAT HAPPENS AT THE GYNAECOLOGY CLINIC

After the investigation

The gynaecologist should be able to give you the results of your tests at the end of the clinic and will then discuss the choices that are open to you.

It may well be that the investigations will not show any obvious reason for your heavy periods. In that case you have three options open to you:

"My handbag is always full of towels..."

* if you are reassured that there is nothing serious wrong with you, you may feel that you can cope with your periods and not seek any further medical treatment for the moment.You can always return to your doctor at a later date, if you change your mind or the bleeding gets heavier;

* you can continue with the drug treatment, or perhaps try a new drug. The drugs listed on the next page might be considered at this stage. The gynaecologist will normally write to your GP in this case, asking him or her to continue to review your progress on these medications;

* you may decide that, even if there is no obvious physical problem, you do not wish to continue coping with your heavy periods and opt for surgery. There are various operations available and these are discussed on page 14. You need to remember that most of the operations discussed may well reduce your chances of becoming pregnant in the future.

On the other hand, the investigations may reveal growths inside the uterus, such as fibroids, polyps or very occasionally, cancerous cells. If the fibroid or polyp is small, the gynaecologist may well offer you the choice of doing nothing more at the moment, continuing with the medication or surgery (see page 14). If the growth is large or is found to be cancerous, he or she is likely to recommend that you have surgery.

Other drugs which may be prescribed by your gynaecologist

DANAZOL: BRAND NAME - DANOL

How the drug works - Danazol is a weak androgen (male hormone) which can be used for the treatment of heavy periods. It is sometimes prescribed for a few weeks before surgery.

The dosage - One or more 200 mg tablets daily for three months.

Reasons why ***you*** **should not take this drug -** Should not be taken if you have severe heart, liver or kidney problems.

Possible side effects - These can include weight gain, acne, growth of facial hair, hair loss and voice changes.

GNRH ANALOGUES: BRAND NAME ZOLADEX

How the drug works - Zoladex is a synthetic hormone which decreases the level of oestrogen and thus reduces menstrual blood loss. This drug is sometimes prescribed for a few days before surgery.

The dosage - Injection into the abdomen every 28 days.

Reasons why you should not take this drug - Not to be taken when breast-feeding.

Possible side effects - Hot flushes and night sweats, loss of sex drive, headaches, mood changes, vaginal dryness and change in breast size.

2.4 THE SURGICAL OPTIONS

Surgery — What Are The Choices?
There are a number of surgical operations for the treatment of menorrhagia. The operations are described below.

Hysterectomy
Hysterectomy is the most common surgical treatment for menorrhagia. The whole uterus is removed and usually the cervix as well. Sometimes the cervix is left in place, when the operation is known as a sub-total hysterectomy. You may be advised to have your ovaries removed at the same time (an oophorectomy). Once the uterus is removed, your periods will stop completely. You will not be able to become pregnant after a hysterectomy. There are three different ways **of** doing **a** hysterectomy.

Abdominal Hysterectomy
A cut of about 6-12 cms is made in the abdomen, either 'up and down' the centre of the abdomen or across the bikini line. The uterus is removed through this opening.

Vaginal Hysterectomy
A cut is made through the top of the vagina and the uterus is removed through the vagina. This operation is not suitable for all patients. For instance if you have large fibroids in your uterus or if you have never had a baby, it may not be recommended for you.

Laparoscopic Hysterectomy
Three to four small cuts, about 0.5 - 1 cm long, are made in the abdomen and a mini camera is used to direct the instruments which are used to remove the uterus, usually through the vagina. It takes specialised training and equipment to do this operation and not all gynaecologists offer it.

Endometrial Ablation
Endometrial resection and endometrial ablation are fairly new operations, in which the endometrium (lining of the uterus) is shaved away using a hysteroscope and diathermy (see glossary). Endometrial resection involves applying electrical energy and removing the endometrium with a rollerball or a resectoscope loop. Ablation is a similar technique which involves using a laser, new "balloon" techniques are becoming available.

Periods are usually much lighter after these operations, although the uterus remains in place. It is technically possible to get pregnant after an operation of this sort, but it is not recommended and your gynaecologist may advise you to have a sterilisation at the same time, to ensure that you do not fall pregnant.

Myomectomy
In a myomectomy, fibroids are removed but the uterus is left in place. This may help to reduce menstrual blood loss, if this is caused by fibroids. However fibroids can grow back and the results may not be permanent. It may be suggested to you if you have large fibroids but want to retain the possibility of becoming pregnant. You should be aware that the fallopian tubes, which carry the egg from the ovaries to the uterus, are occasionally damaged in this operation and sometimes it is not possible to remove the fibroids separately and a full hysterectomy is required. Fertility cannot therefore be guaranteed after this operation.

