Derby and Derbyshire
Integrated Care Board

CLINICAL POLICY ADVISORY GROUP (CPAG)

Hysterectomy for Menorrhagia Policy

Criteria
Black – criteria required to be met prior to referral
Blue – criteria to be met prior to procedure

Statement

Derby and Derbyshire ICB, in line with its principles for procedures of limited clinical value has deemed that hysterectomy for menorrhagia should not routinely be commissioned unless criteria 1,2 AND 3 are met:

1. There has been an unsuccessful trial of a minimum of 6 months with a licensed levonorgestrel intrauterine delivery system (LNG-IUS), which has failed to relieve symptoms (unless medically inappropriate or contraindicated),
   AND
2. The following treatments have either failed, are not appropriate or are contraindicated in line with the National Institute for Health and Clinical Excellence (NICE) guideline NG88 Heavy Menstrual Bleeding:
   - Tranexamic acid and/or non-steroidal anti-inflammatory drugs (NSAIDs), such as naproxen
   - Oral hormonal methods, such as combined oral contraceptives, cyclical oral progesterone

   AND
3. There is evidence of severe impact on quality of life

These commissioning intentions will be reviewed periodically. This is to ensure affordability against other services commissioned by the ICB.

1. Background

Menorrhagia is excessive (heavy) menstrual blood loss that occurs regularly (every 24 to 35 days) which interferes with a woman's physical, emotional, social, and material quality of life. Excessive menstrual blood loss is classified as 80 mL or more and/or a duration of more than 7 days. Menorrhagia is also defined as the need to change menstrual products every one to two hours, passage of clots greater than 2.54 cm, and/or 'very heavy' periods as reported by the woman.

Hysterectomy is a treatment option for menorrhagia, which involves surgical removal of the uterus. Women who have undergone the hysterectomy procedure will no longer be able to get pregnant. Hysterectomies can be carried out vaginally through a cut in the top of the vagina, through keyhole surgery or through a cut in the lower abdomen.

2. Recommendation

Derby and Derbyshire ICB (DDICB) does not routinely commission hysterectomy for menorrhagia unless criteria 1,2 AND 3 are met:

1. There has been an unsuccessful trial of a minimum of 6 months with a licensed levonorgestrel intrauterine delivery system (LNG-IUS), which has failed to relieve symptoms (unless medically inappropriate or contraindicated),
   AND
2. The following treatments have either failed, are not appropriate or are contraindicated in line with the National Institute for Health and Clinical Excellence (NICE) guideline NG88 Heavy Menstrual Bleeding:
   - Tranexamic acid and/or NSAIDs, such as naproxen
   - Oral hormonal methods, such as combined oral contraceptives, cyclical oral progesterone

   AND
3. There is evidence of severe impact on quality of life

   NB The presence of other symptoms during physical examination, such as pelvic pain, pressure– would warrant further investigation with an ultrasound, before proceeding with pharmacological treatment).

3. Rationale for Recommendation

Hysterectomy is a second-line treatment strategy for heavy menstrual bleeding, for which women need to have tried first-line treatment strategies, and for these to be unsuccessful, before being offered a hysterectomy.

LNG-IUS is a first-line treatment for menorrhagia in women with no identified pathology, fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis. Evidence shows that it is as effective as, or more effective than, other treatments in improving health-related quality of life and satisfaction with treatment. Evidence did not show clinically important differences in effectiveness and acceptability among the other pharmacological treatments, so there are several options that may be considered if a woman declines LNG-IUS or it is not suitable.

There is limited evidence that does not favour any one treatment over others for women with fibroids of 3 cm or more in diameter. The evidence for interventional or surgical treatments

was mainly for fibroids substantially greater than 3 cm in diameter.

4. Shared Decision-Making

Shared decision-making ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment.

Decision support tools, also called patient decision aids, support shared decision making by making treatment, care and support options explicit. They provide evidence-based information about the associated benefits/harms and help patients to consider what matters most to them in relation to the possible outcomes, including doing nothing.

5. Useful Resources

- Heavy Periods, NHS, last reviewed 07/06/18, https://www.nhs.uk/conditions/heavy-periods/
- Hysterectomy, NHS, last reviewed 01/02/19, https://www.nhs.uk/conditions/hysterectomy/
- Hysterectomy, Royal College of Obstetricians and Gynaecologists, https://www.rcog.org.uk/en/patients/menopause/hysterectomy/
- NHS England » Decision support tool: making a decision about managing heavy periods

6. References

- Menorrhagia, Clinical Knowledge Summaries, National Institute for Health and Care Excellence, last revised December 2018, accessed 01/04/21, https://cks.nice.org.uk/topics/menorrhagia/
- Hysterectomy, NHS, last reviewed 01/02/19, accessed 07/04/2, https://www.nhs.uk/conditions/hysterectomy/
- Heavy menstrual bleeding: assessment and management , NICE guideline [NG88], updated 31/03/20, accessed 01/04/21, https://www.nice.org.uk/guidance/ng88

7. Appendices

Appendix 1 - Consultation

All relevant providers/stakeholders will be consulted via a named link consultant/specialist. Views expressed should be representative of the provider/stakeholder organisation. CPAG will consider all views to inform a consensus decision, noting that sometimes individual views and opinions will differ.

Consultee	**Date**
Consultant Obstetrician and Fetal Medicine, UHDBFT	October 2020
Consultant specialising in Obstetrics and Gynaecology, UHDBFT	October 2020
Consultant Obstetrician and Gynaecologist, CRHFT	October 2020
Clinical Policy Advisory Group (CPAG)	May 2021
Clinical Lay Commissioning Committee (CLCC)	June 2021
Consultant Obstetrician, UHDBFT	November 2023
Consultant Obstetrician and Urogynaecologist, UHDBFT	November 2023
Consultant Gynaecologist, CRHFT	November 2023
Clinical Policy Advisory Group (CPAG)	November 2023

Appendix 2 - Document Update

Document Update	**Date Updated**
Version 4.0 • Policy reworded and reformatted to reflect the DDCCG clinical policies format, which includes the addition of background information, rationale for recommendations, useful resources, references, consultation, Derbyshire PLCV referral form and the Blueteq form. Policy criteria has been reworded and reformatted to provide further clarity. • Criteria 4 'The patient has been trialed on and failed to respond to a licensed gonadotropin releasing hormone (GnRH) agonist for the management of uterine fibroids following consultation with a gynaecologist, ie: triptorelin/ leuprorelin/ goserelin (where clinically applicable)' has been removed from the policy. • The wording 'levonorgestrel-releasing intrauterine system' has been replaced with 'licensed levonorgestrel intrauterine delivery system (LNG-IUS)' and examples of such systems have been removed.	May 2021

Version 4.1 • CPAG agreed to extend the review date of this policy by 12 months due to reduced capacity within the Clinical Policies team.	November 2023
Version 4.2 • Reference to prior approval removed.	July 2024
Version 4.3 • In line with risk profile, CPAG agreed further extension to review date. • Reference to shared decision making added.	September 2024

Appendix 3 - OPCS Code(s)

Q07, Q071, Q072, Q073, Q074, Q075, Q076, Q078, Q079, Q08, Q081, Q082, Q083, Q088, Q089