



# Menstrual management

## In adolescents and adults

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# Disclosures

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*Honoraria:* Hemophilia Federation of America

*Advisory Board:* Foundation for Women & Girls+ with Blood Disorders



# Objectives

1. To consider indications for menstrual management
2. To review history and initial workup required before treatment
3. To define menstrual management, menstrual suppression, and ovarian suppression
4. To discuss FDA-approved and evidence-based regimens for menstrual management
5. To summarize who should be referred and when



# Conclusions

1. We should treat menstrual management as medications
2. Heavy bleeding is a SYMPTOM that needs a workup
3. Menstrual management does not require suppression
4. Our educational materials aren't that helpful for bleeding expectations
5. Menstrual management isn't the same as contraception or hormone therapy, but they overlap



# Indications for management

- Menstrual volume reduction
- Menstrual regularity
- Menstrual symptom management
- Cycle symptom management
- Ovulation suppression
- Preference



# Baseline history

Medical history

*Targeted risk assessment*

Medications/allergies

Menstrual history

Symptom history

Bleeding history

Family history



# Medical history

Vital signs: resting pulse, weight, height, BP

Developmental history, growth chart

Medical conditions: Seizure disorder, GI disorders

Surgeries: ENT, abdominal

Medications: SSRIs, AEDs

Risk assessment: headaches, VTE, cardiac



# Menstrual history

Menarche

Cycle regularity – ovulatory or anovulatory?

Duration – longer than 7 days?

Amount – heavy? Bothersome?

Pads/tampons – more than every 2 hr?

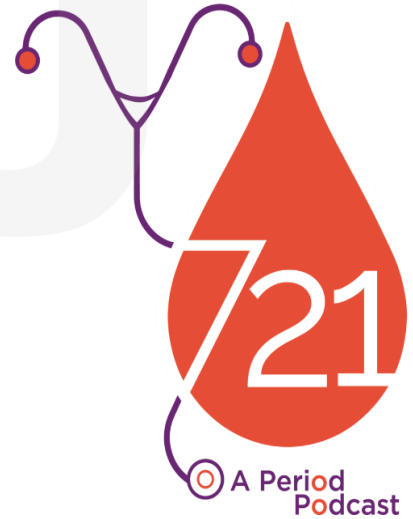
Overflow – any?

Clots – 1 inch or larger?

Nighttime overflow – describe

# What is heavy menstrual bleeding?

**7** – **2** – **1**  
days – hours – clot





# Symptom history

Cramping – how managed, severity, description

Motivational symptoms – breakouts, mood changes

Exercise – intolerance, frequency, type



# Bleeding history

Any epistaxis? More than 10 minutes?

Any ENT procedures – tooth extraction, tonsillectomy?

Extra bruising?

Problems with cuts healing?

Family history? Of unexplained PPH, HMB, any of the above?

Connective tissue disorders? Beighton score



# Screening for ID/A

Ferritin, CBC

Fatigue

Chest pain, shortness of breath

Exercise intolerance

Cardiac flow murmur

Pallor

Leg pain

# FIGO PALM-COEIN

- P – Polyp
- A – Adenomyosis
- L – Leiomyoma
- M – Malignancy
  
- **C – Coagulopathy**
- **O – Ovulatory dysfunction**
- E – Endometrial disorders
- **I – Iatrogenic (includes gonadal hormone-related)**
- N – Not otherwise classified





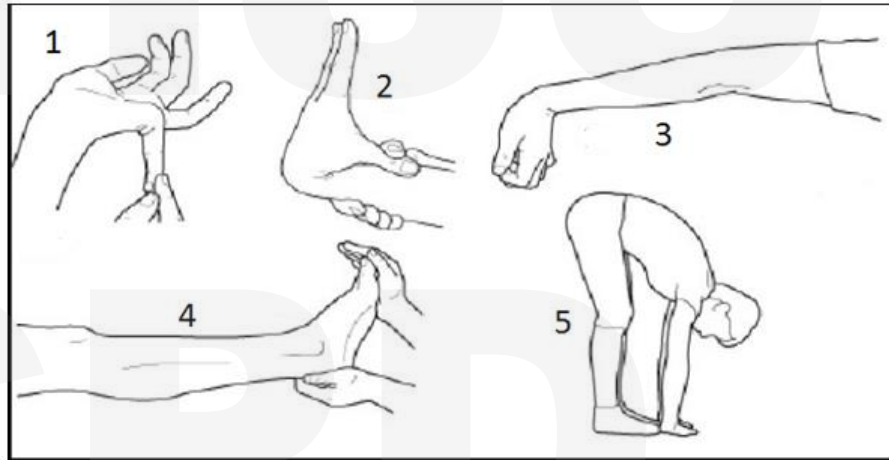
# Basic bleeding disorder workup

Von Willebrand Panel: activity, antigen and FVIII activity  
Coags: PT/PTT, fibrinogen

