Management of heavy menstrual bleeding

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DOI:
10.33612/diss.160486947

Chapter 2

Incidence and treatment of heavy menstrual bleeding in general practice

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Fam Pract. 2017;34(6):673-678

ABSTRACT

Background

Heavy menstrual bleeding (HMB) is a common problem in women of reproductive age. In 2008, the Dutch guideline for general practitioners (GPs) was revised to recommend the levonorgestrel intrauterine system (LNG-IUS) as a first-choice treatment for HMB. However, GP prescribing practices have not been studied in depth.

Objectives

To investigate the incidence and initial treatment of HMB in general practice, and to identify if there were changes in prescribing practices after the revision of the national guideline in 2008.

Methods

Retrospective analysis of data from the Registration Network Groningen, the Netherlands. We selected data for prescriptions and referrals related to women consulting their GP for HMB between 2004 and 2013. We calculated the incidence rates and investigated potential trends in prescribing over time, with particular attention to the prescribing of LNG-IUS.

Results

Over 10 years, 881 women consulted their GP for HMB, with a mean annual incidence of 9.3 per 1000 person years (95% confidence interval: 8.5–10.2). Most women received hormonal treatment (406/881; 46%) within three months of diagnosis, but many (387/881; 44%) received no medication. The LNG-IUS was prescribed for 2.4%, but there was no significant increase in the number of prescriptions over time.

Conclusion

In this cohort, most women with HMB were treated with oral hormone therapy, and few received the LNG-IUS. If patients are to benefit from the LNG-IUS, further research is needed into the reasons for this lack of change in prescribing practices.

INTRODUCTION

Heavy menstrual bleeding (HMB) is a common problem, with a prospective cohort study in the United Kingdom reporting a 12-month cumulative incidence of 25% in all menstruating women.[1] Nevertheless, not every woman with HMB visits her general practitioner (GP).[2] In the Netherlands, literature about the incidence of HMB in general practice indicate that rates vary from 5.2 to 7 per 1000 women per year.[3] Women with HMB symptoms that interfere with daily life are more likely to consult a doctor for HMB. While there has been ample research conducted into the treatment of HMB in secondary care, where HMB accounts for 20% of visits to gynaecology services [4,5], less research has been conducted in primary care settings.

International practice guidelines recommend several first-line treatment options, including the combined oral contraceptive pill (OCP), the levonorgestrel-releasing intrauterine system (LNG-IUS), nonsteroidal anti-inflammatory drugs (NSAIDs) or tranexamic acid.[6-9] However, sufficient research comparing the effectiveness of the OCP with other medication is lacking.[10] Treatment choice depends on patient preference for hormonal or non-hormonal treatment and on the medication's characteristics, such as side effects. Best practice in the Netherlands requires that HMB be re-evaluated after a 3-months period. Referral to a gynaecologist is recommended if HMB persists despite treatment.

Over the past 10 years, the LNG-IUS has been given a more central role in the treatment of HMB in primary care. A recent study reported greater improvement in quality of life following treatment with the LNG-IUS compared with oral medication.[11] In 2008, the Dutch College of General Practitioners revised guideline on Vaginal bleeding recommended the LNG-IUS as a first-line treatment option.[8] However, the extent to which this recommendation is practised is currently unknown. Understanding whether care for women with HMB is optimal requires that we know whether patients are satisfied and whether the treatment chosen by GPs and patients is consistent with current recommendations.

Our primary aim was to determine the incidence of HMB and initial treatment choice in general practice. Furthermore, we aimed to assess how often the LNG-IUS was prescribed for HMB, and if the number of LNG-IUS prescriptions had increased over time.

METHODS

Design and setting

We retrospectively analysed patient data from the Registration Network Groningen (RNG), The Netherlands.[12] This registration network contains data derived from the electronic registration of daily patient care in the participating general practices. The RNG was established in 1989, and comprises three primary care health centres with approximately 30,000 registered patients per year. Diagnoses and prescriptions are recorded according to the International Classification of Primary Care (ICPC) and Anatomical Therapeutic Chemical (ATC) Classification System, respectively. [13,14]

Participants

We included women of reproductive age (between 10 and 59 years old), registered between 1st January 2004 and 31st December 2013 in the RNG (n = 18,357). The study cohort was dynamic, with women able to join or leave the participating practices or aging (women turning ≥10 years old entered the cohort and women turning ≥60 years old left the cohort) during the observation period. Anonymised data about consultations, morbidity, prescriptions and referral rates, including medical history before 1st January 2004, were available for all registered women. See figure 1 for a flow chart of the cohort.

