this & that

08

OBGYN QUICK GUIDES · IF THIS, THEN THAT

NO.

Abnormal Uterine Bleeding

& hormonal treatment

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Obstetrics & Gynaecology

Diagnosis & management

Verified against ACOG · RCOG/NICE · SOGC · FIGO — October 2026

Abnormal uterine bleeding & hormonal treatment

At a glance: the numbers to remember

≥45 y
biopsy before treating (ACOG); younger if unopposed estrogen

<5 mm
thin endometrium in acute bleed → estrogen first

Day 5–26
NET for heavy regular periods; luteal-only (day 19–26) is weak

10–14 d
monthly cyclic progestin for irregular cycles

LNG-IUS
most effective medical treatment for HMB (↓ 74–97%)

Scope: non-pregnant women of reproductive age, including adolescents and the perimenopause. Society names mark disagreements. Abbreviations are listed in Section 12. Brand names are those used locally (Duphaston = dydrogesterone 10 mg; Primolut-N = norethisterone 5 mg; Provera = medroxyprogesterone acetate).

01 Definitions

Parameter	Normal (FIGO 2018)	Abnormal
Frequency	24–38 days	Frequent <24 d · Infrequent >38 d · Absent (amenorrhoea) ≥90 d
Duration	≤8 days	Prolonged >8 d
Regularity (shortest to longest cycle)	Variation ≤9 d at 18–25 y · ≤7 d at 26–41 y · ≤9 d at 42–45 y	Irregular: variation beyond these limits
Volume	Patient-defined: does not interfere with life	Heavy (HMB) = interferes with physical, social, emotional or material quality of life. Research definition >80 mL; PBAC >100
Intermenstrual bleeding (IMB)	—	Bleeding between otherwise normal periods: cyclical or random. Postcoital bleeding is a separate term

IF	THEN
Acute AUB	Bleeding heavy enough to need immediate intervention to prevent further loss. Can sit on top of chronic AUB.
Chronic AUB	Abnormal volume, regularity or timing for most of the previous 6 months.
Terms to stop using	Menorrhagia, metrorrhagia, menometrorrhagia, oligomenorrhoea, polymenorrhoea and "dysfunctional uterine bleeding". FIGO replaced them with the plain descriptors above and the PALM-COEIN causes.
PALM (structural)	Polyp · Adenomyosis · Leiomyoma (submucous vs other; FIGO type 0–8) · Malignancy and hyperplasia
COEIN (non-structural)	Coagulopathy · Ovulatory dysfunction · Endometrial (primary disorder of local haemostasis) · Iatrogenic (hormones, IUD, anticoagulants*) · Not otherwise classified (AVM, isthmocele, chronic endometritis)

* FIGO 2018 moved anticoagulant-related bleeding from AUB-C to AUB-I. A woman can carry several labels at once (e.g. AUB-L(SM) + AUB-O).