2.4 THE SURGICAL OPTIONS

THE QUESTIONS YOU WILL NEED TO ASK

Normally, if you decide that you want surgery, you will be faced with a choice between hysterectomy and endometrial ablation. Each operation has different benefits and risks, so it is important that you discuss these fully with your gynaecologist, or the specialist advisory nurse, to decide what is the most suitable procedure for you.

Gynaecologists have been doing abdominal and vaginal hysterectomies for years, so more is known about the long-term effects of these than for the newer operations. But all new surgical techniques are well researched before they are introduced to ensure that they are safe.

"...you always have to think about what to wear..."

Should my ovaries be removed at the same time?

If you decide to have a hysterectomy, the gynaecologist may suggest that you have a oophorectomy, which is the removal of the ovaries at the same time.

If you have your ovaries removed you cannot develop ovarian cancer and there is some research which indicates that removal of the ovaries reduces the risk of breast cancer. Overall, about one woman in a hundred develops ovarian cancer, but this risk is higher if your mother or sister or another close female relative has had the disease. It probably is a good idea to have your ovaries removed at the same time as a hysterectomy if there is a history of ovarian cancer (or breast cancer) in your family.

However if your ovaries are removed you will go through an immediate menopause, because your body will stop producing certain hormones. This can mean symptoms such as sleeplessness, hot flushes, palpitations, headaches and sexual difficulties. Hormone replacement therapy (HRT) can be prescribed to avoid these problems, to avoid the risk of developing osteoporosis (thinning of the bones) or heart disease.

2.4 THE SURGICAL OPTIONS

What will happen to my periods?

Women who have a hysterectomy no longer have any menstrual bleeding or period pains.

Most women who have an endometrial ablation will continue to have periods after their operation, but the blood loss is usually very light. Sometimes it stops altogether, but it may return after a few years and become heavier over time. Sometimes women still have period pains after this operation.

"I was told that having a baby might help..."

How long will I be in hospital?

Women normally stay in hospital between four to seven days, when they have an abdominal hysterectomy. Vaginal or laporascopic hysterectomies normally only require a three to five day stay in hospital.

Endometrial ablations are normally done as 'day cases', which means that it is not necessary to stay in hospital overnight, but some women stay in for between one and three nights.

Are there any complications?

Nearly half the women who have an abdominal hysterectomy suffer some minor complications after surgery, such as fever, bleeding or infections of the wound, bladder or pelvis. Most women recover quite quickly from these problems, although they may prolong the time it takes to recover fully from the hysterectomy. You can reduce the risk of complications by stopping smoking, eating a healthy diet and taking regular exercise before the operation. If you are taking the oral contraceptive pill your doctor will tell you to stop this at least six weeks before the operation. Complications are less common after vaginal or laparoscopic hysterectomies and quite uncommon after endometrial ablation.

About 80 per cent of women who have an abdominal hysterectomy find they still have some pain one week after the operation, compared with only 20 per cent who have an endometrial ablation. Most women who have vaginal or laparoscopic hysterectomies experience some pain after the operation, but this usually only lasts about three days. Painkillers usually control the pain effectively.

2.4 THE SURGICAL OPTIONS

What are the risks of **dying as a result of the operation?**

All surgical operations carry a small risk of dying. Between one and two women in every 1000 who have a hysterectomy die as a result of the operation, but the risk is lower for women aged under 50. Of every 2000 pre-menopausal women having a hysterectomy for menorrhagia, 1999 will safely survive the operation. Studies of endometrial ablation have been too small to give a reliable estimate of the risk of death but it will be even lower than that for hysterectomies since the post-operative complications rate is lower.

How long before I can return to normal activities?

Women need plenty of rest for the first two weeks after a hysterectomy, although there are physiotherapy exercises to do and gentle walking helps recovery. You can drive again when you feel it no longer causes pain or discomfort, normally five to six weeks. You should always check the cover you have with your motor insurance company. You can expect to resume work and your normal day to day activities between eight and 11 weeks after an abdominal hysterectomy and three to seven weeks after a vaginal hysterectomy. You are advised not to lift anything heavy for three months after a hysterectomy. Women who have had an endometrial ablation can usually resume their normal activities two to three weeks after surgery.

"...long skirts and long boots help to hide the embarassment..."