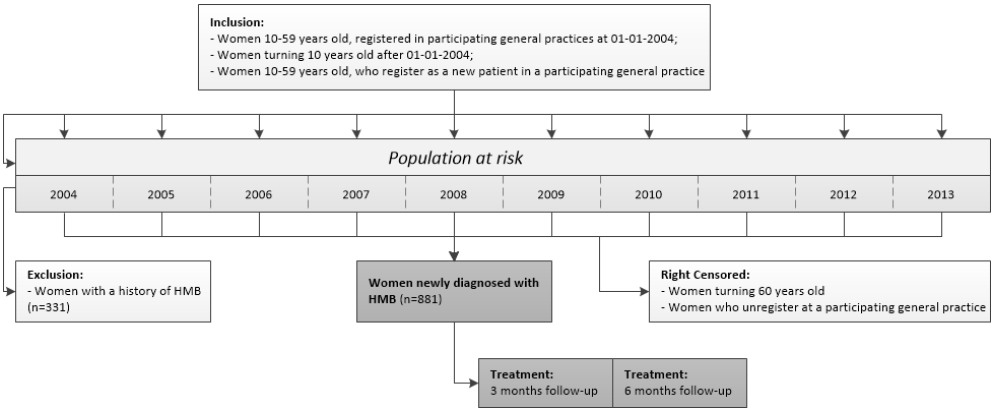

Figure 1. Flow chart cohort 2004-2013

HMB: heavy menstrual bleeding

Incidence rates

The incidence of HMB per year was defined as the number of patients with a first consultation for HMB (ICPC code X-06) per 1000 person years of the population at risk in that year. Women with a history of HMB prior to 1st January 2004 (n = 331) were excluded from the cohort. Women diagnosed with HMB between 2004 and 2013 were excluded from the population at risk from the date of their first HMB consultation. Person years of the population at risk were calculated from the number of days each woman was registered in the cohort in a specific year: person days divided by 365 days (or 366 days in the bissextile years 2004, 2008 and 2012), thereby accounting for the date of patient entry and departure from the population at risk. The end-date was the first occurring of: December 31st of that year, the date a woman turned 60 years old, the date a woman left a general practice or the date a woman was diagnosed with HMB. We defined six age subgroups: 10–14; 15–24; 25–34; 35–44; 45–54; and 55–59 years.

Treatment strategies

Our primary outcome was the initial treatment started within 3 months of HMB diagnosis. As a secondary outcome, we determined whether a second treatment was started within 6 months of diagnosis. The observation period for first consultations for HMB was until 31st December 2013. To allow a 6 months follow-up, the observation period for HMB treatment strategies ended 30th June 2014. Treatment options were divided into nine categories (see Supplementary Data Table S1 for ATC codes): LNG-IUS; OCP; NSAIDs; tranexamic acid; oral progestogens; other progestogens; a combination of medication; other medication (other than defined treatment categories); and watchful waiting (i.e. no new prescription started). The time interval between treatments was calculated. Given that women of reproductive age may use hormonal medication for indications other than HMB (e.g. contraception), which may affect subsequent treatment choices, we made subgroups of women already receiving and not receiving hormonal treatment at the time of diagnosis. To investigate the use of hormonal medication at the time of diagnosis, the maximum prescription period per medication was used (see Supplementary Data Table S1).[15] Medication prescribed within this period before diagnosis was considered to be used at the time of diagnosis. We used the same methods to assess data on other medication that could influence the menstrual bleeding

pattern, including anticoagulants, misoprostol, SSRIs, systemic corticosteroids and the copper intrauterine device.

Referral

The number of gynaecology referrals was only assessed for 2004–2009, because a change in the registration system for referrals after January 2010 led to incomplete registration of the number of referrals since 2010. The time interval between the first consultation for HMB and referral was calculated.