02 Assessment

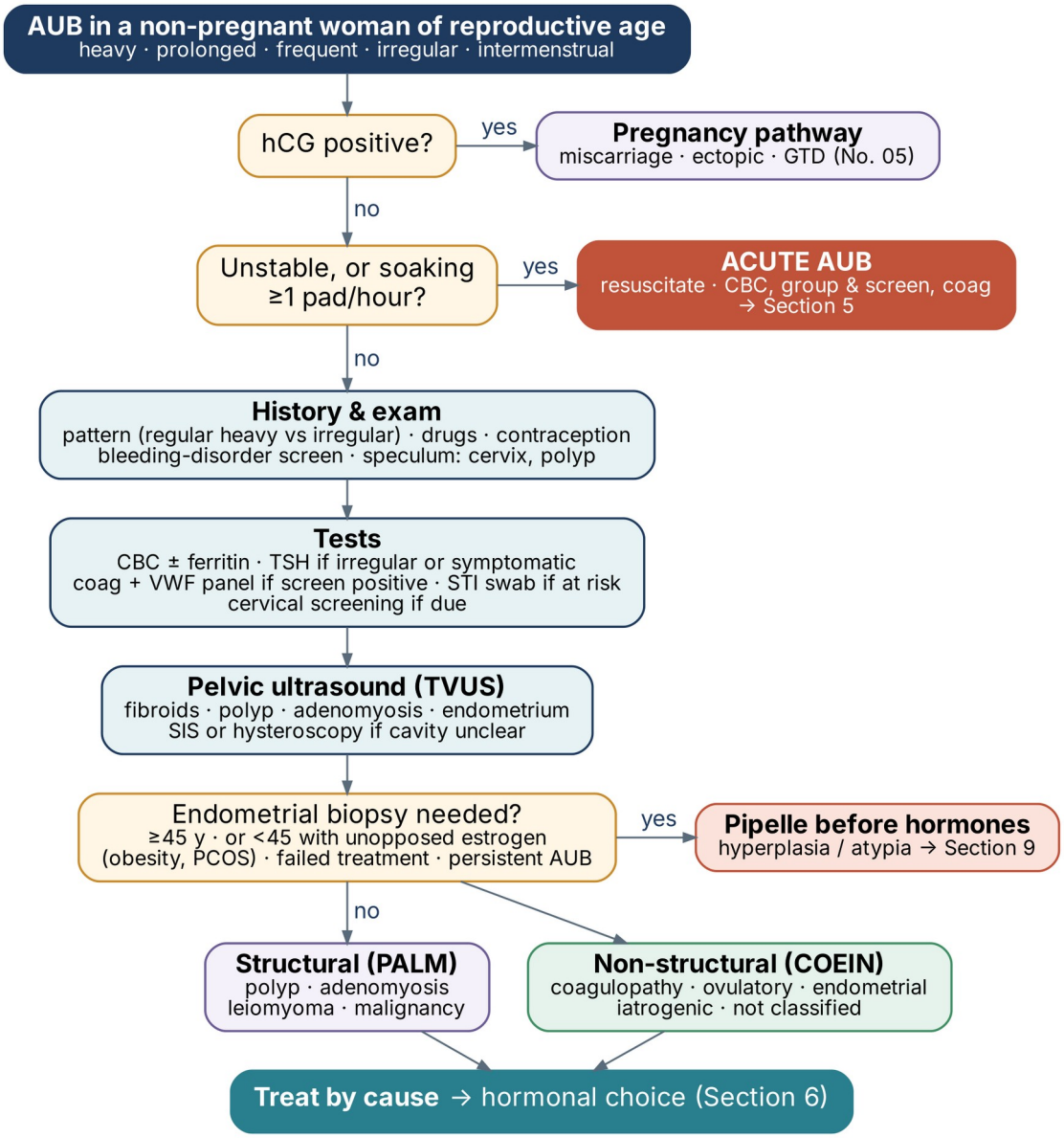


Figure 1. *Assessment of AUB in a non-pregnant woman of reproductive age.*

IF	THEN
Every woman with AUB	• hCG, CBC (ferritin if anaemic or HMB) • Regular cycles, but periods heavy or long → she is ovulating: look for fibroids, adenomyosis or AUB-E • Irregular, unpredictable cycles → she is probably not ovulating (AUB-O): PCOS, adolescence, perimenopause, thyroid, prolactin • Drug history: hormones, anticoagulants, antiplatelets, antipsychotics (prolactin), SSRIs, herbal products

IF	THEN
Bleeding-disorder screen positive	• Adults (ACOG PB 128): HMB since menarche; **or** one of PPH, surgical bleeding, dental bleeding; **or** two of bruising 1–2/month, epistaxis 1–2/month, frequent gum bleeding, family history • Adolescents (ACOG CO 785): any one of: periods ≥7 days with flooding or soaking a pad/tampon in ≤2 h on most periods; ever treated for anaemia; family history of a bleeding disorder; excess bleeding with dental extraction, delivery, miscarriage or surgery • → CBC, PT, aPTT, fibrinogen, VWF antigen, VWF activity (ristocetin cofactor), factor VIII; involve haematology • 5–20% of women with HMB, and more adolescents, have an undiagnosed bleeding disorder, most often VWD (Berek)
Irregular cycles	TSH, prolactin; androgens if hirsute (PCOS). Consider pregnancy again at every unexpected change in pattern.
IMB, postcoital bleeding or STI risk	Speculum: cervix, polyp, ectropion. Chlamydia/gonorrhoea NAAT. Cervical screening if due; a visible cervical lesion needs colposcopy or biopsy, not a smear.
Ultrasound	• TVUS for: enlarged or irregular uterus, IMB, failed medical treatment, suspected structural cause • Saline sonohysterography or outpatient hysteroscopy if the cavity is unclear or a polyp/submucous fibroid is suspected • NICE: outpatient hysteroscopy first if submucous fibroid, polyp or endometrial pathology is suspected (e.g. persistent IMB); ultrasound first if the uterus is palpable, a mass is suspected or examination is difficult; TVUS if adenomyosis is suspected
Endometrial biopsy (Pipelle)	• **≥45 years** with AUB (ACOG) • <45 with unopposed estrogen exposure: obesity, PCOS, chronic anovulation; tamoxifen; Lynch syndrome • Failed medical treatment or persistent AUB at any age • SOGC: consider over age 40 • NICE sets no age cut-off: biopsy at hysteroscopy if persistent IMB or irregular bleeding, tamoxifen, or treatment failure; no "blind" biopsy for HMB alone
Biopsy result insufficient but bleeding continues	Hysteroscopy with directed biopsy. A negative Pipelle does not exclude cancer in someone who keeps bleeding.

03 The hormone toolbox

Most confusion comes from treating all progestins as one drug. They share a target (the endometrium) but differ in potency, whether they stop ovulation, and their estrogenic or androgenic side effects. The dose and the schedule decide what a progestin does.

One idea explains all progestin regimens

- **Short course each month (10–14 days)** copies the luteal phase: the endometrium matures, then sheds in an orderly bleed when the tablets stop. Used to **regulate** anovulatory cycles and protect the endometrium.
- **Long course (21 days) or continuous** keeps the endometrium thin and decidualised. Used to **reduce or stop** heavy bleeding and to treat hyperplasia.
- **High dose for 7–10 days** stabilises a thick, fragile endometrium and **stops an acute bleed**; a heavy, organised withdrawal bleed follows 2–4 days after the last tablet ("medical curettage").
- Progestins need an estrogen-primed endometrium to work on. On a **thin, denuded** endometrium they fail; give estrogen first (Speroff).

Drug	What it is	Ovulation / contraception	Use it for	Watch for / avoid
Dydrogesterone Duphaston 10 mg	Retroprogesterone, close to natural progesterone. No estrogenic, androgenic, anabolic or corticoid activity (SmPC)	Does **not** suppress ovulation → **not** contraceptive. Compatible with trying to conceive	Cycle regulation: 10 mg daily day 11–25 (SmPC; 10–20 mg if needed). Arrest of bleeding: 10 mg bd × 5–7 d. Luteal support; HRT	Little trial evidence in heavy acute bleeding or ovulatory HMB; not for hyperplasia. **Contraindicated with meningioma** (2023–24 label change). Discontinued in the UK
Norethisterone (NET) Primolut-N 5 mg	19-nortestosterone progestin. Potent; partly metabolised to **ethinylestradiol** (SmPC: ≈4–6 µg EE per mg; UK pharmacists equate 10–20 mg/day with a 20–30 µg EE pill)	High doses usually suppress ovulation, but it is **not licensed as a contraceptive**	Stopping a bleed (5 mg tds × 10 d); long-cycle HMB (5 mg tds day 5–26); delaying a period; continuous suppression	Androgenic (acne, weight, lipids). **Treat like a COC for VTE risk**: SmPC contraindicates previous idiopathic or current VTE and high thrombotic risk. Severe liver disease, pregnancy
Medroxyprogesterone acetate (MPA) Provera 5/10 mg	17-OH progesterone derivative; some glucocorticoid activity	Oral cyclic doses do not reliably inhibit ovulation → not contraceptive	Cyclic regulation (10 mg od × 10–14 d; SmPC 2.5–10 mg × 5–10 d from day 16–21); acute bleed (20 mg tds × 7 d); continuous for hyperplasia (10–20 mg/day)	Weight, bloating, mood. Lower VTE concern than NET. DMPA and oral ≥100 mg: contraindicated with meningioma (EMA PRAC 2024; SFDA 2024)
Micronised progesterone Utrogestan/Prometrium	Natural progesterone	Not contraceptive	Cyclic regulation (200–300 mg at night × 12 d); HRT	Drowsiness (take at night); less potent on endometrium
Dienogest 2 mg Visanne	19-nortestosterone derivative; antiandrogenic	Suppresses ovulation; not licensed as contraceptive	Licensed for endometriosis only; used off-label for adenomyosis	SmPC warns bleeding may **worsen** with adenomyosis or fibroids (risk of anaemia). Mood
LNG-IUS 52 mg Mirena	Local levonorgestrel; low systemic levels	Contraceptive for up to 8 years; HMB licence 5 years	**First line for HMB** without major cavity distortion; adenomyosis; hyperplasia; endometrial protection	Spotting for 3–6 months; expulsion higher with HMB/fibroids. Cavity distorted by fibroids → may not fit
Combined oral contraceptive (COC)	EE (or estradiol) + progestin; net effect on endometrium is progestational	Contraceptive	AUB-O needing contraception; HMB (≈35–70% ↓ MBL); PCOS; multidose for acute bleeding	UKMEC 2025 / US MEC 4: VTE history, migraine with aura, age ≥35 smoking ≥15/day, BP ≥160/100, stroke/IHD, breast cancer, major surgery with immobility. MEC 3: BMI ≥35, controlled hypertension, ≥35 smoking <15/day

