Policy statement:	**Heavy Menstrual Bleeding (including uterine fibroids) Hysterectomy/Myomectomy/Uterine Artery Embolisation**
Status:	**Group Prior Approval-Hysterectomy/Endometrial Ablation**
Status:	**Not funded-Myomectomy/Uterine Artery Embolisation**

Hysterectomy for heavy menstrual bleeding will only be funded by M&SECCGs when the following criteria are met:

Heavy Menstrual Bleeding (HMB) is defined as excessive menstrual blood loss which interferes with the woman's physical, emotional, social and material quality of life, and which can occur alone or in combination with other symptoms. **The policy does not apply to post-menopausal, inter-menstrual or post-coital bleeding.**

Hysterectomy for heavy menstrual bleeding will only be funded when:

- There has been a trial with a levonorgestrel-releasing intrauterine system LNG-IUS, e.g. Mirena®, unless contraindicated, for at least 12 months and this has not successfully relieved symptoms or has produced unacceptable side effects. Contraindications to the levonorgestrel intrauterine system are:
    - Distorted or small uterine cavity (with proven ultrasound measurements; uterocervical canal length < 5cm)
    - Genital malignancy
    - Active trophoblastic disease
    - Active pelvic inflammatory disease
    - Large cavity over 10cm length

AND

- At least **two** of the following drug treatments **(for at least 3 months each)** have failed to relieve symptoms (unless contraindicated or inappropriate):
    - Alternative hormonal treatment in keeping with NICE guidance e.g. combined or progestogen only oral contraceptives, injected progesterone, Gn-RH analogues
    - NSAIDs
    - Tranexamic Acid

For those who for ethical reasons cannot accept the use of Mirena®, they should have tried at least two of the alternative treatments.

AND
where ultrasound shows small fibroids <3cms; uterus <12 wks gestation AND severe impact on quality of life and

- Endometrial Ablation or Resection has been unsuccessful (unless contraindicated or inappropriate) as first line surgical treatment for women with heavy menstrual bleeding who do not wish to conceive in the future.

Women offered hysterectomy should have a full discussion of the implication of the surgery before a decision is made. The discussion should include: sexual feelings, fertility impact,

bladder function, need for further treatment, treatment complications, the woman's expectations, alternative surgery and psychological impact.

Women offered hysterectomy should be informed of the increased risk of serious complications (such as intraoperative haemorrhage or damage to other abdominal organs) associated with hysterectomy when uterine fibroids are present.

Women should be informed of the risk of possible loss of ovarian function and its consequences, even if their ovaries are retained during hysterectomy.

Taking into account the need for individual assessment, the route of hysterectomy should be considered in the following order: first line vaginal; second line abdominal or laproscopic.

NICE guidelines state that removal of healthy ovaries at the time of hysterectomy should not be undertaken; however prophylactic removal of fallopian tubes may be considered to reduce the risk of ovarian cancer. Ovary removal should be discussed with the patient on an individual basis and the age of the patient should also be taken into account. Ovary removal should only be undertaken with the expressed wish and consent of the woman.

Interventions not funded by M&SECCGS

Myomectomy and Uterine Artery Embolisation (UAE) are **not funded** by M&SECCGS.

NICE published update guidance in 2010 for UAE NICE interventional procedure guidance [IPG367] stating that 'Current evidence on uterine artery embolisation (UAE) for fibroids shows that the procedure is efficacious for symptom relief in the short and medium term for a substantial proportion of patients'. However re-intervention rates are significantly higher after UAE than after surgery with up to 32% re-intervention rates for either symptom recurrence or complication by 5 years (4% for surgery). Myomectomy has a higher re-intervention rate than UAE.

The evidence for fertility and pregnancy outcomes after myomectomy and after UAE is poor. Currently it is not possible to make an evidence based recommendation about treatment (myomectomy or UAE) for women with fibroids who wish to maintain their fertility. Surgical treatments for fibroids in women of childbearing age who wish, or might wish to become pregnant in the future should be offered only after fully informed discussion.

There is limited evidence on the role of other interventions such as uterine artery ligation, Magnetic Resonance guided Focussed Ultrasound (MRgFUS) and myolysis. NICE assessment of MRgFUS indicates that although the procedure appears effective in the short term, there is a lack of evidence for its longer term effectiveness. **These procedures are not funded.**

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs' website.

References:

NICE Heavy Menstrual Bleeding –Clinical Guideline March 18
https://www.nice.org.uk/guidance/ng88/resources

Clinical recommendations on UAE in management of fibroids
https://www.rcog.org.uk/globalassets/documents/guidelines/23-12-2013_rcog_rcr_uae.pdf