Heavy Menstrual Bleeding Pathway: Inpatient Management

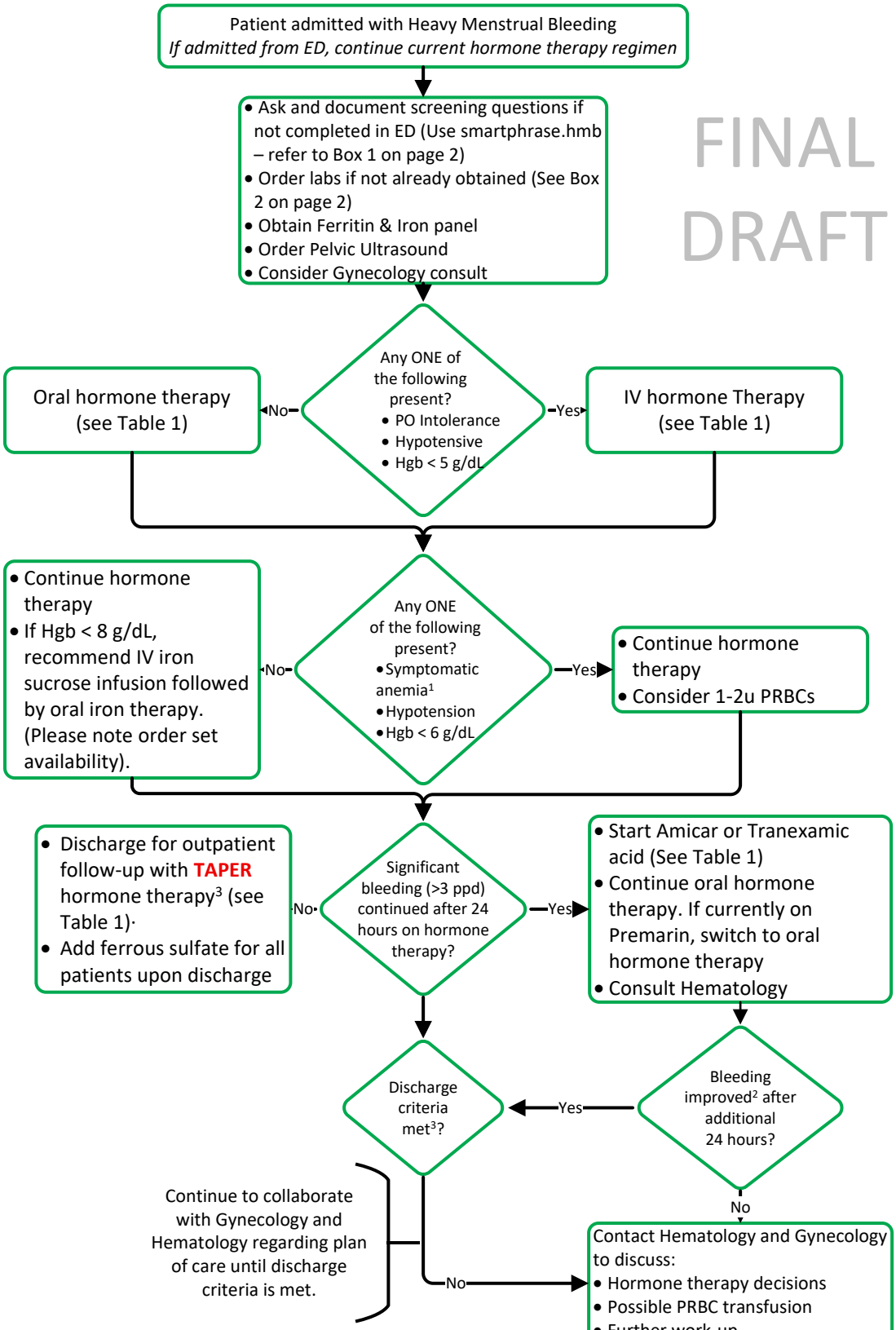
For individuals with concern for heavy menstrual bleeding

Final Draft 2.11.26

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

Algorithm



Considerations

- If known history of blood thinners, consult Hematology
- Start iron when patient tolerating PO
- If unstable/hypotension, consider PICU transfer

General Care

- Monitor vitals per routine
- Obtain orthostatic blood pressure and HR on admission and Qshift
- Start IV if indicated
- Case management consult for discharge medication needs

[1] Symptoms of Anemia

- Tachycardia
- Orthostatic hypotension
- Headache/Dizziness
- Fatigue

[2] Bleeding Improved

- <3 ppd
- Orthostasis resolved
- Fatigue resolved
- No headache/dizziness

[3] Discharge Criteria

- Tolerating PO
- In room air
- No longer bleeding or only spotting
- No longer orthostatic

[4] Discharge Instructions

- Follow-up with CHOA Pediatric Gynecology clinic in 8-12 weeks (404.785.1491), or Hughes Spalding Adolescent Medicine Clinic (404.785.9850). Smartset includes referral to be placed
- Follow-up with the Hematology Clinic (404.785.0376) in 8-12 weeks to complete bleeding disorder workup
- Continue hormone taper until daily regimen achieved. If bleeding recurs, return to previous dose and call PCP. Do not take placebo pills until seen for follow-up (see Table 1).
- Physician should work with case manager when writing discharge hormone therapy orders to ensure access to the necessary quantity.
- Continue iron supplementation and encourage iron rich foods
- Keep menstrual calendar
- Provide teaching sheet: "When Your Child Has Iron-Deficiency Anemia"