Trends in medication prescription

We investigated the trends in the proportions of all nine initial treatment categories over the study period. To investigate whether there was a trend in LNG-IUS prescriptions over time, we calculated the total number of LNG-IUS prescriptions per year and categorised them by indication into use for HMB (women with HMB diagnosis) or contraception (women without HMB diagnosis). A sensitivity analysis was performed calculating the number of new LNG-IUS prescriptions adjusted for repeat LNG-IUS prescriptions.

Statistical Analysis

Microsoft Access 2010 (Microsoft Corp., Redmond, WA, USA) and IBM SPSS for Windows, Version 22 (IBM Corp., Armonk, NY, USA) were used to analyse the data retrieved from the RNG database. Consultation, referral and prescription data were descriptively analysed. Normally distributed continuous data were presented as means and standard deviations, while non-normally distributed continuous data were presented as medians and interquartile ranges (IQR). Differences in initial treatment choice between women with and without hormonal treatment prior to HMB diagnosis were tested by chi-square tests with Bonferroni correction. The non-parametric Jonckheere–Terpstra test was used for trend analysis in the treatment categories.[16] Trend analysis for the annual LNG-IUS prescription rate was done using the Joinpoint Regression Program, version 4.1.1.[17] A p-value of <0.05 was considered significant.

RESULTS

During the 10-years study period, 18,026 women of reproductive age without a previous history of HMB registered in the RNG cohort. Of these, 881 women presented with a first episode of HMB, and 221 (25%) used hormonal medication at the time of diagnosis. The patient characteristics are presented in table 1.

Incidence rates

The mean incidence rate of HMB in reproductive aged women was 9.3 per 1000 person years (95% confidence interval [CI]: 8.5–10.2), with the highest incidence rates for women aged 35–54 years. The incidences of HMB by year and age are presented in table 2.

Treatment strategies

In 494 of the 881 women (56%), medication was prescribed within 3 months of diagnosis. Most were prescribed the OCP (25%) or oral progestogens (17%), while the LNG-IUS (2.4%) and non-hormonal medication (NSAIDs: 3.2%; tranexamic acid: 3.9%) were infrequently prescribed. However, no new medication was prescribed in the first 3 months after diagnosis in 387 women (44%) (Table 3).

The percentages of LNG-IUS prescriptions (4.5% and 1.7%, respectively) and other progestogen prescriptions (4.1% and 1.1%, respectively) were significantly higher in women using hormonal medication compared to women using no hormonal medication prior to HMB diagnosis (Chi-square test; $p = 0.02$).

Within 6 months following HMB diagnosis, 113 women received a second treatment, which was mainly an OCP or oral progestogen. The median time between first prescription and switch to a second treatment was 52 days (IQR: 18.5–94.5). Typically, an OCP was prescribed following a short course of oral progestogen prescription or there was a medication switch within the OCP group. Of the 387 women initially not receiving medication, 36 did end up receiving medication within 6 months of diagnosis, while 351 women (40%) remained untreated at 6 months after diagnosis.

Table 1. Patient characteristics cohort 2004–2013

Characteristics	Total cohort		HMB patients	
Women in population at risk cohort (n)	18,026			
10-14 years (%)	7.7			
15-24 years (%)	20.0			
25-34 years (%)	22.9			
35-44 years (%)	21.0			
45-54 years (%)	19.7			
55-59 years (%)	8.6			
Time in population at risk cohort (mean in years; SD)	5.2	(3.5)		
Incident HMB patients 2004-2013 (n; %)			881	(4.8%)
Follow-up time after HMB diagnosis (mean in years; SD)			4.6	(2.9)
Age at time of HMB diagnosis (median in years; IQR)			39	(27–46)
Medication use prior to HMB diagnosis (n; %)				
Hormonal medication*			221	(25%)
Anticoagulants			9	(1%)
Misoprostol			0	(0%)
SSRIs			40	(4.5%)
Corticosteroids (systemic)			14	(1.6%)
Copper IUD			18	(2.0%)
HMB consultations per patient (median; IQR)			1	(1–2)
Patients with 1 consultation (n; %)			474	(54%)
Patients with 2 consultations (n;%)			205	(23%)
Patients with 3 consultations (n;%)			95	(11%)
Patients with ≥4 consultations, range 4-20; (n; %)			107	(12%)

