

Heavy Menstrual Bleeding Pathway: ED Management

For individuals with concern for heavy menstrual bleeding



February 2026

Exclusion Criteria:

- Patient with previously identified bleeding disorder
- Comorbid condition: concurrent rheumatologic diagnosis, cancer, current anticoagulation, congenital heart disease, sickle cell disease, thalassemia
- Patients with altered mental status, severe hypotension, requiring intubation, or who are otherwise clinically unstable

Screening Questions (Adapted from Claire Philipp Screening Tool; AMJOG 2011)

1. On average does your period last 7 or more days?
2. Do you experience “flooding” or overflow bleeding through your tampon or pad?
3. Do you need to change your tampon or pad more than every 1-2 hours at times during your period?
4. Have you ever been treated (PO iron, IV iron, blood transfusion) for iron deficiency anemia in the past?
5. Do you have a family history of a bleeding disorder?
6. Have you had excessive bleeding with a dental extraction or dental surgery?
7. Have you had excessive bleeding with a miscarriage or following delivery of a child?

Considered to be positive if answered yes to any of the above questions

Algorithm

Concern for Heavy Menstrual Bleeding or Positive Screening

Consult Hematology if known history of blood thinners

- Ask and document screening questions (smartphrase.hmb)
- Obtain CBC and Urine Pregnancy Test for all patients.
- Additional work-up, if indicated (See Box 1 on page 2)

No Anemia
Hgb ≥ 12

Actively Bleeding?

No

Yes

- Discharge for outpatient follow-up³
- No hormone therapy needed

- Discharge for outpatient follow-up with **MAINTENANCE** hormone therapy³ (see Table 2)

Mild to Moderate Anemia
Hgb 8-11.9

Symptomatic Anemia¹?

Yes

No

Actively Bleeding?

No

Yes

- Discharge for outpatient follow-up with **TAPER** hormone therapy³ (see Table 2).
- Add ferrous sulfate for Hgb < 11

Severe Anemia
Hgb < 8

Any one of the following present?
• PO Intolerance
• Hypotensive
• Hgb ≤ 5

Yes

No

Actively Bleeding?

Yes

No

- Admit on IV Hormone Therapy (see Table 1)

- Admit on Oral Hormone Therapy (see Table 1)

General Care

- Monitor vitals per routine
- Start IV if indicated

¹Symptoms of Anemia

- Tachycardia
- Orthostatic Hypotension
- Headache/Dizziness
- Fatigue

²Admission Criteria

- Hgb < 8
- **OR**
- Symptomatic anemia

³Discharge Instructions

- See Table 2 for discharge meds
- Follow-up with a Gynecologist in the CHOA Pediatric Gynecology clinic (404.785.1491), or in the Hughes Spalding Adolescent Medicine Clinic (404.785.9850). Smartset includes referral to be placed
- Follow-up with the Hematology Clinic (404.785.0376) in 4-8 weeks to complete bleeding disorder workup
- Iron supplementation if indicated and encourage iron rich foods
- If bleeding recurs on discharge medication, return to previous dose and call PCP. Skip placebo pill until seen for follow-up.
- Provide teaching sheet: “When Your Child Has Iron-Deficiency Anemia” for all anemic patients.
- For medication Prior Authorizations:
 - **AMBH, SR, HS**: Consult Case Management

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Box 1: Additional Lab Work-up (if indicated)

- If elevated BMI > 85%ile, Acanthosis Nigricans, Hirsutism, or missed period for more than 3 months in a row in patient > 2 years from menarche:
 - Prior to starting hormone therapy, draw FSH, LH, Estradiol, Testosterone. Results not needed prior to starting therapy.
- Consider: Urine GC/Chlamydia, Serum RPR and HIV if sexually active

