

88. Heavy menses on warfarin

Last Updated: 10/04/2005

Q1: "For years I have experienced terrible menses. I am to the point where I cannot call my flow "heavy" ...it is far beyond that...I hemorrhage with horrible pain and extreme swelling in my lower limbs. My primary care physician tells me this has absolutely nothing to do with my other clotting problems (I'm only 40 years of age and have had two DVTs, one PE, and most recently bilateral PEs). Now that I'm on coumadin® again (this time for life), I am to the point where I almost cannot leave my house ten days of each month because of my "problem". If so, is there anything to do/take to lessen the affects?"

A1: If this person is not planning further pregnancies then an endometrial ablation procedure (see discussion below) might be appropriate and would likely give her significant relief of symptoms. The procedure is easy to do (outpatient) and there is no contraindication for doing the procedure in patients with a history of DVT or PE.

Q2: "I have recently been diagnosed with factor V Leiden and I have VERY heavy menstrual cycles. But I have a hard time even wearing a pad because nothing will absorb, it is all clots. I also have a very long cycle and have terrible cramping. I have had episodes of blacking out before from cramping so badly. I have 6 sisters, some of them with similar cycles. To my knowledge there is nothing that can be done about it."

A2: FVL probably does not lead to more vaginal clots. In view of this patient's family history of heavy menstrual bleeding in several sisters it would be appropriate to evaluate the patient for presence of a bleeding disorder, such as von Willebrand's disease or a platelet function abnormality. Furthermore, any such woman should have had an Ob-Gyn evaluation for anatomical causes of bleeding such as endometrial lesions, polyps, etc.

Q3: "I have a problem that, unfortunately, my male primary care doesn't seem to realize...my entire life changes for 10-days each and every month! I usually find myself running home from work to change during the day OR have to leave a couple of outfit changes in my office. If I had stock in Always, I'd be a rich woman. I requested a hysterectomy but, unfortunately, because of my past clotting problems and diabetes, my Ob/Gyn won't do it. He mentioned a new procedure where they burn the inside lining of one's uterus but I haven't really researched it yet and while I trust my Ob immensely, I'm still a bit leery about it all. I'd love to hear if there is any additional advice or information"

A3: One of the endometrial ablation procedures discussed below might be a good treatment option in a person like this

Q4: "I have a lot of bleeding with my cycle and my hematologist told me that it was normal because of the coumadin®. The blood flow is so heavy at time that it runs down my legs and the "cramps" are horrible. Is there any good answer as to what can be done about it?"

A4: See discussion below

Q5: "I am on coumadin®. I have noticed that the coumadin® did increase my flow and did increase the length of time I have it...the pain seems a little less though. I was just frustrated to hear from my doc that one "blood" had absolutely nothing to do with another...in his mind, menses is one entity and circulatory is another"

A5: If a woman starts warfarin (coumadin®) her menstrual bleeding may increase in volume and length. However, in many women there is no change.

Q6: My flow has more than doubled since taking coumadin®. My primary care physician said it is from the coumadin®"

A6: I Agree.

Q7: "I had a pulmonary embolism this past January. I found out I was positive factor V Leiden, and am now permanently on coumadin®. Now, from being on coumadin®, I have extreme dysfunctional bleeding which would normally be a menstrual cycle. I was put on hormones the beginning of every month, which is not helping, PLUS I don't like being on hormones that can cause blood clots as well, its too scary. I had a hysterectomy the end of July to remedy this problem. I am 28."

A7: The Mirena® IUD (see below) is a good option to decrease the heavy menstrual flow in a woman who still plans to have children in the future.

Q8: "Can the endometrial ablation procedures be done while I am on coumadin®?"

A8: Yes, they can be done on coumadin® (hot balloon ablation, NovaSure™, Her Option™), since no cutting is done. There may be blood-tinged discharge after the procedure, but patients do fine without stopping coumadin®. For the hysteroscopic endometrial ablation procedure temporary discontinuation of coumadin® may be appropriate.

Women not on warfarin

In women (not on warfarin) with heavy menstrual bleeding (=menorrhagia) an underlying bleeding disorder is frequently present (ref. 1,2). However, rarely do physicians evaluate a patient for a bleeding disorder (ref 3).

A physician should consider laboratory work-up for a bleeding disorder in women with unusually heavy menstrual bleeds. The suspicion for a bleeding disorder should even be higher if the woman has a history of other bleeding (with teeth extractions, surgery of the tonsils, childbirth, etc.) or a family history of bleeding, such as heavy menstrual bleeds in female family members. The most common bleeding disorders are von Willebrand's disease and platelet defects (ref. 2).

Women on warfarin

Warfarin (coumadin®) often increases the amount of bleeding during menses and sometimes the number of days that a woman bleeds. However, this does not happen in everyone – in some women there is no change in the bleeding pattern. In general, the more vaginal bleeding a patient has, the more cramping she experiences. Since warfarin may increase the vaginal bleeding, more cramps may also result.