HMB: heavy menstrual bleeding; SSRIs: Selective Serotonin Reuptake Inhibitors; IUD: Intrauterine Device; IQR: Interquartile range *hormonal medication: levonorgestrel intrauterine system, combined oral contraceptive pill, progestogens, contraceptive vaginal ring

Table 2. Incidence rates of heavy menstrual bleeding per 1000 person years – 2004-2013

Year Age (years)	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Total
10–14	3.8	2.5	7.7	6.6	2.7	4.1	4.2	13.8	13.4	8.4	**6.6**
15–24	7.1	7.4	7.0	11.1	10.2	6.3	7.0	6.1	6.3	4.4	**7.4**
25–34	6.6	3.8	9.8	13.3	6.9	8.5	4.4	5.3	8.0	7.5	**7.3**
35–44	14.9	12.4	13.0	13.7	8.1	10.9	14.0	13.0	15.7	16.0	**13.0**
45–54	13.7	17.6	12.6	17.7	15.4	15.3	11.1	10.8	13.6	14.7	**14.3**
55-59	2.5	1.2	0	0	2.4	0	1.2	1.1	0	3.5	**1.1**
Total*	**9.3**	**8.7**	**9.5**	**12.2**	**8.8**	**8.8**	**7.9**	**8.4**	**10.0**	**9.6**	**9.3**

* Population at risk: women of reproductive age: 10-59 years old

Referral

Among the 577 women diagnosed with HMB during the 6-years period to 2010, there were 106 (18%) referrals to a gynaecologist. There was no significant difference in the referral rate between 2004 and 2009, or between women prescribed and not prescribed a new medication in the 3 months following diagnosis. The median time between diagnosis and referral was 26 days, with 84% of referrals made within one year after diagnosis.

Trend in initial medication prescriptions

During the study period, the proportion of oral progestogen prescriptions decreased significantly from 19% to 7.8% ($p = 0.016$), but there was no significant trend for the other treatment categories, including the LNG-IUS. The initial treatment of HMB by year is presented in Supplementary Data Table S2.

Table 3. Medication prescription within 3 months of heavy menstrual bleeding diagnosis (*n* = 881; 2004-2013)

Medication prescription within 3 months of HMB diagnosis	Hormonal medication use prior to HMB diagnosis				Total (n; %)	
	No (n; %)		Yes (n; %)			
LNG-IUS	11	(1.7)	10	(4.5)***	21	(2.4)
OCP	173	(26.2)	44	(19.9)	217	(24.6)
NSAIDs	21	(3.2)	7	(3.2)	28	(3.2)
Tranexamic acid	28	(4.2)	6	(2.7)	34	(3.9)
Oral progestogens	112	(17.0)	40	(18.1)	152	(17.3)
Other progestogens	7	(1.1)	9	(4.1) ***	16	(1.8)
Combination*	14	(2.1)	4	(1.8)	18	(2.0)
Other medication**	4	(0.6)	4	(1.8)	8	(0.9)
No new medication	290	(43.9)	97	(43.9)	387	(44)
Total	660	(100)	221	(100)	881	(100)

HMB: heavy menstrual bleeding; LNG-IUS: levonorgestrel intrauterine system; OCP: combined oral contraceptive pill; NSAIDs: nonsteroidal anti-inflammatory drugs *A combination of two different types of medication: LNG-IUS, OCP, NSAID, tranexamic acid or progestogens. **Other medication: estradiol, contraceptive vaginal ring, leuprorelin (GnRH agonist), ergometrine, copper intrauterine device. *** Significant difference compared to women without hormonal medication use prior to HMB diagnosis ($p<0.05$).

Levonorgestrel intrauterine system prescription

During the 10-years study, the LNG-IUS was prescribed 1581 times for 1334 women, of which 122 prescriptions were for women with HMB. The number of prescriptions in women with HMB did not significantly increase between 2004 and 2013. Furthermore, there was no change in trend from before to after the guideline revision (2008). In contrast, the rate of prescribing the LNG-IUS for women without HMB (contraceptive use) significantly increased between 2004 and 2013, with a change of 6.3% in the annual

percentage rate (P < 0.01). A sensitivity analysis adjusted for repeat prescriptions did not alter these results. The trend in LNG-IUS prescriptions is presented in figure 2.

