The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

FAQ

FREQUENTLY ASKED QUESTIONS
FAQ193
GYNECOLOGIC PROBLEMS

Heavy Menstrual Bleeding

How common is heavy menstrual bleeding?

Heavy menstrual bleeding is very common. About one third of women seek treatment for it. Heavy menstrual bleeding is not normal. It can disrupt your life and may be a sign of a more serious health problem. If you are worried that your menstrual bleeding is too heavy, tell your ***obstetrician–gynecologist (ob-gyn)***.

When is menstrual bleeding considered "heavy"?

Any of the following is considered to be heavy menstrual bleeding:

- Bleeding that lasts more than 7 days.
- Bleeding that soaks through one or more tampons or pads every hour for several hours in a row.
- Needing to wear more than one pad at a time to control menstrual flow.
- Needing to change pads or tampons during the night.
- Menstrual flow with blood clots that are as big as a quarter or larger.

How can heavy menstrual bleeding affect my health?

Heavy menstrual bleeding may be a sign of an underlying health problem that needs treatment. Blood loss from heavy periods also can lead to a condition called ***iron-deficiency anemia***. Severe anemia can cause shortness of breath and increase the risk of heart problems.

What causes heavy menstrual bleeding?

Many things can cause heavy menstrual bleeding. Some of the causes include the following:

- ***Fibroids*** and ***polyps***
- ***Adenomyosis***
- Irregular ***ovulation***—If you do not ovulate regularly, areas of the ***endometrium*** (the lining of the ***uterus***) can become too thick. This condition is common during ***puberty*** and ***perimenopause***. It also can occur in women with certain medical conditions, such as ***polycystic ovary syndrome*** and ***hypothyroidism***.
- Bleeding disorders—When the blood does not clot properly, it can cause heavy bleeding.

- Medications—Blood thinners and aspirin can cause heavy menstrual bleeding. The copper ***intrauterine device (IUD)*** can cause heavier menstrual bleeding, especially during the first year of use.
- Cancer—Heavy menstrual bleeding can be an early sign of ***endometrial cancer***. Most cases of endometrial cancer are diagnosed in women in their mid 60s who are past ***menopause***. It often is diagnosed at an early stage when treatment is the most effective.
- Other causes—***Endometriosis*** can cause heavy menstrual bleeding. Other causes include those related to pregnancy, such as ***ectopic pregnancy*** and ***miscarriage***. ***Pelvic inflammatory disease*** also can cause heavy menstrual bleeding. Sometimes, the cause is not known.

How is heavy menstrual bleeding evaluated?

When you see your ob-gyn about heavy menstrual bleeding, you may be asked about the following things:

- Past and present illnesses and surgical procedures
- Pregnancy history
- Medications, including those you buy over the counter
- Your birth control method
- Your ***menstrual cycle***—If you can, use a calendar or period-tracking smartphone app to keep track of your menstrual cycle before your visit. Your ob-gyn will want to know detailed information about several menstrual cycles, including the dates that your period started, how long bleeding lasted, and the amount of flow (light, medium, heavy, or spotting).

What tests and exams may be used to evaluate heavy menstrual bleeding?

You will have a physical exam, including a ***pelvic exam***. Several laboratory tests may be done. You may have a pregnancy test and tests for some ***sexually transmitted infections***. Based on your symptoms and your age, additional tests may be needed:

- ***Ultrasound exam***—Sound waves are used to make a picture of the pelvic organs.
- ***Hysteroscopy***—A thin, lighted scope is inserted into the uterus through the opening of the ***cervix***. It allows your ob-gyn to see the inside of the uterus.
- ***Endometrial biopsy***—A sample of the endometrium is removed and looked at under a microscope. Sometimes hysteroscopy is used to guide this test. A surgical procedure called ***dilation and curettage (D&C)*** is another way this test can be done.
- ***Sonohysterography***—Fluid is placed in the uterus through a thin tube while ultrasound images are made of the uterus.
- ***Magnetic resonance imaging***—This imaging test uses powerful magnets to create images of the internal organs.

Which medications can be used to treat heavy menstrual bleeding?

Medications often are tried first to treat heavy menstrual bleeding:

- Heavy bleeding caused by problems with ovulation, endometriosis, polycystic ovary syndrome, and fibroids often can be managed with certain hormonal birth control methods. Depending on the type, these methods can lighten menstrual flow, help make periods more regular, or even stop bleeding completely.
- ***Hormone therapy*** can be helpful for heavy menstrual bleeding that occurs during perimenopause. Before deciding to use hormone therapy, it is important to weigh the benefits and risks (increased risk of heart attack, stroke, and cancer).
- ***Gonadotropin-releasing hormone (GnRH) agonists*** stop the menstrual cycle and reduce the size of fibroids. They are used only for short periods (less than 6 months). Their effect on fibroids is temporary. Once you stop taking the drug, fibroids usually return to their original size.
- ***Tranexamic acid*** is a prescription medication that treats heavy menstrual bleeding. It comes in a tablet and is taken each month at the start of the menstrual period.
- ***Nonsteroidal antiinflammatory drugs***, such as ibuprofen, also may help control heavy bleeding and relieve menstrual cramps.
- If you have a bleeding disorder, your treatment may include special medications to help your blood clot.

Which procedures can be used to treat heavy menstrual bleeding?

