Treatment Comparison Chart

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Compare your options.

This chart shows the advantages and disadvantages of various treatments for abnormal uterine bleeding.

	Indication/Description	Advantages	Disadvantages	Candidates
Hormone Therapy[1]	• Frequently prescribed as first course of action for abnormal uterine bleeding caused by hormonal imbalance. Often used by women who want to retain their fertility. • Administered orally these agents reduce bleeding by slowing growth of endometrium during cycle, modify hormone levels or eliminate ovulation.	• Relief from dysfunctional uterine bleeding • Non invasive–no procedure required • Once therapy is stopped, the patient can get pregnant	• Short term solution. Must be used daily or period resumes. • Used to manage bleeding rather than stop it. • Repeated long-term dosing is often required. • Risks and complications vary, depending on the drug include: bleeding, headaches, nausea, breast tenderness or swelling, loss of libido or moodiness. • Approximately 50% of women taking birth control pills continue to suffer from heavy bleeding.[2] • In one study, by 5 years, 90% of women taking drug treatments had gone on to additional therapy.[3] • Oral contraceptives are not recommended for women with a history of cardiovascular disease, blood clots, a family history of breast cancer, or women over the age of 35.[4]	• Younger women that want to maintain childbearing status.
IUD	• A hormone-releasing intrauterine device (IUD) is inserted into the uterus and releases a steady amount of progestins which may help control bleeding.	• May provide shorter, lighter periods • Once therapy is stopped the patient can get pregnant	• It can take up to 6 months to regulate bleeding.[5] • Breakthrough bleeding is a common complaint and a primary reason for discontinued use.[6] • More than 40% of women do not experience a satisfactory improvement in bleeding and go on to have a hysterectomy.[7] • Hormonal side effects include: breast tenderness, mood changes and acne. • Potential drawbacks include abdominal pain, infection, and difficult insertion.	• Younger women who may not be compliant with oral medication and wish to maintain child bearing status.
Dilation & Curettage (D&C)	• Often the first surgical step if drug therapy fails • Typically an outpatient procedure that requires general anesthesia. A curette is used to scrape the uterine walls and the endometrial lining that causes bleeding is removed.	• Reduces heavy flow for next few cycles • May remove polyps	• 2-4 hours of supervised recovery • Nausea and vomiting from the general anesthesia • Short term solution • Perforation of the uterine wall is a risk	• Procedure typically indicated to stop heavy bleeding until cause of bleeding can be determined.

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	Indication/Description	Advantages	Disadvantages	Candidates
Global Endometrial Ablation	• Uses heat or cold to destroy the endometrium • Indicated to correct excessive menstrual bleeding due to benign causes. For premenopausal women who have no plans for pregnancy. • Procedure can be done in hospital setting or in the office. Anesthesia needs are based on method of ablation and pain tolerance of patient.	• Light to moderate periods, possible elimination of bleeding • No need to disrupt natural hormones • Potential for reduction in PMS symptoms such as fatigue, irritability and cramping • Return to normal activities the next day when performed with minimal anesthesia in a doctor's office • Patient is typically able to leave the office 15 minutes after the procedure • When done in a doctor's office may require only office co-pay	• Cramping post procedure • Other risks and complications dependent on therapy but may include: vaginal burn, infection, nausea and vomiting and perforation. • Two to four hour supervised recovery when done in a surgery center • Possible nausea and vomiting associated with anesthesia	• Premenopausal women past child bearing years.
Hysterectomy	• Surgical removal of the uterus. Indicated for abnormal uterine bleeding, fibroids, cancer, endometriosis, prolapse, pelvic inflammatory disease. • The type of hysterectomy depends on the condition being treated	• Complete elimination of menstrual bleeding.	• Hospital stay required. One to 6 days depending on type of hysterectomy. • Catheter for 1-3 days • IV drip with fluids and painkillers for first 24 hours • Discomfort and pain for several days • Tired/fatigue- up to six weeks • Removal of ovaries will induce menopause • Possible safety risks and complications, depending on type of hysterectomy performed. May include: blood loss, infection, bowel and bladder damage, depression and stress urinary incontinence	

[1] Ely, JW et. al. Abnormal Uterine Bleeding: A Management Algorithm. JABFM 2006; 19: 590-602

[2] Davis, A et. al. Triphasic norgestimate-ethinyl estradiol for treating dysfunctional uterine bleeding. Obstet Gynecol 2000; 96:913-920.

[3] Cooper K et. al. Five-year follow up of women randomized to medical management or transcervical resection of the endometrium for heavy menstrual loss: clinical and quality of life outcomes. Br J Obstet Gynaecol 2001; 108: 1222-1228.

[4] Pymar, HC et. al. The risks of oral contraceptive pills. Semin Reprod Med 2001; 19:305-312.

[5] Mirena Instructions for Use.

[6] ACOG Committee Opinion Number 337, June 2006, Noncontraceptive uses of the levonorgestrel intrauterine system, Obstet. Gynecol. 206; 107: 1479-1482.

[7] Hurskainen R et. al. Clincial outcomes and costs with the levonorgestrel-releasing intrauterine system of hysterectomy for treatment of menorrhagia; randomized trial 5-year follow-up. JAMA 2004; 291:1456-1463.