How will I feel in the longer term after the operation?

Most women say that they feel much better, with more energy and less depressed after hysterectomy or endometrial ablation. Studies indicate that overall, after about four months, satisfaction levels are even higher for women who have had a hysterectomy than those who have had an endometrial ablation, because their menstrual periods have stopped altogether.

What will be the effect on my sex life?

You are advised not to have full sexual intercourse until you have fully healed. If you experience pain in the longer term, you should discuss the problem with your doctor. A recent study showed that about a quarter of women who had had a hysterectomy or an endometrial ablation reported that their sex lives had improved after the operation; about the same number said it was less enjoyable than before and the remainder said that it had made no difference. The results were very similar for hysterectomy and endometrial ablation.

2.4 THE SURGICAL OPTIONS

Can I get pregnant after the operation?

You should not have a hysterectomy or an endometrial ablation if you are planning to get pregnant. There is no chance of falling pregnant after a hysterectomy, because the uterus is removed. It is technically possible to fall pregnant after an endometrial ablation but it is not a good idea. Your gynaecologist may well recommend a sterilisation at the same time, to remove the risk of pregnancy.

Will I continue to need cervical smear tests?

Cervical smears are not normally necessary after most hysterectomies, but you will still be called for routine cervical smear tests every three to five years if you have had a sub-total hysterectomy or an endometrial ablation, where the cervix is left in place.

Are there likely to be any long-term effects on my health?

More is known about the long-term effects of hysterectomy than about endometrial ablation because the operation has been around longer, although there is no evidence of any significant risks to health after an ablation. Some women find that they pass water more frequently or have problems with bladder control following a hysterectomy, although others find such problems improve after the operation. If you do have such difficulties, you should ask your doctor for help. A hysterectomy removes the risk of uterine diseases, such as cancer and if your ovaries are removed at the same time, the risk of ovarian cancer. Since you can't become pregnant, it also eliminates any risks associated with pregnancy.

If your ovaries are left in place after a hysterectomy, there is a chance that they will stop producing hormones, thus triggering an early menopause. These are the hormones which help protect you against heart disease and osteoporosis, a disease where the bones get thinner and more fragile. If the ovaries are removed then such risks are higher but you can reduce these risks by taking a long-term course of hormone replacement therapy (HAT).

Will I need more operations?

Hysterectomy is a once-and-for-all cure for menstrual problems. However about one in every five women who have an endometrial ablation, need another operation within four or five years, either a repeat ablation or a hysterectomy. Unfortunately there is no way of predicting who is likely to need a second operation, although the risk of further surgery rises significantly following a second endometrial ablation.

CONCLUSION

The basic message is that there is no one right solution for all women who suffer from menorrhagia. There are different causes, women's circumstances vary and they react differently to different medicines. You can help your doctor to find the right treatment for you by making sure you give him or her all the facts and by asking questions if you are unsure why a particular treatment is being suggested. The rest of this booklet is for your notes — to jot down your symptoms and any questions you want to ask.

"Remember: you are not alone!"

3. YOUR PERSONAL RECORD OF SYMPTOMS

This section of the booklet is for you to keep a record of your symptoms and the way your heavy periods are affecting your life, any medicines you may be prescribed and their effects, any investigations or operations that you undergo and most important, any questions you want to ask your doctor, nurse or pharmacist. Don't be afraid to ask for clarification, if you are not sure of the name of a drug or if you can't remember what is likely to happen next. Patients who understand their treatment, tend to get better quicker.

If you decide, having talked to your doctor and read this booklet, that you will try to cope with your periods for a bit longer, keep this booklet in a safe place, so you can show your doctor, if you decide to seek help again at a later stage.

First Consultation

Date you were given this booklet

Name of GP

Problems discussed with GP at this first consultation and next steps agreed

Name of any medicine prescribed and instructions for taking it

Impact of treatment on periods and any side effects
(you may find it helpful to fill in the diary at the end of the booklet)

Questions for your next consultation with your GP

YOUR PERSONAL RECORD OF SYMPTOMS ND TREATMENTS

Further consultation with **GP**

Date of second consultation _____
Name of GP _____
Summary of discussion

Next steps

No further treatment at this stage
Continue with same medicine _____
Try an alternative medicine _____

Refer to gynaecology clinic

Name, address and contact number of hospital

Name of consultant gynaecologist
Date of clinic appointment

Gynaecology clinic appointment

Name of doctor (and nurse) seen
Tests undertaken
physical examination _____
blood tests _____
transvaginal ultrasound _____
hysteroscopy _____
endometrial sample _____

