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Managing Perimenopausal Bleeding with Evidence-Based Options

Announcer:
You're listening to *Advances in Women's Health* on ReachMD. Here's your host, Dr. Mary Katherine Cheeley.

Dr. Cheeley:
This is *Advances in Women's Health* on ReachMD, and I'm Dr. Mary Katherine Cheeley. Joining me to discuss evidence-based approaches for managing heavy bleeding in perimenopausal patients are Drs. Monica Christmas and Mary Jane Minkin.

Dr. Christmas is an Associate Professor of Obstetrics and Gynecology, the Director of the Center for Women's Integrated Health, the Associate Medical Director for the Menopause Society, and the Director of the Menopause Program at the University of Chicago Medicine. Dr. Christmas, welcome to the program.

Dr. Christmas:
Thank you for having me.

Dr. Cheeley:
Also joining us is Dr. Minkin, who is a Clinical Professor in the Department of Obstetrics, Gynecology, and Reproductive Sciences at the Yale School of Medicine, in addition to being the Co-Director of the Sexuality, Intimacy, and Menopause Program at Smilow Cancer Hospital in New Haven, Connecticut. Dr. Minkin, it is great to have you here with us.

Dr. Minkin:
A pleasure being with you, Dr. Cheeley. Thank you so much.

Dr. Cheeley:
All right, let's jump in. This is going to be a really great discussion. Dr. Christmas, let's start with you. What are the primary therapeutic approaches you consider for perimenopausal patients experiencing heavy bleeding?

Dr. Christmas:
Well, the first thing I like to do is make sure that the cause is truly just perimenopausal bleeding, and so that means that I want to make sure that there's not fibroids and endometrial polyps, adenomyosis, an infectious etiology, or even hypothyroidism that may be contributing to the bleeding that they're experiencing, and looking at any other medications that they might be on as well. And if everything comes back that this is just wacky perimenopausal bleeding, which often it is, that can run the gamut. Some people are very fortunate—their bleeding might get shorter, lighter, and then it spaces out, while other people might be at the opposite end of the spectrum, where they have much heavier bleeding for a longer duration of time, and it may even be closer together. But even for those lucky people, where the bleeding is very light, when it's unscheduled bleeding, it can be extremely unnerving and unsettling.

Perimenopause is treated differently than menopause at times because of the bleeding. The irregular bleeding signals that this is perimenopause along with other associated symptoms, but sometimes just treating them with hormone therapy could potentially make some of those other symptoms, like hot flashes and night sweats—potentially even mood swings—better. But it could make their bleeding worse. And so that's where things like hormonal birth control comes in, like a low-dose combination pill, or even the levonorgestrel IUD is a nice option as well.

Dr. Cheeley:
Dr. Minkin, how do patient's goals and other clinical factors shape your treatment decisions in this case?

Dr. Minkin:
Those are extremely important in making a decision. And one thing that Dr. Christmas did mention very nicely, of course, is the fact that perimenopause is different than menopause. And one of the major factors is, in perimenopause, we still have to worry about pregnancy, and if somebody is fully menopausal, we don't.

And of course, the patient's goals are really important and we have to talk about them. Some people do want to get pregnant, and of course, the IUD does give them that option of having a progestin-coated IUD, where you basically can maintain the option for pregnancy at the future if you wanted to, and you don't have to do anything that would be an appropriate permanent sterilization type procedure at the same time. So that's a good thing about it.

Many women do want to avoid surgery, which is understandable, and insertion of a levonorgestrel IUD obviates that necessity. Many people don't want to be exposed to extra hormones, and if you have an intrauterine device with progestin in there, it very much minimizes the systemic exposure, which is great. And again, the fertility option.

And the other thing is, if we can achieve not having periods, that's a very good thing for many patients. So we need to find out what their goal is.

