1. **Policy Summary**

1.1 This policy has been revised from previous policies. It is specific to hysterectomy as a treatment for heavy menstrual bleeding and reflects the 2013 NICE clinical guidance CG44 Heavy Menstrual Bleeding (HMB) and Royal College of Obstetricians and Gynaecologists most recent publication on standards in gynaecology. 

1.2 The NICE definition of HMB emphasises the importance of the patient’s experience over the volume of blood lost: “Excessive menstrual blood loss which interferes with the woman’s physical, emotional, social and material quality of life.” NICE recommend interventions should be aimed at improving quality of life, and advocate the provision of patient information to enhance understanding and aid decision making.

1.3 This policy doesn’t apply to anyone <19 years of age.

1.4 The policy does not apply to post-menopausal, inter-menstrual or post-coital bleeding.

2. **Eligibility Criteria**

2.1 Hysterectomy for HMB will only be funded if all the following criteria are met:

2.2 Clinicians should investigate and manage HMB as per NICE recommendations laid out in the HMB pathway, CG44 and QS47.

a) A levonorgestrel intrauterine system or LNG-IUS (e.g. Mirena) has been trialled for at least 6 months (unless contraindicated or declined by patient) and has not successfully relieved symptoms.

b) A trial of at least 3 months each of two other pharmaceutical treatment options has not effectively relieved symptoms (or is contraindicated, intolerable or declined by the patient). These treatment options include:

- NSAIDs e.g. mefenamic acid
- Tranexamic acid
• Combined oral contraceptive pill
• Oral and injected progestogens

c) Surgical treatments such as endometrial ablation, thermal balloon ablation, microwave endometrial ablation, myomectomy or uterine artery embolisation (UAE) have either been ineffective or are not appropriate, contraindicated or declined by the patient.

*Contraindications to LNG-IUS use include suspected or confirmed untreated sexually transmitted infections (STIs), pregnancy, pelvic inflammatory disease (PID), distorted or small uterine cavity, active trophoblastic disease, genital malignancy and immunosuppression.**

**UAE may be appropriate for some women with HMB associated with uterine fibroids, for more information see CCG policy on UAE.

2.3 Additional Considerations

a) Patients should be provided with information on all the treatment options including their outcomes, complications and risks in a format they can understand (e.g. a leaflet).

b) Patients should have the opportunity to participate in decision making that relates to their care. Clinicians could consider giving patient’s details of the online NHS shared decision making tool on heavy menstrual bleeding as referenced below.

c) LNG-IUS fittings must only be undertaken by appropriately trained staff following a physical examination, and where possible this should take place in primary care/community setting.

3. Rationale to the Decision

3.1 Guidance emphasizes that the aim of treatment for HMB should be improved quality of life and that patients should be supported to make informed decisions regarding their care.

3.2 The first line treatment for HMB should be the LNG-IUS, (unless contraindicated or declined by the patient), as this has been found to reduce menstrual blood loss by 90% in patients with HMB. The LNG-IUS has been shown to be equally effective in improving quality of life and psychological well-being as hysterectomy. The evidence compiled by NICE suggests that it may take at least 6 months before the full effect of treatment may be seen.

3.3 Both NICE and the Royal College recommend that any medical treatment should be trialled for at least 3 menstrual cycles, and that a second medical treatment should be offered if the first does not successfully relieve the symptoms. By utilising the non-surgical treatments, patients can be managed in primary care and are protected from the complications associated with surgery. If these non-surgical treatments do not successfully relieve the symptoms, the patient and clinician may go on to consider surgery.

3.4 The Royal College recommend that endometrial ablation or resection be considered in preference to hysterectomy. This is because hysterectomy is associated with considerable risk. The complication rate and length of admission is inconvenient for the patient and costly to the NHS, hence ablation techniques can offer a safe, effective alternative as reflected in NICE publications.
4. References

1. NICE guidelines [CG44] Heavy menstrual bleeding: assessment and management
   https://www.nice.org.uk/guidance/cg44
2. Royal College Obstetricians and Gynecologists Publication standards for gynecology
5. NHS Shared decision making tool HMB http://sdm.rightcare.nhs.uk/pda/menorrhagia/