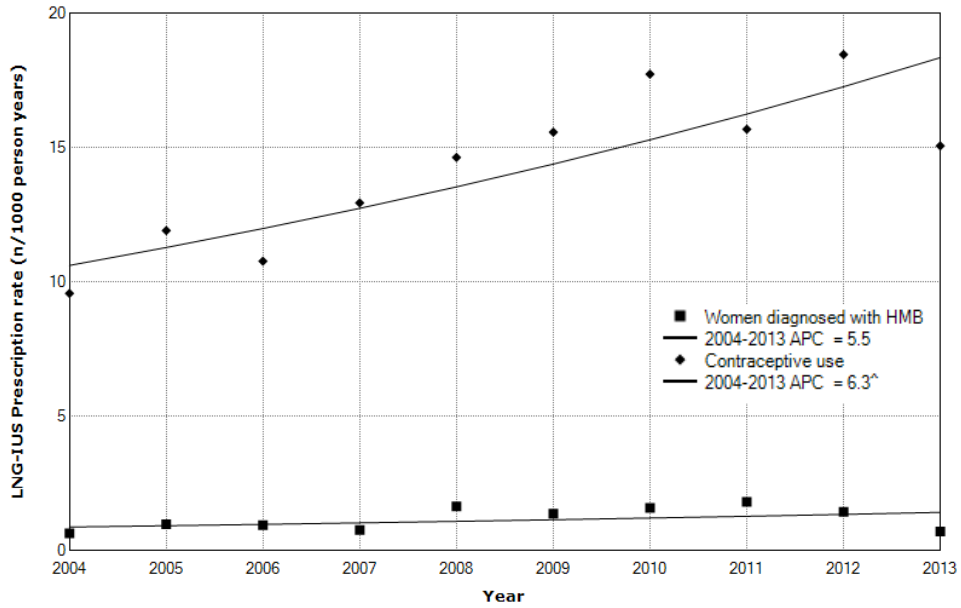

Figure 2. Levonorgestrel intrauterine system prescriptions – 2004-2013
HMB: heavy menstrual bleeding; LNG-IUS: levonorgestrel intrauterine system; APC: Annual Percentage Change; ^ Significant trend (p < 0.01)

CONCLUSIONS

Summary

In our cohort, the mean annual incidence of HMB was 9.3 per 1000 women in reproductive age (95% CI: 8.5–10.2), with the highest incidence (13.0–14.3 per 1000 women) among women aged 35–54 years. In the first three months following diagnosis, medication was started in 56% of women, which mainly comprised oral hormonal treatment with an OCP (24.6%) or oral progestogen (17.3%). However, LNG-IUS was prescribed as the initial treatment in only 2.4% of cases, and there was no significant increase in the number of LNG-IUS prescriptions for HMB between 2004 and 2013. At six months after diagnosis, 13% of the women switched to a second treatment. Women

with HMB were referred to a gynaecologist in 18% of cases, mainly within one year of diagnosis.

Strengths and limitations

This study benefitted from using data collected over 10 years in a representative database of the Dutch patient population.[12] In the Netherlands, the GP is the gatekeeper in the Dutch health-care system controlling access to specialised medical care. Virtually all noninstitutionalised Dutch citizens are registered in a general practice, so the total practice population represents the general population. Every patient needs a referral from the GP to visit a medical specialist. This makes it possible to provide a complete overview of the medical history and prescriptions of each registered patient. However, there are some limitations. For example, ICPC-coding system requires GPs to register one code per symptom. In our registry study patients presenting with both HMB and irregular bleeding (X-07) or intermenstrual bleeding (X-08), could have been missed when the latter symptom was more prominent. Furthermore, it is possible that recording was not accurate by the participating GPs. Indeed, some medication was prescribed without registration of a diagnostic code. While NSAIDs can be prescribed for several indications, we only included NSAID prescriptions clearly related to a diagnosis of HMB, such as those with the same prescribing and diagnosis dates or the ICPC code HMB. Thus, we may have underestimated the number of HMB-related prescriptions. In addition, only the initiation of medication was registered, not whether there was early termination, so we cannot evaluate the actual duration of treatment. Among the patients already using hormonal medication before HMB diagnosis, and who did not receive a new medication, we do not know if the GP suggested that they stop or continue their medication. In fact, we conservatively defined treatment for HMB as new prescriptions only. Furthermore, we did not have information on patient satisfaction with treatment in this registry study.