- Preferably draw at a hospital lab
- VWD activity and antigen should be similar
- Acute phase reactants >100 is reassuring
- Refer for <60% with bleeding symptoms
- Diagnosis (<40%) requires 2-3 rechecks

# Beighton score for hypermobility

hypermobile >6  
joint laxity >4





# Hyperandrogenemia evaluation

Hirsutism: Ferriman-Galloway score, treatments

Cystic acne: treatments

Free and total testosterone (women/children)

DHEA-sulfate

17-OHP @ 8 am

Metabolic testing: lipids, 2 hr OGTT and/or HbA1c

\*Serum testing not recommended in most adolescents

## Workup prior to treatment or referral – adolescent

Normal periods	Screening for iron deficiency and anemia*
Ovulatory heavy bleeding	Basic bleeding disorder workup
Anovulatory excessive bleeding	TSH, PRL, <u>growth chart</u> , screening for hyperandrogenemia, basic BD workup
Anovulatory infrequent periods	TSH, PRL, <u>growth chart</u> , screening for hyperandrogenemia
Dysmenorrhea	Ultrasound if unilateral focal pain or concern for outlet obstruction

## Workup prior to treatment or referral – adult

Normal periods	Screening for iron deficiency and anemia*
Ovulatory heavy bleeding	Basic bleeding disorder workup, pelvic ultrasound, pelvic exam
Anovulatory excessive bleeding	TSH, PRL, T, DHEA-S, metabolic screening, basic BD workup, UPT, pelvic ultrasound, pelvic exam
Anovulatory infrequent periods	...and FSH, AMH, E2
Dysmenorrhea	Pelvic ultrasound, pelvic exam

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Menstrual  
Management

Improving predictability, regularity, decreasing amount and/or duration, and improving menstrual-associated symptoms.

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Cyclic or extended combined  
Cyclic progestogens

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Menstrual  
Suppression

Completely suppressing menstrual flow – goal is amenorrhea  
Downside is breakthrough bleeding, ovulation

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Continuous progestogens  
Continuous combined

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Cycle  
suppression

Suppressing ovarian cycle – goal is anovulation  
Downside is breakthrough bleeding

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Continuous progestogens  
Continuous combined

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# Prior meds history

Dosing

Route of administration

Duration of use

Bleeding experiences

Symptoms – pros and cons

# Dosing regimens



CYCLIC

21/7

24/4

5/25

10/20



EXTENDED

84/4

timed



CONTINUOUS

daily

### **Tranexamic acid (TXA) - Lysteda®**

- 1300 mg TID for 5 days for heavy regular menstrual bleeding

### **Norethindrone acetate (NETA) - Aygestin®**

- 2.5-10 mg for 10 days per month for abnormal uterine bleeding

### **Estradiol valerate / Dienogest - Natazia®**

- 5 phases including 2 days inert for heavy menstrual bleeding

### **Medroxyprogesterone acetate (MPA) - Provera®**

- 5-10 mg for 5-10 days per cycle for abnormal uterine bleeding

### **Levonorgestrel IUD (LNG-IUD) - Mirena® and Liletta®**

- 52 mg IUD for 5 years for heavy menstrual bleeding



# #periodgoals

EXPECTATIONS	with CYCLIC	with CONTINUOUS
bleeding timing	expected	unexpected
bleeding duration	shorter	daily
pregnancy indication	not pregnant	unsure
other symptoms	cyclic, lessened	erratic
white pants	sometimes	no!

Menstrual suppression  
(continuous dosing)  
usually fails in heavy  
bleeders.

—Me

## Combined

- Ethinyl estradiol + progestin (EE/P)
- Estradiol valerate + dienogest (E2V/DNG)

## Lower dose progestins

- Levonorgestrel intrauterine device (LNG-IUD) – 13.5, 19.5, 52 mg
- Norethindrone (NET) 0.35 mg
- Norgestrel (NOG) 0.075 mg
- Etonogestrel implant (ENG)

## Ovulation inhibition dose progestins

- Depot medroxyprogesterone acetate (DMPA)
- Medroxyprogesterone acetate (MPA) 5 mg
- Norethindrone acetate (NETA) 2.5 mg
- Drospirenone (DRSP) 4 mg

OUTCOME	YES	MAYBE	NO
Cycle regulation	Cyclic DRSP, NETA, MPA, EE/P		Any continuous dosing including LNG-IUD
Menstrual suppression	Continuous NETA 2.5 mg, DRSP 4 mg 52 mg LNG-IUD	Continuous EE/P, 19.5 mg LNG-IUD, ENG implant, DMPA, NOG	13.5 mg LNG-IUD, NET 0.35 mg
Ovulation suppression	Cyclic or continuous DRSP, NETA, EE/P DMPA	Cyclic MPA and NETA (unless 21/7)	ENG implant Any LNG-IUD NET 0.35 mg, NOG 0.075 mg
Cycle suppression	Continuous NETA 2.5 mg, DRSP 4 mg, EE/P, MPA, DMPA		Everything else



# Case 1: menstrual regulation

S: 19 yo with menarche age 10. History of erratic and prolonged bleeding episodes, not that heavy, lasting 4-14 days. No significant cycle symptoms. No clinical hyperandrogenism.