Duphaston or Primolut-N? The bedside rule

IF	THEN
She wants to get pregnant, or is trying now	**Duphaston.** It regulates bleeding without stopping ovulation. Primolut-N and continuous regimens will suppress ovulation.

IF	THEN
She needs a heavy bleed to stop now	**Primolut-N 5 mg tds × 10 days** (or MPA, or a multidose COC). The Duphaston label has an arrest dose (10 mg bd × 5–7 d), but evidence in heavy acute bleeding is thin; keep it for light to moderate episodes.
Regular but heavy periods, no IUS	• **Primolut-N long cycle**, 5 mg tds day 5–26 (21 days) • The Primolut-N leaflet regimen for menorrhagia (5 mg bd–tds day 19–26) is the luteal-only pattern that Cochrane found inferior to other treatments; SOGC: luteal progestins do not reduce blood loss • Duphaston has no role here
Irregular anovulatory bleeding, no contraception needed	Either. Cyclic **Duphaston 10 mg daily (up to 10 mg bd)**, **MPA 10 mg od** or **NET 5 mg bd** for 10–14 days a month all work; Duphaston has the fewest side effects.
VTE history, thrombophilia, or immobile	**Avoid Primolut-N** (estrogenic metabolite; SmPC contraindication). Use MPA, Duphaston or the LNG-IUS.
Acne, hirsutism, PCOS	Avoid NET for long-term use (androgenic). Prefer a COC with an antiandrogenic progestin, or Duphaston/MPA cyclically.
Hyperplasia without atypia	Neither Duphaston nor cyclic regimens. **LNG-IUS**, or continuous MPA 10–20 mg/day or NET 10–15 mg/day (Section 9).

04 Progestin and COC regimens decoded

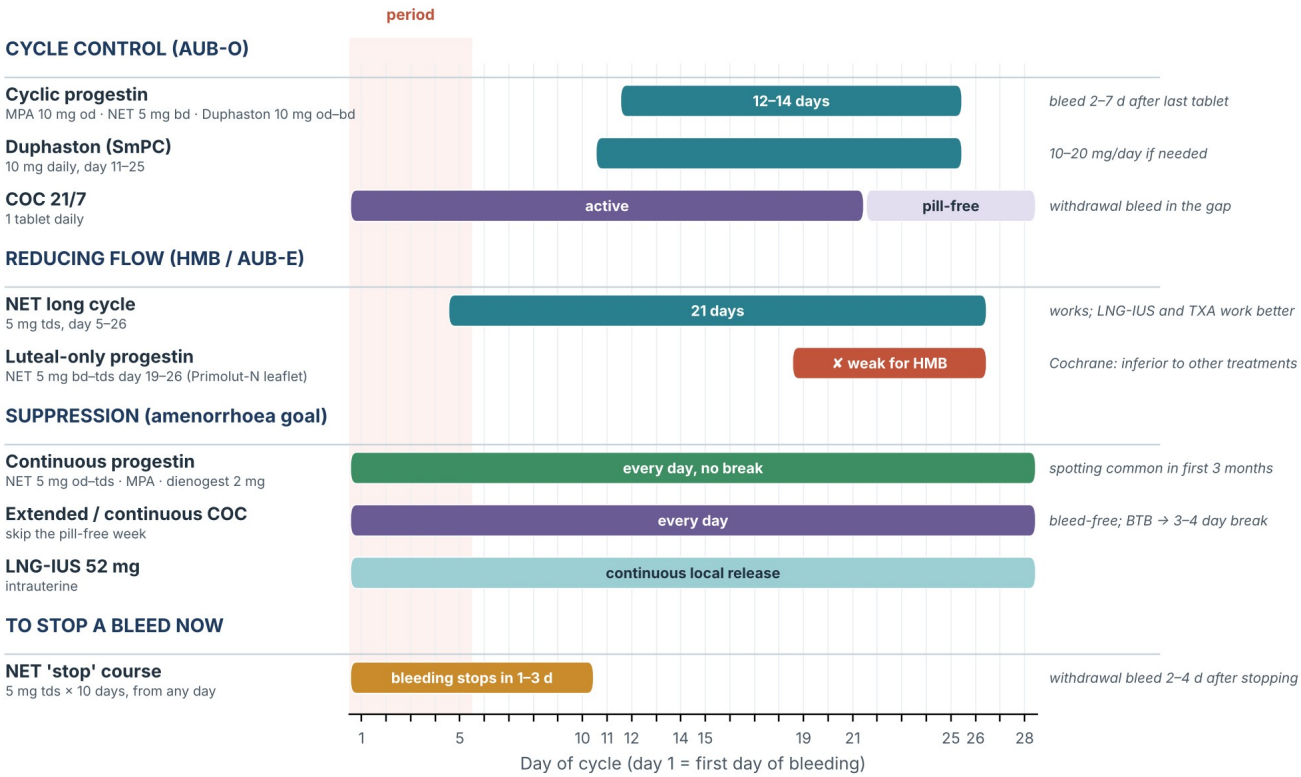


Figure 2. *Where in the cycle each regimen sits, and what it is for.*

Goal	Regimen	Expect
Regulate irregular (anovulatory) bleeding	Cyclic progestin 10–14 days every month: **MPA 10 mg od**, **Duphaston 10 mg od–bd** (label: day 11–25) or **NET 5 mg bd**; e.g. day 12–25, or the first 12–14 days of each calendar month (Speroff). Irregular cycles: see below	Withdrawal bleed 2–7 days after the last tablet. No bleed → check hCG, consider low estrogen state

