

Commissioning Statement:

Condition or Treatment:	2019 NHSE Evidence Based Intervention: Hysterectomy for heavy menstrual bleeding
Background:	Hysterectomy is the surgical removal of the uterus.
Commissioning position:	<p>Based on NICE guidelines [Heavy menstrual bleeding: assessment and management [NG88] Published date: March 2018], hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.</p> <p>It is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices.</p> <p>Hysterectomy should be considered only when: other treatment options have failed, are contradicted; there is a wish for amenorrhoea (no periods); the woman (who has been fully informed) requests it; the woman no longer wishes to retain her uterus and fertility.</p> <p><i>1.13.1.1.1 NICE guideline NG88 1.5 Management of HMB</i></p> <p>1.5.1 When agreeing treatment options for HMB with women, take into account: the woman's preferences, any comorbidities, the presence or absence of fibroids (including size, number and location), polyps, endometrial pathology or adenomyosis, other symptoms such as pressure and pain.</p> <p><i>1.13.1.1.2 Treatments for women with no identified pathology, fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis</i></p> <p>1.5.2 Consider an LNG-IUS (levonorgestrel-releasing intrauterine system) as the first treatment for HMB in women with: no identified pathology or fibroids less than 3 cm in diameter, which are not causing distortion of the uterine cavity or suspected or diagnosed adenomyosis.</p> <p>1.5.3 If a woman with HMB declines an LNG-IUS or it is not suitable, consider the following pharmacological treatments: non-hormonal: tranexamic acid, NSAIDs (non-steroidal anti-inflammatory drugs), hormonal: combined hormonal contraception, cyclical oral progestogens.</p> <p>1.5.4 Be aware that progestogen-only contraception may suppress menstruation, which could be beneficial to women with HMB.</p> <p>1.5.5 If treatment is unsuccessful, the woman declines pharmacological treatment, or symptoms are severe, consider referral to specialist care for: investigations to diagnose the cause of HMB, if needed, taking into account any investigations the woman has already had and alternative treatment choices, including: pharmacological options not already tried (see recommendations 1.5.2 and 1.5.3), surgical options: second-generation endometrial ablation, hysterectomy.</p> <p>1.5.6 For women with submucosal fibroids, consider hysteroscopic removal.</p> <p><i>1.13.1.1.3 Treatments for women with fibroids of 3 cm or more in diameter</i></p>

	<p>1.5.7 Consider referring women to specialist care to undertake additional investigations and discuss treatment options for fibroids of 3 cm or more in diameter.</p> <p>1.5.8 If pharmacological treatment is needed while investigations and definitive treatment are being organised, offer tranexamic acid and/or NSAIDs.</p> <p>1.5.9 Advise women to continue using NSAIDs and/or tranexamic acid for as long as they are found to be beneficial.</p> <p>1.5.10 For women with fibroids of 3 cm or more in diameter, take into account the size, location and number of fibroids, and the severity of the symptoms and consider the following treatments: pharmacological: non-hormonal: tranexamic acid, NSAIDs, hormonal: LNG-IUS, combined hormonal contraception, cyclical oral progestogens, uterine artery embolization, surgical: myomectomy, hysterectomy.</p> <p>1.5.12 Be aware that the effectiveness of pharmacological treatments for HMB may be limited in women with fibroids that are substantially greater than 3 cm in diameter.</p> <p>1.5.13 Prior to scheduling of uterine artery embolisation or myomectomy, the woman's uterus and fibroid(s) should be assessed by ultrasound. If further information about fibroid position, size, number and vascularity is needed, MRI should be considered. [2007]</p> <p>1.5.14 Consider second-generation endometrial ablation as a treatment option for women with HMB and fibroids of 3 cm or more in diameter who meet the criteria specified in the manufacturers' instructions.</p> <p>1.5.15 If treatment is unsuccessful: consider further investigations to reassess the cause of HMB, taking into account the results of previous investigations and offer alternative treatment with a choice of the options described in recommendation 1.5.10.</p> <p>1.5.16 Pre-treatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus.</p> <p>For further information, please see: https://www.nice.org.uk/guidance/nq88 https://www.nhs.uk/conditions/heavy-periods/#Causes</p>
<p>Effective From:</p>	<p>1 July 2021</p>
<p>Summary of evidence/ rationale:</p>	<p>NICE's Guideline Development Group considered the evidence (including 2 reviews, four randomised control trials and one cohort study comparing hysterectomy with other treatments) as well as the views of patients and the public and concluded that hysterectomy should not routinely be offered as first line treatment for heavy menstrual bleeding. The Group placed a high value on the need for education and information provision for women with heavy menstrual bleeding.</p>

	Complications following hysterectomy are usually rare but infection occurs commonly. Less common complications include: intra-operative haemorrhage; damage to other abdominal organs, such as the urinary tract or bowel; urinary dysfunction –frequent passing of urine and incontinence. Rare complications include thrombosis (DVT and clot on the lung) and very rare complications include death. Complications are more likely when hysterectomy is performed in the presence of fibroids (non-cancerous growths in the uterus). There is a risk of possible loss of ovarian function and its consequences, even if the ovaries are retained during hysterectomy. If oophorectomy (removal of the ovaries) is performed at the time of hysterectomy, menopausal-like symptoms occur.
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Additional Information/References:

1. NICE guidance: <https://www.nice.org.uk/guidance/ng88>
2. NHS website: <https://www.nhs.uk/conditions/heavy-periods/#Causes>
3. Hurskainen R, Teperi J, Rissanen P, et al. Clinical outcomes and costs with the levonorgestrel-releasing intrauterine system or hysterectomy for treatment of menorrhagia: randomized trial 5-year follow-up. JAMA: the journal of the American Medical Association 2004;291(12):1456–63.
4. Learman LA, Summitt Jr RL, Varner RE, et al. Hysterectomy versus expanded medical treatment for abnormal uterine bleeding: Clinical outcomes in the medicine or surgery trial. Obstetrics and Gynecology 2004;103(5 1):824–33.
5. Zupi E, Zullo F, Marconi D, et al. Hysteroscopic endometrial resection versus laparoscopic supracervical hysterectomy for menorrhagia: a prospective randomized trial. American Journal of Obstetrics and Gynecology 2003;188(1):7–12.
6. Lethaby A, Hickey M, Garry R. Endometrial destruction techniques for heavy menstrual bleeding. Cochrane Database Syst Rev. 2005 Oct 19;(4):CD001501. Review. Update in: Cochrane Database Syst Rev. 2009;(4):CD001501. PubMed PMID: 16235284.
7. Hehenkamp WJ, Volkers NA, Donderwinkel PF, et al. Uterine artery embolization versus hysterectomy in the treatment of symptomatic uterine fibroids (EMMY trial): peri-and postprocedural results from a randomized controlled trial. American Journal of Obstetrics and Gynecology 2005;193(5):1618–29.

8. Pinto I, Chimeno P, Romo A, et al. Uterine fibroids: uterine artery embolization versus abdominal hysterectomy for treatment – a prospective, randomized, and controlled clinical trial. *Radiology* 2003;226(2):425–31.