Comparison with existing literature

The incidence of HMB in this cohort was higher than in other Dutch studies, which vary from 5.2 to 7.0 per 1000 women per year.[3] However, these incidence rates were derived from community based epidemiological studies. Our study was a clinical epidemiological

study, including only women of reproductive age in the population at risk, resulting in a more informative measure.

In our cohort, watchful waiting was used for the first 3 or 6 months after diagnosis in 44% and 40% of patients, respectively. These high rates are consistent with the study by De Vries et al. on the initial management of abnormal vaginal bleeding in general practice, who reported that an expectative policy was followed in 43% of cases.[18] The fact that more than 50% of patients in our cohort had only one consultation for HMB, supports the assumption that a substantial proportion of patients in primary care benefits from information and reassurance about their symptoms without a medication prescription. We also showed that hormonal treatment was chosen more frequently than non-hormonal treatment. An OCP or oral progestogen was prescribed most frequently, with the proportion of oral progestogen prescriptions decreasing over the 10-years period. This likely relates to the changes in the GP guideline that recommends oral progestogens be reserved for women with acute HMB, preferably followed by an OCP.[8] Only 26% of the patients initially treated with an oral progestogen subsequently received hormonal medication in our cohort. It is possible that many of the women presented with a single episode of HMB, rather than cyclical episodes, and did not need additional treatment. It was also noteworthy that some patients switched from one OCP to another. To our knowledge, there is no evidence demonstrating the efficacy of this approach in blood loss reduction.

Implications for practice

Despite the current guideline recommending the LNG-IUS as a first-line treatment option for HMB, the proportion of LNG-IUS prescriptions was below 2.5% in our cohort. Although the LNG-IUS is increasingly being prescribed by Dutch GPs for contraceptive purposes, we found no increase in the prescribing rates for HMB over the past 10 years, suggesting that clinical practice has not yet caught up with current guidelines. We believe this offers room for improvement in the treatment of HMB, because the LNG-IUS is an effective and relatively non-invasive treatment option compared with alternative treatments offered by gynaecologists. [11,19] However, treatment decisions are made collaboratively, and we do not know whether GPs fail to suggest the LNG-IUS or whether women prefer oral medication or an expectant policy. We need a better understanding of the factors

influencing this shared decision making process; for example, by qualitative research of GPs prescribing habits and women's preferences in the treatment of HMB. This would help individualise patient counselling and optimise treatment for HMB.

Ethical approval

This study concerned a retrospective analysis of anonymised data. The Medical Ethics Review Board of the University Medical Centre Groningen has discussed the protocol of the Registration Network Groningen and ascertained that the registry is not a clinical research with test subjects as meant in the Medical Research involving Human Subjects Act (WMO).

Funding

No funding was obtained to support this study.

Conflict of interest

No competing interests to declare.

Acknowledgements

We thank Dr Robert Sykes (www.doctored.org.uk) for his editorial assistance.

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SUPPLEMENTARY DATA

Table S1. Prescriptions with their corresponding ATC codes

LNG-IUS *	
G02BA03	Levonorgestrel Intra Uterine Device
OCP**	
G03AA03	Ethinylestradiol and lynestrenol (fixed combination)
G03AA05	Ethinylestradiol and norethisterone (fixed combination)
G03AA07	Ethinylestradiol and levonorgestrel (fixed combination)
G03AA09	Ethinylestradiol and desogestrel (fixed combination)
G03AA10	Ethinylestradiol and gestodene (fixed combination)
G03AA11	Ethinylestradiol and norgestimate (fixed combination)
G03AA12	Ethinylestradiol and drospirenone (fixed combination)
G03AA13	Ethinylestradiol and norelgestromin (fixed combination)
G03AB03	Ethinylestradiol and levonorgestrel (sequential preparation)
G03FA14	Estrogen and dydrogesterone (fixed combination)
G03FB01	Estrogen and norgestrel (sequential preparation)
G03FB06	Estrogen and medroxyprogesterone (sequential preparation)
G03FB08	Estrogen and dydrogesterone (sequential preparation)
G03HB01	Estrogen and cyproterone
NSAIDs	
M01AE01	Ibuprofen
M01AB05	Diclofenac
M01AB55	Diclofenac and misoprostol
M01AE02	Naproxen
Tranexamic acid***	
B02AA02	Tranexamic acid
Oral progestogens***	
G03AC09	Desogestrel
G03DA02	Medroxyprogesterone
G03DB01	Dydrogesterone