Goal	Regimen	Expect
Reduce heavy regular periods (HMB)	**NET 5 mg tds day 5–26** (21 days), or MPA 10 mg tds day 5–26 (Williams). **LNG-IUS** is better if acceptable	Network meta-analysis (Cochrane 2022), ↓ blood loss per cycle: LNG-IUS 106 mL > TXA 80 mL > long-cycle progestin 77 mL > NSAID 41 mL
Suppress bleeding (amenorrhoea goal)	Continuous: NET 5 mg od, increasing to bd–tds if breakthrough; MPA 10–20 mg/day; dienogest 2 mg/day; DMPA 150 mg IM q12 wk; continuous COC; LNG-IUS	Breakthrough spotting in the first 3 months is expected, not failure
Stop a current bleed (stable)	**NET 5 mg tds × 10 days** (SmPC), or MPA 20 mg tds × 7 days, or COC 35 µg EE tds × 7 days (ACOG)	Bleeding usually stops in 1–3 days (SmPC). Heavy withdrawal bleed 2–4 days after stopping (Speroff). Prevent recurrence: SmPC gives NET 5 mg bd day 19–26 for 2 cycles; a COC, cyclic progestin or LNG-IUS is the usual longer plan
Delay a period (travel, Hajj/Umrah, exams)	Already on a monophasic COC → skip the pill-free week. Otherwise NET 5 mg tds from 3 days before the expected period. See "Delaying a period" below	Bleed 2–3 days after stopping
Protect the endometrium (anovulation, PCOS, HRT)	Progestin ≥10–14 days each 1–3 months (PCOS: at least every 3 months), or LNG-IUS, or COC	Prevents hyperplasia from unopposed estrogen

Delaying a period (Hajj, Umrah, travel, exams)

The choice turns on VTE risk. Norethisterone is partly metabolised to ethinylestradiol, so a 5 mg tds course behaves like starting an estrogen-containing pill, and VTE risk is highest in the first weeks of any new estrogen exposure. A woman already established on a COC adds nothing new by skipping her break. Travel adds its own risk: long flights, immobility, heat and dehydration.

IF	THEN
Already taking a monophasic COC (same dose in every active tablet)	• **Best option.** Skip the pill-free or placebo days and start the next pack straight away • Can run 2–3 packs back to back; stop when she wants to bleed (withdrawal bleed in 2–4 days) • No new VTE exposure, so preferred even when the trip itself raises risk • Breakthrough spotting is possible in the second pack; warn her
Taking a phasic COC (e.g. triphasic, estradiol valerate/dienogest)	Back-to-back packs are less predictable and spotting is common. Check the product leaflet; switching to a monophasic pill one cycle before the event is more reliable.
Not on a COC, no VTE risk factors	• **NET (Primolut-N) 5 mg tds**, starting 3 days before the expected period, continued until she wants to bleed; withdrawal bleed 2–3 days after stopping (licensed use) • Alternative with planning: start a monophasic COC on day 1–5 of the period before the event and run packs through it (if UKMEC/US MEC eligible)
Not on a COC, with VTE risk factors (previous VTE, thrombophilia, BMI ≥35, smoker, recent surgery, long-haul flight with immobility)	• **Avoid NET** (SmPC contraindicates it after idiopathic or current VTE) and do not start a new COC for this • **MPA 10 mg tds**, from 3 days before the expected period (off-label; lower VTE concern than NET) • Previous VTE or thrombophilia: discuss with haematology, or accept the period • Advise mobility, hydration and flight stockings in all

IF	THEN
On LNG-IUS, implant, DMPA or POP	No reliable way to delay a bleed; bleeding is usually light. Adding NET carries the same VTE considerations as above.
Irregular cycles, no predictable period	Hard to time. Options: continuous progestin (MPA or NET) through the event, or a monophasic COC started a cycle ahead if eligible.

Irregular cycles: how do I start on "day 12" if she has no regular day 1?

Cycle-day instructions assume a predictable period. In anovulatory bleeding there is none, so you create one: the first course induces a withdrawal bleed, and that bleed becomes day 1. Exclude pregnancy before every course that starts without a recent bleed.

IF	THEN
Not bleeding now (weeks of amenorrhoea or a long gap)	• hCG negative → **start today**; there is no need to wait for a period • e.g. MPA 10 mg od, Duphaston 10 mg od–bd or NET 5 mg bd for 10–14 days • Withdrawal bleed 2–7 days after the last tablet: **its first day is day 1**
Bleeding now, light to moderate	• Start the course now (treat today as the start of a 10–14-day course) • Bleeding settles on the progestin; the withdrawal bleed after the last tablet becomes day 1
Bleeding now and heavy	Stop it first (Section 5: NET 5 mg tds × 10 d, MPA, or multidose COC). The withdrawal bleed after that course is day 1.
After the first withdrawal bleed: choose one way to time the courses	• **Anchor to the bleed:** start the next course on day 15–16 counted from the first day of the last withdrawal bleed (equals the label "day 16–21" for MPA; day 11–25 for Duphaston if she prefers a longer course) • **Calendar (simplest):** the same dates every month, e.g. the 1st to the 12th; ignore cycle days altogether (Speroff: both work equally well)
She has a spontaneous bleed between courses	• A spontaneous period means she probably ovulated: reassuring • Anchor method: that bleed is the new day 1; restart counting • Calendar method: keep to the fixed dates
Bleeding starts during a course	Usually an ovulation out of step with the tablets. Finish the course; hCG if in doubt. If it keeps happening, switch to a COC or LNG-IUS.
No withdrawal bleed after a course	• hCG first • Negative → probably a thin, low-estrogen endometrium (hypothalamic amenorrhoea, POI, hyperprolactinaemia): check FSH, estradiol, prolactin, TSH • Progestin courses add little here; treat the cause, and replace estrogen if she is hypoestrogenic (bone)
She wants fewer bleeds	Courses every 1–3 months still protect the endometrium in chronic anovulation (Berek: MPA 5–10 mg for 10–13 days every 1–2 months; PCOS: at least every 3 months). Or LNG-IUS: no schedule at all.