Results of tests

Next steps discussed w ith gynaecologist

anaemia: low blood count due to iron deficiency or some other cause
hysteroscope: a mini camera for examining the inside of the womb
anti-fibrinolytic: a drug that helps blood to clot so preventing bleeding
hysteroscopy: an examination of the inside of the womb using a mini camera
cervix: neck of the womb
idiopathic menorrhagia: menorrhagia with no obvious cause
diathermy: technique for removing the lining of the womb using electrical energy and a rollerball or cutting loop
intermenstrual bleeding: bleeding between periods
dilatation and **curettage (D&C):** a scrape of the lining of the womb
intrauterine device (IUD): a coil inserted into the womb
dysfunctional uterine bleeding: menorrhagia with no obvious cause
endometrial ablation **or** resection: removal of the lining of the womb using a retroscope loop, rollerball or laser
laparoscopic hysterectomy: hysterectomy done with special instruments while viewing with a mini camera inserted through a small 'keyhole' in the abdomen
endometrial ablation or resection: removal of the lining of the womb using a resectoscope loop, rollerball or laser
laser: instrument used with a hysteroscope to remove the lining of womb in endometrial ablation
menopause: the 'change of life'
endometrial **biopsy:** a small sample of lining of the womb taken for analysis in the laboratory
menorrhagia: excessive regular menstrual blood loss; blood loss of more than 80m1 per menstrual period
endometrium: lining of the womb
fallopian tubes: tubes which carry eggs from the ovary to the womb
oophorectomy: surgical removal of ovary; bilateral oophorectomy is the removal of both ovaries
fibroid: benign growth of fibrous tissue in the womb, NOT cancer
osteoporosis: thinning of the bones, making them more likely to fracture
hormones: chemicals produced in one part of the body which pass into the bloodstream and affect the way other parts of the body function
ovulation: release of eggs from the ovaries
hormone replacement therapy (HRT): female hormones taken as tablets, patches, gel or implant under the skin
polyp: a small benign growth or tumour, NOT cancer
hysterectomy: removal of the womb through the abdomen or the vagina
post-coital bleeding: bleeding after sexual intercourse
resectoscope loop: instrument used with a hysteroscope to remove the lining of the womb in endometrial resection or ablation
sub-total hysterectomy: the womb is removed but the cervix stays in place
ultrasound: a scanner to check for abnormalities in the body
rollerball: instrument used with a hysteroscope to remove the lining of the womb in endo-metrial resection or ablation
uterus: womb

NHS DIRECT
A free telephone helpline service for access to health care
0845 4647

Healthpoint
A comprehensive health information and literature service
based at Poole library with telephone links throughout Dorset
01202 675377

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East Dorset Community Health Council
Chief Officer: Denise Holden
28 Poole Hill, Bournemouth BH2 5PS
Tel: 01202 292961
Fax: 01202 292971
e-mail: office@eastdorset-chc.nhs.uk

West Dorset Community Health Council
Chief Officer: Jennifer Bromley
Damers House, Damers Road, Dorchester DT1 2JX
01305 251302
e-mail: chc.officers@westdorset-chc.nhs.uk

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Hysterectomy Support Group
Based in Basingstoke but advice and help available for women from Dorset
Mrs Pat Nelson 01256 357879 (after 6 pm)
Mrs Elizabeth Banks 01256 850514

Women's Environmental Network
PO Box 30626
London El 1TZ
0207 481 9004
e-mail: info@wen.org.uk

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Women's Health Information Centre
52 Featherstone Street
London EC1Y 8RT
0845 125 5254
minicom: 0207 490 5489
e-mail: health@womenshealthlondon.org.uk
www.womenshealthlondon.org.uk

National Endometriosis Society
50 Westminster Palace Gardens
Artillery Row
London SW 1 P 1RL
0207 222 2776

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A Survival Guide for Heavy Menstrual Bleeding

Written by women for women

Try using incontinence or maternity pads for maxium protection at especially heavy times;

Always keep some emergency sanitary supplies with you `just in case';

Use a folded towel to sit on during long car journeys;

Stock up on soft toilet rolls;

You can use two tampons at the same time, but knot the strings together for safety;

A coat or cardigan can hide stains if you flood;

It is a good idea to wear dark colours during your period;

If you need time off work regularly, ask your doctor for a note for your employer;

Don't be afraid to ask your doctor questions;

Don't forget that you are not alone – other women who suffer can give you support!