Table 1: ED Medications

Medication	Indications	Dosage	Max Dose	Contraindications/Comments
Hormone Therapy <i>If already taking a combined oral contraceptive (COC), discontinue and begin the following therapy</i>				
Preferred Oral Norethindrone Acetate	Use if ALL of the following are true: - Tolerating PO - Hemodynamically Stable - Hgb \geq 5 g/dL	10 mg PO x1	10 mg/dose	Contraindication: Previous intolerance <i>Not a preferred method of birth control</i>
Preferred IV Conjugated Estrogens (Premarin)	Use if being admitted, actively bleeding, and ANY of the following is true: - Unable to tolerate PO - Hypotensive - Hgb < 5 g/dL	25 mg IV x1	25 mg/dose	Common Contraindications: Personal history of thrombosis or stroke, thrombosis in first degree relative or family history of hypercoagulability, migraine with aura, SBP >160 or DBP >100, <6 weeks post-partum, congenital heart disease, active cancer, renal failure, or uncontrolled rheumatologic disease.* <i>Call Hematology or Gynecology if contraindications present</i>
Alternate Oral Medroxyprogesterone	Alternate if: - Norethindrone acetate is contraindicated	20 mg PO x1	20 mg/dose	Contraindication: Previous intolerance <i>Not a method of birth control</i>
Supplemental Medications (As Appropriate)				
Ondansetron (Zofran)	For side effects related to IV and oral hormone therapy	0.15 mg/kg PO or IV x1	8 mg/dose	N/A
Famotidine (Pepcid)	For side effects related to IV and oral hormone therapy	20 mg PO x1	20 mg/dose	N/A

Table 2: Discharge Medications

Discharge Medications	Indications	Dosage	Max Dose	Comments	Prescription Details
Discharge Hormone Therapy					
Norethindrone Acetate <i>Preferred</i>	Preferred discharge hormone therapy if no contraindications present	TAPER: 10 mg BID until 3 days after bleeding stops. Then, start maintenance dose MAINTENANCE: 10 mg once a day until follow-up appointment.**	10 mg/dose	Contraindication: Previous intolerance <i>Not a preferred method of birth control</i>	Prescribe as 90 tabs for 30 days with 1 refill
Lo-Ovral <i>Alternate</i>	Alternate if: - Norethindrone acetate is contraindicated	TAPER: - 1 tab PO Q8H x 3 days from initiation - Then, 1 tab PO Q12H x 2 days. - Then, start maintenance dose MAINTENANCE: 1 tab PO QD until follow-up.**	1 tab/dose	Alternate for Medicaid Patients: Seasonique (uses same dosing schedule as Lo-Ovral) Common Contraindications: Personal history of thrombosis or stroke, thrombosis in first degree relative or family history of hypercoagulability, migraine with aura, SBP >160 or DBP >100, <6 weeks post-partum, congenital heart disease, active cancer, renal failure, or uncontrolled rheumatologic disease.* <i>Call Hematology or Gynecology if if</i>	Lo-ovral: Prescribe as a 1-month supply with 3 refills Seasonique: Prescribe 1 (84-pill) pack with 1 refill
Medroxyprogesterone <i>Alternate</i>	Alternate if: - Norethindrone acetate and Lo-Ovral are contraindicated	TAPER: 20 mg BID until 3 days after bleeding stops, then start maintenance dose MAINTENANCE: 20 mg once a day until follow-up appointment.**	20 mg/dose	Contraindication: Previous intolerance <i>Not a preferred method of birth control</i>	Prescribe as 90 tabs for 30 days with 1 refill
Discharge Medications:					
Ferrous Sulfate	If Hgb < 11 g/dL	325 mg (65 mg elemental iron) PO daily		N/A	Prescribe 60 tabs for 30 days with 1 refill
Other Medications (As Appropriate)					
Ondansetron (Zofran)	For side effects related to oral hormone therapy	0.15 mg/kg PO Q8H x 4 days, then 0.15 mg/kg PO Q8H PRN	8 mg/dose	N/A	Prescribe per patient's needs
Famotidine (Pepcid)	For side effects related to oral hormone therapy	10-20 mg PO Q12H	20 mg/dose	N/A	Prescribe per patient's needs
Docusate (Colace)	If iron given	50-100 mg PO QD	100 mg/dose	N/A	Prescribe per patient's needs

*Refer to [CDC Summary of Medical Eligibility Criteria for Contraceptive Use](#) for complete list of contraindications for estrogens

**If bleeding recurs, return to previous dose and call PCP. Skip placebo pills until seen for follow-up.