Worked example

- A 24-year-old with PCOS, no period for 10 weeks, not sexually active, hCG negative.
- **Today:** MPA 10 mg once daily × 12 days. She stops on day 12 of treatment.
- **3 days later:** withdrawal bleed starts. Call this day 1.
- **Day 15 of that bleed:** next 12-day course. Repeat monthly, re-anchoring to each new bleed. Or simply prescribe the 1st to the 12th of every month.
- Review at 3–6 months: cycle control, weight, and whether she now needs contraception (switch to a COC).

Common prescribing errors

- Giving Duphaston day 15/16–25 for **regular heavy** periods. That is the luteal-only pattern: it adds nothing in ovulatory HMB.
- Calling a withdrawal bleed after a 10-day NET course "treatment failure". Warn her it will come, and that it may be heavy.
- Stopping a continuous progestin for early spotting. Persist for 3 months, or add a short estrogen course if the endometrium is thin.
- Telling a woman on cyclic Duphaston or MPA that she is protected from pregnancy. She is not.
- Using DMPA for an **acute** bleed. Once given it cannot be withdrawn (Speroff); keep it for maintenance.

05 Acute heavy bleeding

IF	THEN
Unstable or Hb falling fast	• Resuscitate; transfuse; correct coagulopathy with haematology • Intrauterine Foley (30 mL balloon) tamponade • IV TXA ± IV estrogen; no response in 12–24 h → hysteroscopy ± D&C
Adolescent with acute HMB	• Screen for VWD/platelet disorder **before** transfusion or estrogen (results stay interpretable) • Hormones are first line; D&C is rarely needed • Unstable, symptomatic anaemia or ongoing heavy loss → admit; serial Hb (the first value underestimates loss)
Thick endometrium (>10–12 mm), irregular, or risk factors	Biopsy (Pipelle) before or alongside hormones; hysteroscopy if focal lesion.
No response to hormones in 24–48 h	Stop and rethink: structural lesion, retained products, coagulopathy, wrong drug for the endometrium (thin → needs estrogen).
Bleeding controlled	• Plan long-term treatment before discharge (Section 6) • Iron: oral (Williams: 150–200 mg elemental iron daily); IV iron if severely anaemic or oral iron not tolerated • Follow-up with CBC and the biopsy result

Regimen	Dose	Then	Notes
Conjugated equine estrogen IV (Premarin)	25 mg IV every 4–6 h, up to 24 h	Oral COC or oral estrogen + progestin once bleeding slows	ACOG CO 557. Works within hours in most; antiemetic. Not available in many units; oral estrogen is an alternative
Oral estrogen (thin endometrium)	CEE 2.5 mg or estradiol 2 mg every 6 h	Taper to daily; add MPA 10 mg/day for 7–10 d or switch to COC by 14–21 d	Speroff. Avoid in VTE risk
Multidose COC	Monophasic 35 µg EE: 1 tablet tds × 7 days (ACOG CO 557). Adolescents (CO 785): 30–50 µg EE every 6–8 h until bleeding stops, then taper (q8h → q12h → daily)	Continue daily ≥1 week after bleeding stops; then cyclic or continuous COC	Most practical first line if estrogen is safe. Nausea common: antiemetic
MPA	20 mg tds × 7 days (ACOG)	20 mg daily for 3 weeks (Munro RCT)	76% stopped within 3 days; equal to multidose COC. Estrogen-free; first choice when estrogen is contraindicated

IF	THEN		
Norethisterone (Primolut-N)	5 mg tds × 10 days (SmPC); adolescents 5–10 mg 6-hourly (ACOG CO 785)	Withdrawal bleed 2–4 days after stopping; then maintenance	Partly metabolised to EE: treat like a COC for VTE risk
DMPA + MPA	DMPA 150 mg IM + MPA 20 mg tds × 3 days	Depot acts as the taper	One series: all 48 stopped within 5 days. Speroff cautions against depot in the acute phase
Tranexamic acid	IV 10 mg/kg (max 600 mg/dose) every 8 h (ACOG); oral 1.3 g tds × 5 days (US) or 1 g tds up to 4 days (UK)	Combine with progestin	Avoid with active VTE or high thrombotic risk; US label contraindicates use with combined hormonal contraception. Useful in coagulopathy