There are also some clinical considerations that we as practitioners need to know for the patient. For some people, there are going to be contraindications to certain approaches. For example, hormonal contraceptive combination of contraceptive may not be ideal for somebody who's a smoker—somebody we haven't achieved in trying to keep her off the cigarettes permanently. Age is important. Other medical conditions are important. Somebody who's got hypertension and things like that may not be an ideal birth control pill candidate. So these are all options. The size of the uterus is important. Is she going to need further care along those lines? And things like adenomyosis, as mentioned, or fibroids—all of these can contribute to our decision-making, or, actually, shared decision-making, because we want to share this option with our patients, of course.

Dr. Cheeley:
Dr. Christmas, I want to dive a little bit more into what we need to know about the first-line use of levonorgestrel-releasing IUDs.

Dr. Christmas:
The first thing is determining who's a good candidate, and making sure that there are no uterine anomalies. Someone that has a bicornuate uterus, has fairly large fibroids, or had some other pelvic surgery that might prevent the placement of the intrauterine device might not be a good candidate for it as well.

There are contraindications for many people. Dr. Mary Jane Minkin mentioned some of them, like smoking, poorly controlled high blood pressure, obesity in some cases, where being on an estrogen-containing contraceptive option might increase their risk of either blood clots or stroke, which is far worse than the bleeding that they're experiencing. So in those patients, especially if they don't have any other uterine anomalies, as I said, to make it difficult for placement or uncomfortable, I think they're a great candidate for levonorgestrel IUD.

There are a number of different ones, I should say too. But usually, if we're going to get the biggest bang for our effort, especially during this perimenopause timeframe, using one of the devices that has efficacy for five years is good. And then when you're using them just for birth control, they actually can be kept in place for eight years.

Dr. Cheeley:
Dr. Minkin, despite all of the amazing things that we've heard in talking through all of this, levonorgestrel-releasing IUDs are underused in clinical practice. Help me understand what barriers are at play. What do we think the challenge is?

Dr. Minkin:
Well, there's always challenges to everything in medicine, I think. And Dr. Monica Christmas will attest to that as well; we're faced with that regularly. One thing that I would like to add is, if you have somebody who's dealing with significant perimenopausal type bleeding, and somebody you might be thinking about doing a D&C in an operating room because she's anxious about that, you may go ahead and do the D&C, and at the end, if she wishes, you can pop in a levonorgestrel-coated IUD while you're there, and she won't feel anything. And that will take care of her progestin needs for her uterus for about the next five years.

And one nice thing is that we can emphasize to our patients, because of its placement in the uterus, you get very minimal systemic absorption of the progestin. We see a little bit of it, but not very much. So we really, in general, avoid the side effects of systemic progestins, which can be very problematic for women. So I think we have a lot of benefits there.

And of course, one thing we do have to discuss with our patients beforehand is, unfortunately, that there are some cost issues involved

with placing a progestin-coated IUD, a levonorgestrel-coated IUD. And we try to review this with our patients first and get the business folks in to talk to them about getting coverage and things, which can be helpful for them.

Dr. Cheeley:
For those of you just tuning in, you're listening to *Advances in Women's Health* on ReachMD. I'm Dr. Mary Katherine Cheeley, and I'm speaking with Drs. Monica Christmas and Mary Jane Minkin about patient-centered approaches to managing heavy bleeding during perimenopause.

All right, Dr. Christmas, I want to come back around to you, because I'm really enjoying this conversation. When it comes to counseling patients about their levonorgestrel-releasing IUD, what concerns do you commonly hear from patients? How do you address them? Take me into your exam room with you.

Dr. Christmas:
It can be daunting thinking about having something put into your uterus in the office, especially for someone that may have had a poor experience before, like a traumatic experience getting their Pap smear. There's also some structural changes that start to happen during perimenopause and into the menopause transition, where vaginal tissues become a little bit drier. So sometimes there's just the apprehension about having the IUD placed.

But then people always know someone. "I know somebody that had it placed, and it was horrible for them. Either it was malpositioned or not in the correct place, and they had to have it removed, and it caused them a lot of pain."