O: High BMI, ferritin 8, Hgb 11.5, TSH and PRL NL, FSH NL  
High TG, HgbA1c pre-diabetic



# Case 1: menstrual regulation

A: AUB-O with iron deficiency and anemia. Metabolic syndrome.

P: PCP treats iron deficiency, manages follow-up

Nutrition and weight management

Shared decision-making for menstrual management

prefers predictable, regular pattern of bleeding

offered: cyclic P (consider whether to avoid EE)

chosen: cyclic DRSP and metformin



# Case 1: menstrual regulation

Follow-up: cyclic DRSP and metformin

Reports cyclic predictable bleeding lasting 5 days, changing pads every 3-4 hours

Switches to GLP-1, stops DRSP, has regular cycles

## Case 2: menstrual suppression

S: 23 yo with migraine with aura has long history of worsening painful periods since menarche age 14. Having acyclic pain and dyspareunia. NSAIDs aren't working. Periods are regular, q28d lasting 4-5 days. Worse on CD 1-2. Doesn't like to take medications.

O: Ferritin 18, Hgb 13.5.

# Case 2: menstrual suppression

A: Secondary dysmenorrhea

P: PCP treats iron deficiency, arranges follow-up

Pelvic exam indicates levator myalgia, US normal.

NSAIDs: naproxen 500 mg BID or celecoxib 100 mg BID

Shared decision-making for menstrual management

goal is ovulation suppression, okay with BTB

offered: continuous NETA, LNG-IUD

chosen: NETA 5 mg daily

# Case 2: menstrual suppression

Follow-up: continuous NETA 5 mg daily

Pain improved, no bleeding after initial transition.

Requests LNG-IUD. Continue NETA and increase to BID.

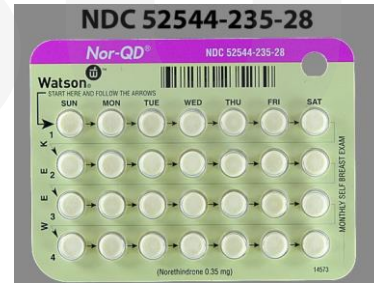
Consult gynecology for consideration of surgical intervention and alternative therapies.

# NET versus NETA

NET 0.35 mg

“mini-pill”

postpartum contraception



NETA 5 mg

period delay

ovulation suppression

endometriosis treatment



## Case 3: breakthrough bleeding

S: 24 yo with no sig PMH. Menarche age 12. Periods lasted 8-10 days, heavy, changed pads every 2 hours, doubled up overnight, overflowed, missed school. Started cyclic oral contraceptive age 16. Periods became 5-6 days and fine. Recently switched to continuous dosing to suppress periods and is having erratic breakthrough bleeding.

O: ferritin 8, Hgb 11.5, VWD panel: all ~50%, coags NL, US NL, pap NL



## Case 3: breakthrough bleeding

A: AUB-C with iron deficiency and anemia.

Basic workup for BD equivocal, bleeding score low

P: Treat iron deficiency, schedule follow-up

Consult hematology for continued workup for VWD

Shared decision-making for menstrual management

prefers predictable, less bleeding

offered: go back to cyclic EE/P, LNG-IUD

chosen: LNG-IUD

# Case 3: breakthrough bleeding

Follow-up: cyclic EE/P until LNG-IUD placement

Reports return to cyclic bleeding lasting 5-6 days

LNG-IUD placed under sedation at CWH

Continue EE/P for 1 month, then spotting for 3 more weeks

Mostly amenorrhea – happy with this!

Ferritin improves to 15 after 4 weeks of oral iron – continue for 3-6 months, recheck

## Case 4: new onset AUB

S: 46 yo premenopausal G2P2 with no sig PMH. Previously normal periods, no bleeding history. Started having two periods per month. Erratic, light to heavy. Reports fatigue, irritability and hot flashes for which she recently started transdermal estradiol and oral progesterone.

O: ferritin 8, Hgb 9.3, US NL, exam NL, UPT neg

## Case 4: new onset AUB

A: AUB-I due to exogenous estradiol and continuous progestin.