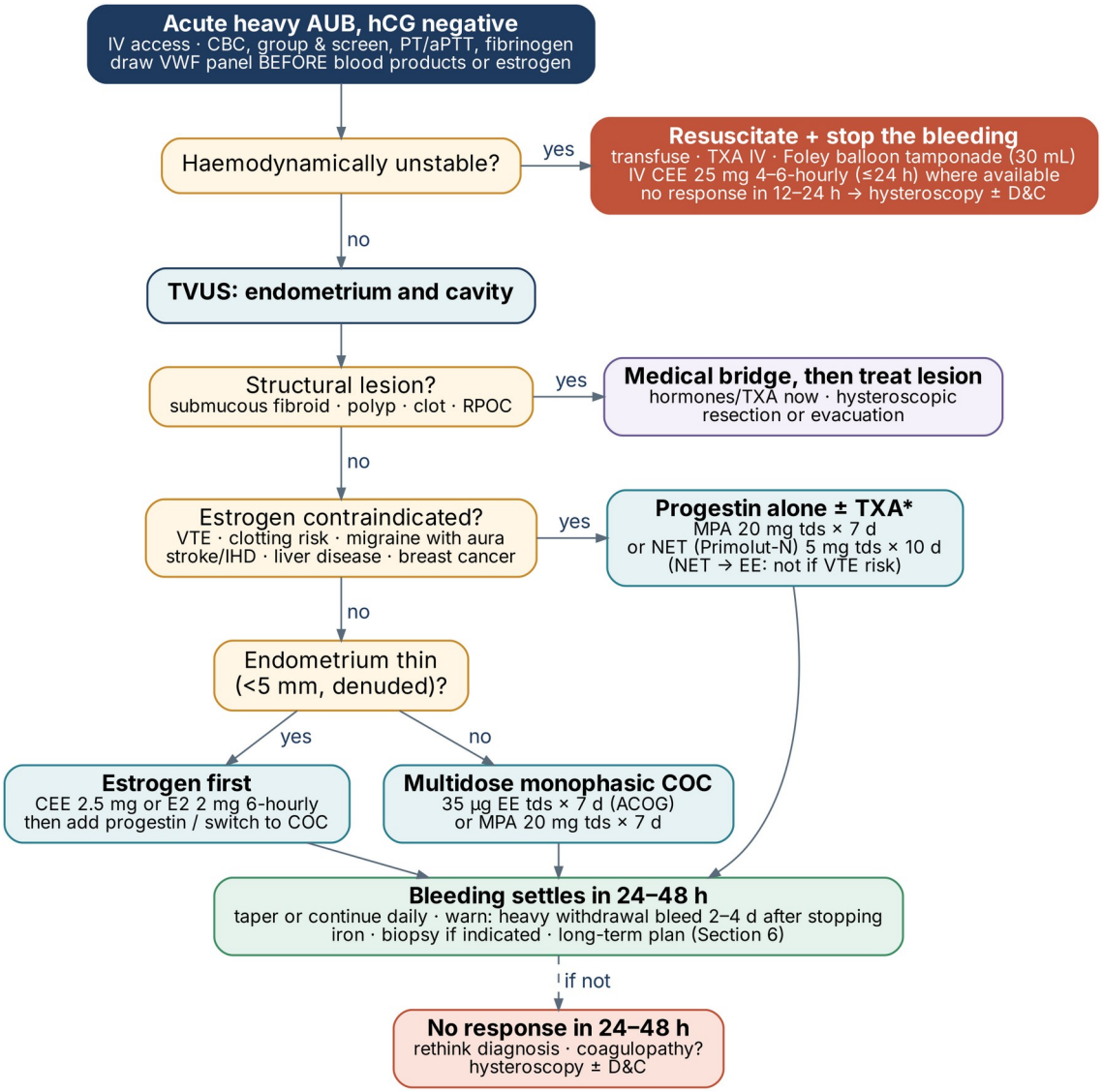


Figure 3. *Acute heavy AUB: choosing estrogen, COC or progestin by stability, cavity, contraindications and endometrial thickness.*

* TXA with a COC: the US label (Lysteda) contraindicates combined hormonal contraception; ACOG advises caution and Williams lists it as a contraindication. Pair TXA with a progestin instead where possible. NET 5 mg tds × 10 days is the label dose; higher doses (norethindrone acetate 5–10 mg 6-hourly in ACOG CO 785, 4-hourly in Williams) are expert practice with no UK source.

06 Chronic AUB: treatment by cause

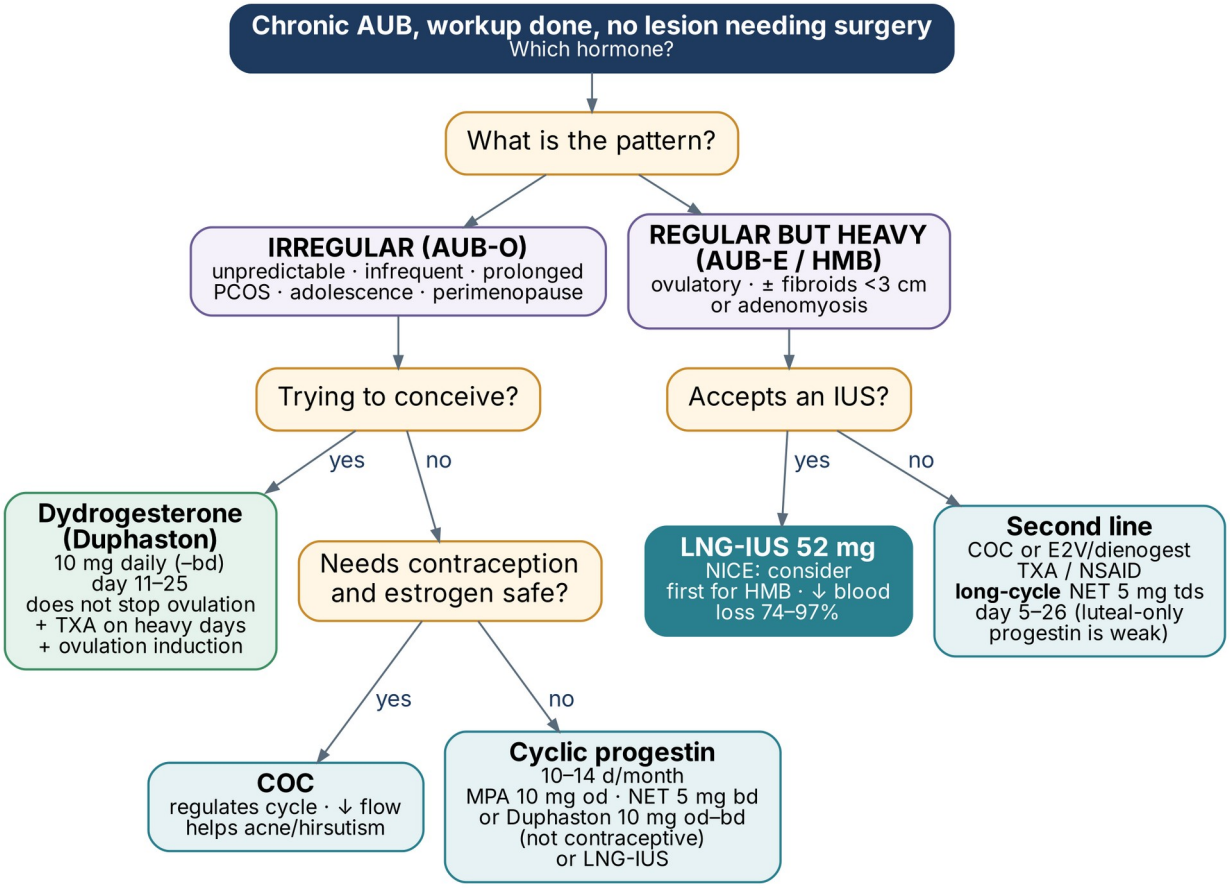


Figure 4. *Choosing a hormonal treatment for chronic AUB once structural surgery is not needed.*