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Box 1: 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 thru 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

Box 2: Labs (if not already obtained)

Obtain: Ferritin & Iron panel. CBC Q12H while bleeding (can be more frequent if heavy bleeding), then QD | Urine Pregnancy and Type & Screen

- **If elevated BMI (BMI >85%ile), Acanthosis Nigricans, Hirsutism, or missed periods >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.
- **If sexually active**: Consider Urine GC/Chlamydia, Serum RPR and HIV
- **If strong personal history of bleeding or family history of bleeding disorder**: Consider VWD profile, PT, PTT, and fibrinogen

Table 1: Medications

Hormone Therapy for Admitted Patients

Medication	Indications	Dosage	Max Dose	Contraindications/Comments
Preferred Oral *Norethindrone Acetate*	**Use if ALL of the following are true:** - Tolerating PO - Hemodynamically Stable - Hgb > 5 g/dL	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 ***Not a preferred method of birth control***
Preferred IV *Conjugated Estrogens (Premarin)*	**Use if actively bleeding and at least ONE of the following is true:** - Unable to tolerate PO - Hypotensive - Hgb < 5 g/dL	- 25 mg IV Q4H until bleeding stops or 6 doses have been given - Then, switch to oral hormone therapy.	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.* ***Call Hematology or Gynecology if***
Alternate Oral *Lo-Ovral*	**Alternate if:** -Norethindrone acetate is contraindicated	1 tab PO Q8H until discharge	1 tab/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.* ***Call Hematology or Gynecology if contraindications present***
Alternate Oral *Medroxyprogesterone*	**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 ***Not a method of birth control.***

Discharge Hormone Therapy

Medication	Indications	Dosage	Max Dose	Contraindications/Comments	Presciption Notes
Norethindrone Acetate *Preferred*	**Preferred:** Recommended maintenance/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 ***Not a preferred method of birth control***	Prescribe 90 tabs for 30 days with 1 refill
Lo-Ovral *Alternate*	**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.* ***Call Hematology or Gynecology if if***	***Lo-ovral:*** Prescribe as a 1-month supply with 3 refills ***Seasonique:*** Prescribe one 84-pill pack with 1 refill
Medroxyprogesterone *Alternate*	**Alternate if:** - Lo-ovral and Norethindrone acetate 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 ***Not a preferred method of birth control***	Prescribe as 90 tabs per 30 days with 1 refill

Other Inpatient Medications

Medication	Indications	Dosage	Max Dose	Contraindications/Comments
Ferrous Sulfate (Iron)	Recommended for all admitted patients	325 mg (65 mg elemental iron) PO daily		N/A
Iron Sucrose (Venofer): IV Administration	Hemoglobin <8 g/dL	200 mg	200 mg or 7mg/kg (whichever is smaller)	**Contraindications**: Previous hypersensitivity reaction to IV iron; known history of or suspicion of hereditary hemochromatosis or thalassemia **Considerations**: If concern for other cause of anemia than iron deficiency, discuss with hematology prior to dose; add supportive care orders from order set; please separate at least 6 hours from PRBC transfusion to ensure any adverse events attributed to appropriate intervention; no test dose required.
Ondansetron (Zofran) *As needed*	For side effects related to hormone therapy	0.15 mg/kg PO or IV Q8H as needed	8 mg/dose	N/A
Famotidine (Pepcid) *As needed*	For side effects related to hormone therapy	20 mg PO or IV BID	20 mg/dose	N/A
Docusate (Colace) *As needed*	If iron given	50-100 mg QD	100 mg/dose	N/A

Antifibrinolytics (Admitted patients only)

Medication	Indications	Dosage	Max Dose	Contraindications/Comments
Aminocaproic acid (Amicar)	For patients soaking >3 ppd after 24 hours on hormone therapy	- 100 mg/kg IV or PO x1 loading dose, - Then 50 mg/kg IV or PO Q6H	5 g/dose	**Contraindication**: Hematuria *Consult Hematology if using Amicar or Tranexamic acid*
Tranexamic acid	For patients soaking >3 ppd after 24 hours on hormone therapy	10 mg/kg IV Q8H **OR** 1300 mg PO TID	IV: 600 mg/dose PO: 1300 mg/dose	

Other Discharge Medications

Medication	Indications	Dosage	Max Dose	Contraindications	Presciption Notes
Ferrous Sulfate (Iron)	Recommended for all patients	325 mg (65 mg elemental iron) PO daily		N/A	Prescribe 60 tabs for 30 days with 1 refill
Ondansetron (Zofran) *As needed*	If oral hormone therapy given	0.15 mg/kg PO Q8H as needed	8 mg/dose	N/A	Prescribe per patient's needs
Famotidine (Pepcid) *As needed*	If oral hormone therapy given	20 mg PO BID	20 mg/dose	N/A	Prescribe per patient's needs
Docusate (Colace) *As needed*	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.***