P: Options include switch to cyclic P, increase P to ovulation suppression dose, or switch to combined ethinyl estradiol with progestin

# Case 4: endometrial protection

## Micronized progesterone - Prometrium®

- 100-200 mg cyclically or continuously for endometrial protection

## Medroxyprogesterone acetate (MPA) - Provera®

- 5-10 mg for 5-10 days per cycle for endometrial protection

## Levonorgestrel IUD (LNG-IUD) - Mirena® and Liletta®

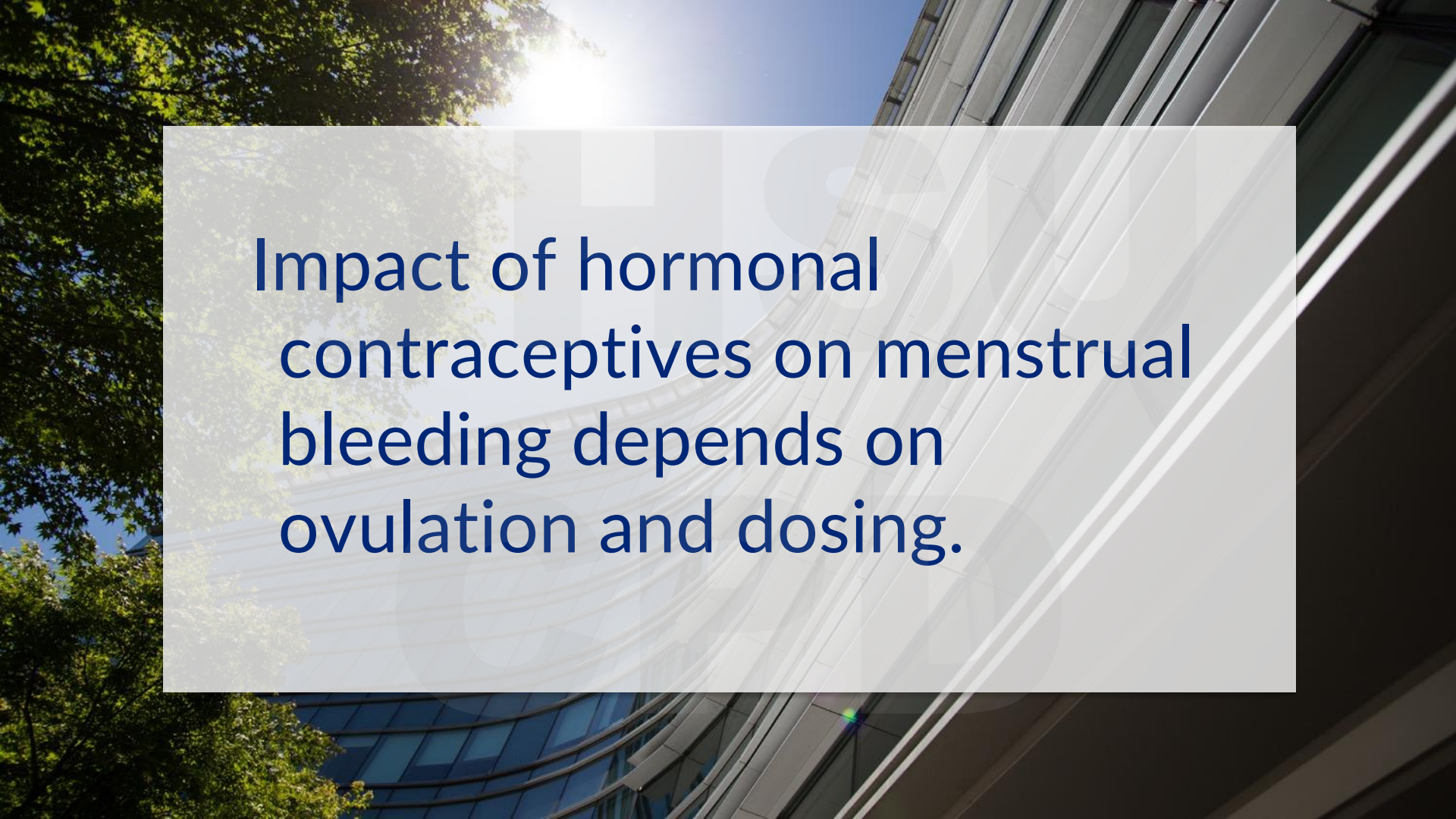
- 52 mg IUD for 5 years for endometrial protection

I discussed the risks, benefits, alternatives, potential side effects, usage instructions, and warning signs.



# Consult to CWH

- PCP referral after initial evaluation and management
- Referrals in acute cases are reviewed quickly – consider external eConsult (EpicCare Link Portal)
- Referrals are reviewed centrally and will be sent to the soonest appointment for the specific problem
- May be re-routed to adolescent medicine, peds endo



Impact of hormonal  
contraceptives on menstrual  
bleeding depends on  
ovulation and dosing.



**Thank You**