Especially when people come in with fears, I always validate what their concerns are and really try to address them. And a big part of counseling is, fortunately, there's not always just one treatment option that's going to work for them. And so we really do go through the gamut of options with what the benefits and the pros and cons might be for each. Most people are afraid of the pain, so I address that issue, and things that we can do to minimize pain. What are things that we can do to try to minimize that nuisance breakthrough bleeding?

And then I also end with, if you don't think it's as nifty as I think it is, I will remove it, no questions asked. And I also will not force it. If you may feel a cramp, I'm going to tell you when you're going to feel the cramp. I'm going to tell you what you may feel. But if you're feeling more than that, then I'm going to stop. We can go to plan B, or if you still want the IUD placed, then it might be that person that we discussed placing it with some additional anesthetic.

Dr. Cheeley:
Dr. Minkin, we know that there's times where medical therapy isn't effective or isn't appropriate for patients. When do you consider escalating to procedures like ablation or hysterectomy? And how do you help patients navigate through that decision-making process?

Dr. Minkin:
Well, I think we always try to give patients the good side and the bad side of any of our interventions, particularly surgical interventions. And one procedure that I am not in love with—and maybe I do put my prejudices in this, and I've never talked with Monica about this one—I'm not a big lover of ablations.

Dr. Christmas:
I agree with you 100%.

Dr. Minkin:
The problem with doing an ablation—yes, it is a relatively straightforward procedure, that's correct, and it's done—but a couple of things about it. Number one, it is not contraceptive. There are people that can get pregnant who've had ablations, and it's not really good to have an ablation and get pregnant afterwards. That's not really good for the pregnancy. So you still have to use contraception if you are at risk for pregnancy. And if they are perimenopausal, they are still at risk. So that's one simple thing.

The other thing is, the subsequent consequences can be pretty bad, because—and I don't want to sound gross—you're frying the lining of the uterus. And you never fry every gland. You don't fry every endometrial gland, so some of them are still active, and you get bleeding behind a scar, and this gives people pain. But there are a lot of people I've seen who have had this problem, and then they end up with a hysterectomy, which is what they did ablation to avoid. So this is a problem. So I'm not a big lover of an ablation.

As far as a hysterectomy, I mean, yes, hysterectomies are definitive. There's no question about it. And it is a major surgical procedure and attendant with all sorts of potential complications. Thank goodness, most of the time it's done quite safely, but there are potential issues, and there can be potential issues long term. I mean, somebody can get adhesions and show up in your emergency room years later with scarring. So you have all of these things to deal with.

And when you can put in something like a levonorgestrel IUD, again, if it doesn't work, you take it out, and that's fine. I think that we're dealing with a much lower invasive type procedure and not offering somebody the complications.

Now, there are people that the hyst is going to be an ideal thing for: somebody that's got nasty, big fibroids that bleed, she's pretty miserable, she's somebody who's going to want to take hormone therapy after menopause, and she may do well with a hyst. So there surely are good candidates, but you have to really address the issue with the patient.

Dr. Cheeley:
Dr. Christmas, I'm going to leave you with the last words here. Are there any key takeaways that you want to share about the evolving approach to heavy bleeding in perimenopausal patients?

Dr. Christmas:
No one should suffer. I think that's the takeaway point. No one should suffer. And there are treatment modalities that run the gamut. As I said, first we want to establish what the true etiology and cause is. If it just does come down to that this is perimenopause-related bleeding—oftentimes it can be with something else too—but there are minimally invasive treatment options that we've talked about today that run the gamut, from using oral combination pills to a progestin-only pill, up to the levonorgestrel IUD. And when and if those things don't work, or they don't give us the satisfaction that the patient is looking for, then there are surgical interventions to help as well.

But the key is not to suffer. There are things that we can do.

Dr. Cheeley:
Ladies, this has been such a wonderful discussion. Thank you so much, Dr. Monica Christmas and Dr. Mary Jane Minkin, for joining me and sharing your perspective on managing heavy bleeding in perimenopausal patients. Ladies, it was lovely to have you on the program.

Dr. Minkin:
Well, thank you all for the kind invitation.

Dr. Christmas:
Yes, it was fun.

Announcer:
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