If medication does not reduce your bleeding, a surgical procedure may be needed:

- ***Endometrial ablation*** destroys the lining of the uterus. It stops or reduces menstrual bleeding. Pregnancy is not likely after ablation, but it can happen. If it does, the risk of serious complications is greatly increased. You will need to use a birth control method until after menopause following endometrial ablation. ***Sterilization*** (permanent birth control) may be a good option to prevent pregnancy for women having ablation. Endometrial ablation should be considered only after medication or other therapies have not worked.
- ***Uterine artery embolization (UAE)*** is used to treat fibroids. In UAE, the blood vessels to the uterus are blocked, which stops the blood flow that allows fibroids to grow.

- ***Myomectomy*** is surgery to remove fibroids without removing the uterus.
- Hysteroscopy can be used to remove fibroids or stop bleeding caused by fibroids in some cases.
- ***Hysterectomy*** is surgical removal of the uterus. Hysterectomy is used to treat fibroids and adenomyosis when other types of treatment have failed or are not an option. It also is used to treat endometrial cancer. After the uterus is removed, a woman can no longer get pregnant and will no longer have periods.

Glossary

Adenomyosis: A condition in which the tissue that normally lines the uterus begins to grow in the muscle wall of the uterus.

Cervix: The lower, narrow end of the uterus at the top of the vagina.

Dilation and Curettage (D&C): A procedure in which the cervix is opened (dilated) and tissue is gently scraped (curettage) or suctioned from the inside of the uterus.

Ectopic Pregnancy: A pregnancy in which the fertilized egg begins to grow in a place other than inside the uterus, usually in one of the fallopian tubes.

Endometrial Ablation: A minor surgical procedure in which the lining of the uterus is destroyed to stop or reduce menstrual bleeding.

Endometrial Cancer: Cancer of the lining of the uterus.

Endometrial Biopsy: A procedure in which a small amount of the tissue lining the uterus is removed and examined under a microscope.

Endometriosis: A condition in which tissue that lines the uterus is found outside of the uterus, usually on the ovaries, fallopian tubes, and other pelvic structures.

Endometrium: The lining of the uterus.

Fibroids: Growths, usually benign, that form in the muscle of the uterus.

Gonadotropin-releasing Hormone (GnRH) Agonists: Medical therapy used to block the effects of certain hormones.

Hormone Therapy: Treatment in which estrogen and often progestin are taken to help relieve some of the symptoms caused by low levels of these hormones.

Hypothyroidism: A condition in which the thyroid gland makes too little thyroid hormone.

Hysterectomy: Removal of the uterus.

Hysteroscopy: A procedure in which a device called a hysteroscope is inserted into the uterus through the cervix to view the inside of the uterus or perform surgery.

Intrauterine Device (IUD): A small device that is inserted and left inside the uterus to prevent pregnancy.

Iron-Deficiency Anemia: Abnormally low levels of iron, which is the part of the red blood cells that carries oxygen to the cells and tissues of the body.

Magnetic Resonance Imaging: A method of viewing internal organs and structures by using a strong magnetic field and sound waves.

Menopause: The time in a woman's life when menstruation stops; defined as the absence of menstrual periods for 1 year.

Menstrual Cycle: The monthly process of changes that occur to prepare a woman's body for possible pregnancy. A menstrual cycle is defined from the first day of menstrual bleeding of one cycle to the first day of menstrual bleeding of the next cycle.

Miscarriage: Loss of a pregnancy that occurs in the first 13 weeks of pregnancy.

Myomectomy: Surgical removal of uterine fibroids only, leaving the uterus in place.

Nonsteroidal Antiinflammatory Drugs: A type of pain reliever that relieves pain by reducing inflammation. Many types are available over the counter.

Obstetrician–Gynecologist (Ob-Gyn): A physician with special skills, training, and education in women's health.

Ovulation: The release of an egg from one of the ovaries.

Pelvic Exam: A physical examination of a woman's reproductive organs.

Pelvic Inflammatory Disease: An infection of the uterus, fallopian tubes, and nearby pelvic structures.

Perimenopause: The period before menopause that usually extends from age 45 years to 55 years.

Polycystic Ovary Syndrome: A condition characterized by two of the following three features: the presence of growths called cysts on the ovaries, irregular menstrual periods, and an increase in the levels of certain hormones.

Polyps: Benign (noncancerous) growths that develop from tissue lining an organ, such as that lining the inside of the uterus.

Puberty: The stage of life when the reproductive organs become functional and secondary sex characteristics develop.

Sexually Transmitted Infections: Infections that are spread by sexual contact, including chlamydia, gonorrhea, human papillomavirus, herpes, syphilis, and human immunodeficiency virus (HIV, the cause of acquired immunodeficiency syndrome [AIDS]).

Sonohysterography: A procedure in which sterile fluid is injected into the uterus through the cervix while ultrasound images are taken of the inside of the uterus.

Sterilization: A permanent method of birth control.

Tranexamic Acid: A medication prescribed to treat or prevent heavy bleeding.

Ultrasound Exam: A test in which sound waves are used to examine internal structures. During pregnancy, it can be used to examine the fetus.

Uterine Artery Embolization (UAE): A procedure in which the blood vessels to the uterus are blocked. It is used to treat postpartum hemorrhage and other problems that cause uterine bleeding.

Uterus: A muscular organ located in the female pelvis that contains and nourishes the developing fetus during pregnancy.

If you have further questions, contact your obstetrician–gynecologist.

FAQ193: Designed as an aid to patients, this document sets forth current information and opinions related to women's health. The information does not dictate an exclusive course of treatment or procedure to be followed and should not be construed as excluding other acceptable methods of practice. Variations, taking into account the needs of the individual patient, resources, and limitations unique to the institution or type of practice, may be appropriate.