IF	THEN
AUB-O: anovulatory, irregular	• Treat the cause: weight loss in PCOS, thyroid, prolactin • Needs contraception → COC (or LNG-IUS) • No contraception needed → cyclic progestin 10–14 d/month (Duphaston, MPA or NET) • Trying to conceive → Duphaston cyclically + ovulation induction
AUB-E / HMB: ovulatory, regular heavy	• **1st:** LNG-IUS (NICE) • **2nd (NICE):** non-hormonal: TXA 1 g tds for up to 4 days from the start of bleeding (max 4 g/day) or NSAID (mefenamic acid 500 mg tds); hormonal: combined hormonal contraception (estradiol valerate/dienogest is licensed for HMB) or cyclical oral progestogen, best as NET 5 mg tds day 5–26 • Options can be combined (e.g. NSAID + COC, TXA + progestin); avoid TXA + COC

IF	THEN
AUB-L: fibroids	• <3 cm, cavity normal → treat as HMB (LNG-IUS first) • Submucous (type 0–2) → hysteroscopic myomectomy; hormones as a bridge • ≥3 cm → specialist referral (NICE); options include LNG-IUS (if cavity allows), TXA, NSAID, hormones, UAE, myomectomy, hysterectomy • Pre-operative: GnRH agonist ≤6 months (with add-back if longer) to correct anaemia and shrink fibroids • Long-term medical: relugolix CT (Ryeqo/Myfembree; NICE TA832; US label limit 24 months) or linzagolix (Yselty; NICE TA996). Contraindicated with past/current VTE • Ulipristal 5 mg: only for premenopausal women who cannot have, or have failed, surgery or UAE; not as a pre-surgery bridge; LFTs before, during and after (EMA 2021)
AUB-A: adenomyosis	LNG-IUS first; continuous progestin (NET; dienogest off-label, may worsen bleeding at first) or continuous COC; GnRH analogue; hysterectomy if family complete.
AUB-P: polyp	Hysteroscopic polypectomy (treats and gives histology). Hormones do not remove polyps.
AUB-C: bleeding disorder (e.g. VWD)	• With haematology: TXA, COC (raises VWF and FVIII), LNG-IUS, desmopressin, factor concentrate • **Avoid NSAIDs and aspirin** • Plan for procedures and pregnancy
AUB-I: on anticoagulants	• LNG-IUS or progestin-only methods preferred; COC only after anticoagulation ends (estrogen adds VTE risk) • Avoid TXA while treating active VTE • Rivaroxaban is linked to more HMB than apixaban: discuss a switch with haematology
AUB-I: unscheduled bleeding on hormonal contraception	See Section 8.
AUB-M: hyperplasia or cancer	Section 9; refer cancer to gynae-oncology.

07 By life stage and situation

IF	THEN
Adolescent (first 2–3 years after menarche)	• Anovulation is the commonest cause; screen for bleeding disorder if HMB • Mild, Hb normal → reassurance, menstrual chart, iron • Moderate → COC (continue 3–6 cycles) or cyclic MPA 10 mg / Duphaston 10 mg for 10–14 d/month (MPA 5–10 mg for 10–13 days every 1–2 months: Berek) • LNG-IUS is suitable at any age • COCs do not hasten sexual debut; explain this to parents (Berek)
PCOS	• COC first if no contraindication (cycle control, acne, hirsutism, endometrial protection) • If not: progestin ≥ every 3 months for withdrawal, or LNG-IUS • Biopsy if long amenorrhoea then heavy bleed, thick endometrium, or obesity + AUB
Wants pregnancy soon	• Duphaston cyclically for regulation; TXA or NSAID for heavy days • Avoid suppressive regimens (continuous NET, COC, DMPA) • Treat structural causes (polyp, submucous fibroid) before conception

IF	THEN
Perimenopause (≈ 40–52 y)	• Biopsy ≥45 years before treatment • LNG-IUS: treats HMB and later provides the progestogen for estrogen HRT (check the local licence for duration) • Healthy, non-smoking, normotensive, BMI <35 → low-dose COC is acceptable until 50; Lobo suggests 20 µg EE • Cyclic progestin protects the endometrium but controls bleeding poorly because ovulation is erratic (Lobo)
Estrogen contraindicated	Progestin-only: LNG-IUS, MPA, Duphaston, DMPA, POP, implant. Avoid high-dose NET if VTE is the reason. TXA only if no active VTE.
Obesity BMI ≥35	COC: UKMEC 2025 category 3. Prefer LNG-IUS (also protects the endometrium); low threshold for biopsy.
Postmenopausal bleeding	Outside this guide. ACOG 2026 update: TVUS **plus** endometrial sampling for most women; biopsy may be omitted only after a single episode with a fully seen endometrium ≤4 mm, no strong risk factors and reliable follow-up. Never start hormones to "stop" postmenopausal bleeding before investigation.

08 Troubleshooting: bleeding on hormones

IF	THEN
Any new unscheduled bleeding	Check adherence, vomiting/diarrhoea, enzyme-inducing drugs (rifampicin, carbamazepine, St John's wort), smoking, hCG, chlamydia, cervix. Persistent or new after months of good control → TVUS ± biopsy.
On a COC (first 3 months)	Common and settles. Reassure.
On a COC, persisting	Try a higher EE dose (30–35 µg) or a different progestin. On continuous/extended use: a 3–4-day hormone-free break (not in the first 21 days, not more than once a month).
On POP, implant or DMPA	• Exclude pathology as above • NSAID for 5–7 days, or low-dose COC or estrogen for 10–20 days if eligible (CDC SPR) • Persisting and unacceptable → change method
LNG-IUS, first 3–6 months	Expected spotting. Check position (threads/ultrasound) if heavy or pain; NSAID helps.
Cyclic progestin, bleeding mid-cycle	Usually a spontaneous ovulation that does not match the tablet schedule (common in the perimenopause). Not a drug failure. Consider COC or LNG-IUS instead; hCG if late.
Continuous progestin, breakthrough	Raise the dose (e.g. NET 5 mg od → bd → tds) or add estrogen for 7–10 days (estradiol 2 mg or CEE 1.25 mg) if the endometrium is thin and atrophic (Speroff).
Failed 3–6 months of correct treatment	Re-evaluate: TVUS/SIS or hysteroscopy, biopsy, coagulation screen. Offer surgery (ablation if family complete and endometrium normal; hysterectomy).