G03DC02	Norethisterone
G03DC03	Lynestrenol

Other progestogens

G03AC03	Levonorgestrel
G03AC06***	Medroxyprogesterone (parenteral)
G03AC08†	Etonogestrel (implant)
G03AD01	Levonorgestrel

Combination of medicine

B02AA02 & G03AA07	Tranexamic acid & Ethinylestradiol and levonorgestrel
B02AA02 & G03DA02	Tranexamic acid & Oral medroxyprogesterone
B02AA02 & G03FB01	Tranexamic acid & Estrogen and norgestrel
B02AA02 & M01AE02	Tranexamic acid & Naproxen
G02BA03 & M01AB05	Levonorgestrel Intra Uterine Device & Diclofenac
G03HB01 & M01AE01	Estrogen and cyproterone & Ibuprofen
G03AA07 & G03DA02	Ethinylestradiol and levonorgestrel & Oral medroxyprogesterone
G03AA07 & G03DC02	Ethinylestradiol and levonorgestrel & Norethisterone
G03AA07 & G03DC03	Ethinylestradiol and levonorgestrel & Lynestrenol
G03DC02 & M01AE01	Norethisterone & Ibuprofen
G03DC03 & M01AB05	Lynestrenol & Diclofenac
G03HB01 & G03DA02	Estrogen and cyproterone & Oral medroxyprogesterone

Other medication

G02AB03	Ergometrine
G02BA02	Copper IUD
G02BB01***	Vaginal ring with progestogen and estrogen
G03CA03	Estradiol
L02AE02	Leuprorelin (Gonadotropin releasing hormone analogue)

Iron supplementation***

B03AA02	Ferrous fumarate
B03AA03	Ferrous gluconate
B03AA07	Ferrous sulfate

Other prescriptions prior to HMB diagnosis

B01AA07	Acenocoumarol (vitamin K antagonist)
H02AB06	Prednisolone (corticosteroid for systemic use)
H02AB07	Prednisone (corticosteroid for systemic use)
H02AB08	Triamcinolone (corticosteroid for systemic use)
N06AB03	Fluoxetine (SSRI)
N06AB04	Citalopram (SSRI)
N06AB05	Paroxetine (SSRI)
N06AB06	Sertraline (SSRI)
N06AB08	Fluvoxamine (SSRI)

Maximum prescription period:

* = 5 years

** = 1 year

*** = 3 months

† = 3 years

Table S2. Medication prescription within 3 months of heavy menstrual bleeding diagnosis – per year (n = 881; 2004-2013)

Year Treatment (%)	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
LNG-IUS	2.0	3.2	2.1	1.7	1.1	2.4	1.3	1.3	6.7	1.6
OCP	18.2	21.5	24.2	20.7	29.2	27.7	22.7	34.6	27.0	23.4
NSAIDs	2.0	3.2	4.2	3.4	5.6	2.4	4.0	3.8	2.2	0
Tranexamic acid	6.1	5.4	2.1	4.3	3.4	7.2	0	6.4	1.1	1.6
Oral progestogens*	19.2	25.8	17.9	19.0	20.2	13.3	20.0	12.8	12.4	7.8
Other progestogens	2.0	1.1	2.1	0	2.2	1.2	2.7	2.6	0	6.3
Combination of medicine	3.0	1.1	1.1	1.7	4.5	3.6	1.3	0	1.1	3.1
Other medication	1.0	1.1	0	0.9	1.1	0	2.7	0	0	1.6
No medical treatment	46.5	37.6	46.3	48.3	32.6	42.2	45.3	38.5	49.4	54.7
Total (%, n)	100 (n=99)	100 (n=93)	100 (n=95)	100 (n=116)	100 (n=89)	100 (n=83)	100 (n=75)	100 (n=78)	100 (n=89)	100 (n=64)

OCP=combined oral contraceptive pill. *Significant trend 2004 – 2013 ($p<0.05$)