

ACOG Releases Guidelines on Management of Abnormal Uterine Bleeding Associated with Ovulatory Dysfunction

Key Points for Practice from *AFP*

- PALM-COEIN was developed to describe uterine bleeding abnormalities in women of reproductive age. It includes the structural causes (polyp, adenomyosis, leiomyoma [submucosal or other myoma], and malignancy and hyperplasia) and nonstructural causes (coagulopathy, ovulatory dysfunction, endometrial, iatrogenic, and not yet classified).
- Medical treatments for abnormal uterine bleeding associated with ovulatory dysfunction include progestin-only contraception and combined hormonal contraception.
- If medical treatment fails, is contraindicated, or is not tolerated, or if the patient has concomitant significant intracavitary lesions, surgery, including endometrial ablation and hysterectomy, may be an option.

From the AFP Editors

Coverage of guidelines from other organizations does not imply endorsement by *AFP* or the AAFP.

A collection of Practice Guidelines published in *AFP* is available at <http://www.aafp.org/afp/practguide>.

Abnormal uterine bleeding related to ovulatory dysfunction (i.e., oligo-ovulation and anovulation) is a range of disorders often associated with heavy, irregular bleeding. Assessment includes a medical history, physical examination, and selected laboratory and imaging tests (i.e., pregnancy test; beta subunit of human chorionic gonadotropin test; measurement of thyroid-stimulating hormone and prolactin levels; endometrial biopsy; and saline infusion sonohysterography, hysteroscopy, or transvaginal ultrasonography). Causes of anovulation, which should be considered during the evaluation, include adolescence, perimenopause, lactation, pregnancy, hyperandrogenic conditions, hypothalamic dysfunction, hyperprolactinemia, thyroid disease, primary pituitary disease, premature ovarian failure, iatrogenic, and medications. The American College of Obstetricians and Gynecologists (ACOG) treatment recommendations are based on the assumption that a physician has confirmed the diagnosis, as well as ruled out endometrial and structural pathologies.

A classification system called the PALM-COEIN was

developed to describe uterine bleeding abnormalities in women of reproductive age. It includes the structural causes (polyp, adenomyosis, leiomyoma [submucosal or other myoma], and malignancy and hyperplasia) and nonstructural causes (coagulopathy, ovulatory dysfunction, endometrial, iatrogenic, and not yet classified). Each potential cause is linked with at least one letter qualifier specifying its etiologies.

Recommendations

BASED ON LIMITED OR INCONSISTENT EVIDENCE

The underlying problem causing abnormal uterine bleeding associated with ovulatory dysfunction should be treated medically, not surgically. Treatment options include progestin-only contraception (i.e., levonorgestrel-releasing intrauterine device [IUD; Mirena], medroxyprogesterone acetate [Provera], megestrol [Megace], norethindrone, and depot medroxyprogesterone acetate [Depo-Provera]) and combined hormonal contraception (e.g., transdermal patches, vaginal rings, oral contraceptives). These options thin the endometrium and protect it from hyperplastic transition. Additionally, combined hormonal contraception prompts regular withdrawal bleeding with cyclical use. There are no randomized trials of progestin-only or combined hormonal contraception for the treatment of abnormal uterine bleeding associated with ovulatory dysfunction, but the levonorgestrel-releasing IUD has been shown to be effective and should be considered for females of all ages.

If medical treatment fails, is contraindicated, or is not tolerated, or if the patient has concomitant significant intracavitary lesions, surgery may be an option. Endometrial ablation and hysterectomy are options; however, endometrial ablation is not considered a first-line option. Hysterectomy without cervical preservation can be considered in women who have completed childbearing, in whom medical therapy has failed, or with contraindications to treatment. Although not specifically evaluating women with anovulatory abnormal uterine bleeding, some studies have found significant improvement in quality of life after hysterectomy vs. medical treatment, but similar results vs. levonorgestrel-releasing IUD. ►

GO MOBILE

with **Family Practice Management**

Now you can access **FPM's peer-reviewed journal content dedicated to improving primary care on your iPhone®, iPad®, or other smartphones and tablets.**

Make the most of the new apps:

- Download for offline reading.
- Share articles instantly with colleagues.
- Bookmark content.
- Enjoy the more mobile-friendly formats.
- Receive real-time news and content feeds from the AAFP and *FPM*.



Search for “FPM Journal”



Also available:
American Family Physician app



BASED PRIMARILY ON CONSENSUS AND EXPERT OPINION

If medical treatment fails, further investigation (e.g., imaging, hysteroscopy) is indicated. Hysteroscopy allows for visualization of the endometrial cavity and endocervix and can help diagnose focal lesions possibly missed by endometrial sampling. Of note, because endometrial biopsy is less invasive, safer, and has a lower cost compared with dilation and curettage, it is preferred for diagnosing endometrial hyperplasia or cancer. However, the sensitivity of endometrial biopsy can be affected by a variety of factors, including lesion type (focal or diffuse) or size; quantity of lesions; pathologic diagnosis (intracavitary leiomyoma or polyp); whether or not uterine malformation is present; volume of pathology; and surface area of the endometrial cavity. Transvaginal ultrasonography is not typically recommended in virgins. Transabdominal imaging is less sensitive and has less value in assessing the endometrium; however, it can be useful for assessing other structural abnormalities. Saline infusion sonohysterography has a sensitivity of 96% to 100% and negative predictive value of 94% to 100% for assessing the uterus and endometrium for pathology. It can confirm whether intracavitary lesions are present, can determine the myometrial involvement with leiomyomas, and can provide more accurate assessment of the endometrium vs. transvaginal ultrasonography alone.

Treatment decisions for abnormal uterine bleeding associated with ovulatory dysfunction should be based on the therapeutic goals (e.g., stop acute bleeding, avoid heavy bleeding, concurrently provide contraception, prevent complications). Although endometrial ablation is not a first-line treatment option, informed consent and counseling should be provided to those women wanting the procedure. Possible long-term complications of endometrial ablation include postablation Asherman syndrome, synechiae, cervical stenosis, contracture of the endometrium, strictures, endometrial distortion, and delayed endometrial cancer diagnosis.

Guideline source: American College of Obstetricians and Gynecologists

Evidence rating system used? Yes

Literature search described? Yes

Guideline developed by participants without relevant financial ties to industry? Not reported

Published source: *Obstetrics & Gynecology*, July 2013

Available at: http://journals.lww.com/greenjournal/Citation/2013/07000/Practice_Bulletin_No__136___Management_of_Abnormal.38.aspx [subscription required]

LISA HAUKE, Senior Associate Editor, *AFP Online* ■