09 Endometrial hyperplasia found on biopsy

IF	THEN
Hyperplasia without atypia	• Treat the cause (unopposed estrogen, obesity, HRT regimen) • **1st: LNG-IUS 52 mg** (higher regression, fewer side effects); keep for 5 years if tolerated (RCOG/BSGE GTG 67) • If declined: **continuous** MPA 10–20 mg/day or NET 10–15 mg/day. **Cyclical progestogens should not be used** • Treat ≥6 months; biopsy at least every 6 months until 2 consecutive negatives; longer surveillance if BMI ≥35 or on oral progestins
Atypical hyperplasia / EIN	• Hysterectomy is definitive (up to 40% have co-existing cancer; ACOG Clinical Consensus 5, 2023) • Wants fertility or unfit for surgery: LNG-IUS first (RCOG), with or without oral progestin (megestrol or MPA). ACOG: intrauterine regresses more than oral, continuous more than cyclic • Biopsy every 3 months; hysterectomy once family complete

10 Do not

- Start hormones before excluding pregnancy, or before a biopsy when she is ≥45 or has risk factors.
- Prescribe Duphaston or any luteal-only progestin for regular heavy periods.
- Give a progestin alone to a woman bleeding from a thin, denuded endometrium; give estrogen first.
- Give high-dose Primolut-N or high-dose estrogen to a woman with VTE history, thrombophilia or a recent long flight without weighing the risk.
- Combine TXA with a COC (contraindicated on the US label), or give TXA during active VTE.
- Give NSAIDs to a woman with VWD or a platelet disorder.
- Use DMPA to treat an acute bleed.
- Count on cyclic Duphaston, MPA or NET as contraception.
- Treat hyperplasia without atypia with cyclic progestins.
- Use the old terms (menorrhagia, DUB) in notes or referrals.

11 Where the guidelines differ

Topic	ACOG (USA)	NICE / RCOG (UK)	SOGC (Canada)
Who gets a biopsy	≥45 y; <45 with unopposed estrogen, failed treatment or persistent AUB	No age cut-off. At hysteroscopy if persistent IMB/irregular bleeding, tamoxifen or treatment failure; no blind biopsy for HMB	Consider >40 y, or younger with risk factors, or failed treatment
First-line imaging	TVUS (± SIS/hysteroscopy)	Hysteroscopy first if suspected cavity lesion; TVUS if large uterus/adenomyosis	TVUS
First-line HMB treatment	Individualise: LNG-IUS, COC, progestins, TXA, NSAIDs	Consider LNG-IUS first if no pathology, fibroids <3 cm or adenomyosis; then TXA/NSAID or CHC/cyclical progestogen	LNG-IUS, COC, TXA, NSAID
Acute AUB	IV CEE, multidose COC, MPA 20 mg tds, TXA (CO 557; adolescents CO 785)	No UK guideline; NET 5 mg tds × 10 d is the label regimen	High-dose estrogen and TXA may help (grade III-C)

Topic	ACOG (USA)	NICE / RCOG (UK)	SOGC (Canada)
Oral progestin for HMB	Norethindrone acetate/MPA day 5–26 (Williams)	"Cyclical oral progestogens" after LNG-IUS declined; no regimen given. Primolut-N label: day 19–26	Luteal-phase progestins do not reduce blood loss (I-E)
Dydrogesterone	Not marketed in the USA (since the 1980s); no ACOG guidance	Discontinued in the UK	Not marketed

12 Abbreviations

Abbr.	Meaning	Abbr.	Meaning	Abbr.	Meaning
ACOG	American College of Obstetricians & Gynecologists	**GnRH**	gonadotrophin-releasing hormone	**POP**	progestogen-only pill
AUB	abnormal uterine bleeding	**GTG**	RCOG Green-top Guideline	**PPH**	postpartum haemorrhage
AVM	arteriovenous malformation	**HMB**	heavy menstrual bleeding	**PRAC**	EMA pharmacovigilance committee
BMI	body mass index	**HRT**	hormone replacement therapy	**PT / aPTT**	prothrombin / activated partial thromboplastin time
BP	blood pressure	**IHD**	ischaemic heart disease	**RCOG**	Royal College of Obstetricians & Gynaecologists
BSGE	British Soc. for Gynaecological Endoscopy	**IMB**	intermenstrual bleeding	**SFDA**	Saudi Food and Drug Authority
CBC	complete blood count	**IV / IM**	intravenous / intramuscular	**SIS**	saline infusion sonohysterography
CEE	conjugated equine estrogen	**LFTs**	liver function tests	**SmPC**	summary of product characteristics
CHC	combined hormonal contraception	**LNG-IUS**	levonorgestrel intrauterine system	**SOGC**	Soc. of Obstetricians & Gynaecologists of Canada
CO	ACOG Committee Opinion	**MBL**	menstrual blood loss	**SPR**	US Selected Practice Recommendations
COC	combined oral contraceptive	**MEC**	Medical Eligibility Criteria	**SSRI**	serotonin reuptake inhibitor
D&C	dilatation and curettage	**MPA**	medroxyprogesterone acetate	**STI**	sexually transmitted infection
DMPA	depot medroxyprogesterone acetate	**NAAT**	nucleic acid amplification test	**TA**	NICE technology appraisal
DUB	dysfunctional uterine bleeding (obsolete)	**NET**	norethisterone (Primolut-N)	**TSH**	thyroid-stimulating hormone
E2 / E2V	estradiol / estradiol valerate	**NICE**	National Institute for Health & Care Excellence	**TVUS**	transvaginal ultrasound
EE	ethinylestradiol	**NSAID**	non-steroidal anti-inflammatory drug	**TXA**	tranexamic acid
EIN	endometrial intraepithelial neoplasia	**od / bd / tds**	once / twice / three times daily	**UAE**	uterine artery embolisation
EMA	European Medicines Agency	**PB**	ACOG Practice Bulletin	**UKMEC**	UK Medical Eligibility Criteria
FDA	US Food and Drug Administration	**PBAC**	pictorial blood loss assessment chart	**VTE**	venous thromboembolism
FIGO	Int. Federation of Gynecology & Obstetrics	**PCOS**	polycystic ovary syndrome	**VWD / VWF**	von Willebrand disease / factor
FSH	follicle-stimulating hormone	**POI**	primary ovarian insufficiency	**WHO**	World Health Organization

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Decision aid only: it does not replace clinical judgement or local protocols. Verify drug doses against your formulary.