Treatment

If a bleeding disorder is present, then consideration of treatment for the disorder is appropriate (for example use of the medication DDAVP in women with von Willebrand's disease). If no bleeding disorder is present and the bleeding is significant enough to require intervention, there are several treatment options that can be discussed with the Ob-Gyn and hematologist. They are either (a) hormone treatment, (b) so called ablation procedures during which the layering of the uterus is destroyed, or (c) hysterectomy. If a woman does not plan to have any children in the future, the ablation procedures are, generally, a very good option to prevent or decrease the bleeding. In a woman still wants to be able to have children in the future the Mirena® IUD or oral progestins are a good first choice. If these methods fail, continuous estrogens could be considered. However, the woman needs to be aware that estrogens increase the risk for thrombosis.

1. Mirena® IUD

The Mirena® IUD is a device that continuously releases very low doses of progestins in the uterus. This leads to a suppression of build-up of the layering of the uterus (endometrium) and thus to a decrease and, eventually, a disappearance of bleeding. Only little of the released progestins is absorbed into the blood stream; therefore, Mirena® likely does not lead to an increased risk for thrombosis (DVT or PE) and appears to be a good choice to control bleeding or to use as a contraceptive method in women with (a) thrombophilia (such as factor V Leiden), (b) a history of blood clots (DVT or PE), and (c) the woman on warfarin (coumadin®). The WHO has classified Mirena® IUD as “advantages of using the method generally outweigh the theoretical or proven risks” for individuals with known thrombophilia (FVLeiden, II20210, or deficiencies of protein C and S or ATIII) and in patients with history of DVT or PE (ref 6:www.who.int/reproductive-health/publications/mec). Further information can also be found at: www.mirena-us.com/index.html.

2. Progestins:

Continuous progestins (for example Aygestin® 2.5 mg per day to start off with; may have to be increased to 10-15 mg per day) sometimes work, but this is a trial-and-error approach. Some women will develop breakthrough bleeding and spotting and will, therefore, not find this a suitable option. Because continuous progestins can cause breakthrough bleeding and spotting (from atrophy=thinning of the endometrium), it can be considered to discontinue them every 3-4 months, to let the woman have a period; progestins can then be restarted. However, Progestins can also be taken without a break. High doses of progestins increase the risk for blood clots (ref 7). However, one may argue that the person on warfarin is protected, to a large degree, from further blood clots and that the slightly increased risk that occurs with high doses of progestins may clinically not be important (see also www.fvleiden.org/ask/14.html).

3. Continuous estrogens:

Taking the usual birth control pill (combined estrogen-progestin pill) may be attempted and may result in lighter periods because there is less build-up of the endometrial layer while on the pill. For those with continued heavy bleeding, continuous estrogen pills can be considered. To achieve continuous estrogen-progestin dosing a woman would either need to take (a) regular birth control pill packs and discard the pills of the last week (placebo pills) and start a new pack every 3 weeks, or (b) take a prepackaged continuous estrogen-progestin pill that does not contain placebo pill (for example Seasonale®). Since estrogens increase the risk for blood clots, this is to be kept

in mind when considering an estrogen-containing pill, and they are, therefore, typically not the first choice of treatment

4. **Hot balloon ablation:**

This procedure is also called “endometrial ablation” or “thermal balloon ablation” or ThermaChoice™. It is performed as an outpatient procedure in the operating room. A balloon is inserted into the uterus and a hot fluid is filled into it, which burns and destroys (ablates) the lining of the uterus. Thus, the build-up of the lining of the uterus (endometrium) that typically occurs is prevented. The discomfort experienced during this procedure is easily controlled with minimal sedation or pain killers. Usually, a woman who has had this procedure done can not get pregnant any more. The procedure should therefore not be chosen by women who still want to have children. www.gynecare.com/bgdisplay.jhtml?itemname=thermchoice_about&mi=1

5. **NovaSure™**

This method/device is also called “Uterine Electrofrequency ablation”. This is an outpatient procedure performed in the operating room. The lining of the uterus is destroyed (ablated) by application of radiofrequency waves that dry out and destroy the endometrial lining; menstrual bleeding is thus prevented. Usually, a woman who has had this procedure done can not get pregnant any more. The procedure should therefore not be chosen by women who still want to have children. For details see www.fda.gov/cdrh/pdf/p010013.html

6. **Her Option™**

This method/device is also called “Uterine Cryoablation Therapy™ System”. This is an outpatient procedure performed in the operating room. The lining of the uterus is destroyed (ablated) by application of extreme cold; menstrual bleeding is thus prevented. Usually, a woman who has had this procedure done can not get pregnant any more. The procedure should therefore not be chosen by women who still want to have children. For details see www.fda.gov/cdrh/pdf/P000032b.pdf

7. **Hysteroscopic endometrial ablation procedure**

This is a surgical procedure performed under general or epidural anesthesia, during which a video scope is introduced into the uterus. The inner layer of the uterus (endometrium) is then destroyed (ablated) with an electrode loop, roller ball, or laser. The procedure should therefore not be chosen by women who still want to have children

8. **Hysterectomy**

Surgical removal of the uterus can also be considered. However, this is, obviously, an invasive procedure and, as any major surgery, has a risk for deep vein thrombosis and pulmonary embolism. This may, therefore, not be a good choice, in the patient who already has a history of venous blood clots or has a thrombophilia

References:

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