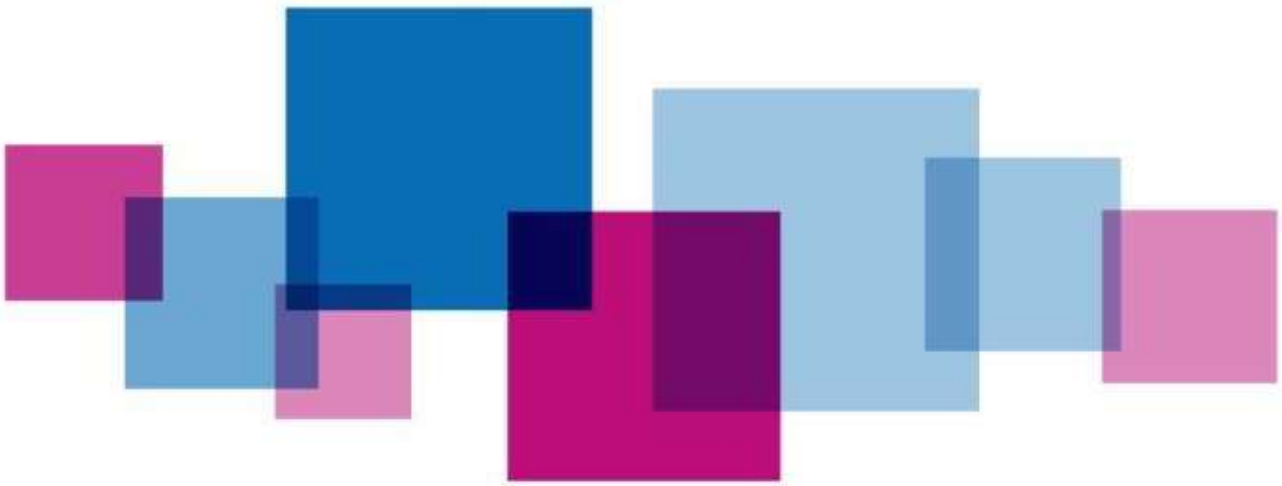
NHS
Bristol, North Somerset
and South Gloucestershire
Integrated Care Board

# Commissioning Policy

## Hysterectomy for Menorrhagia

### Criteria Based Access



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Shaping better health

## Document Control

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## Version Control

| Version | Date | Reviewer | Comment |
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| 1617.1.01 | 26/03/2018 | IR Coordinator | Rebranded to BNSSG CCG |
| 1819.2.00 | 26/10/2018 | Commissioning Policy Development Support Officer | Smoking and BMI references updated, BNSSG branding refreshed, PALS update. Approved on 14th February 2019 by Commissioning Executive. |
| 1920.1.01 | | CPD | Reviewed and refreshed in line with NHS England EBI Work |

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|---|---|---|---|
| 1920.1.02 | 21/06/2019 | Commissioning Policy Development Manager | Post CPRG Admin corrections and addition of Remedy link |

**THIS IS A CRITERIA BASED ACCESS POLICY**
**TREATMENT MAY BE PROVIDED WHERE PATIENTS MEET THE CRITERIA BELOW**

**THIS POLICY RELATES TO ALL PATIENTS**

# Hysterectomy for Menorrhagia Policy

## General Principles

**Treatment should only be given in line with these general principles. Where patients are unable to meet these principles in addition to the specific treatment criteria set out in this policy, funding approval may be sought from the ICB Exceptional Funding Request Panel.**

1. Clinicians should assess the patients against the criteria within this policy prior to referring patients seeking treatment. Referring patients to secondary care that do not meet these criteria not only incurs significant costs in out-patient appointments for patients that may not qualify for surgery, but inappropriately raises the patient's expectation of treatment.
2. Patients will only meet the criteria within this policy where there is evidence that the treatment requested is effective and the patient has the potential to benefit from the proposed treatment. Where the patient has previously been provided with the treatment with limited or diminishing benefit, it is unlikely that they will qualify for further treatment and the EFR team should be approached for advice.
3. On limited occasions, the ICB may approve funding for a further assessment in secondary care only in order to confirm or obtain evidence demonstrating whether a patient meets the criteria for funding. In such cases, patients should be made aware that the assessment does not mean that they will be provided with surgery and surgery will only be provided where it can be demonstrated that the patients meets the criteria to access treatment in this policy.
4. Where funding approval is given by the Exceptional Funding Request Panel, it will be available for a specified period of time, normally one year.
5. Patients with an elevated BMI of 30 or more may experience more post-surgical complications including post-surgical wound infection so should be encouraged to lose weight further prior to seeking surgery. https://www.sciencedirect.com/science/article/pii/S1198743X15007193 (Thelwall, 2015)
6. Patients who are smokers should be referred to smoking cessation services in order to

reduce the risk of surgery and improve healing (ASH, 2016)

7. In applying this policy, all clinicians and those involved in making decisions affecting patient care will pay ***due*** regard to the need to eliminate unlawful discrimination, harassment, victimisation, etc., and will advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not. In particular, due regard will be paid in relation to the following characteristics protected by the Equality Act 2010: age, disability, sex, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief and sexual orientation.

## Background / Purpose and Scope

Heavy periods, also called menorrhagia, are defined as being when a woman loses an excessive amount of blood during consecutive periods. In most cases, no underlying cause of heavy periods is identified. However, some conditions and treatments have been linked to menorrhagia, such as uterine fibroids; intrauterine contraceptive devices (IUDs); anticoagulant medication and polycystic ovary syndrome (PCOS). Menorrhagia can occur by itself or in combination with other symptoms, such as menstrual pain (dysmenorrhoea).

Medication is the main treatment for menorrhagia and is most commonly used in the first instance, but surgery may also be used. In some cases, treatment is not necessary. If the heavy bleeding doesn't affect the patient's life or no serious cause is suspected, the patient may just be reassured that bleeding can vary over time for some women.

The aim of treating menorrhagia is to:

- reduce or stop excessive menstrual bleeding
- improve the quality of life of women with menorrhagia
- prevent or correct iron deficiency anaemia caused by heavy menstrual bleeding

There are several types of operation that can be used to treat menorrhagia. A hysterectomy (removal of the womb) will stop any future periods, but should only be considered after other options have been tried or discussed. The operation and recovery time are longer than for other surgical techniques for treating heavy periods.

**Risks**

As with all major operations, there is a small risk of heavy bleeding (haemorrhage) after having a hysterectomy.

**Other complications can include:**

- Ureter damage
- Bladder or bowel damage

- Infection
- Thrombosis
- Vaginal problems

| POLICY CRITERIA – COMMISSIONED<br><br>CRITERIA BASED ACCESS |
|---|
| The ICB will fund hysterectomy for heavy menstrual bleeding (menorrhagia) only when:<br><br>1. There has been an unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena®) and it has failed to relieve symptoms unless it is medically inappropriate, declined by the patient or contraindicated.<br>**AND**<br>2. At least two of the following treatments have failed, are not appropriate or are contra-indicated in line with the National Institute for Health and Clinical Experience (NICE) guideline CG44 (National Institute for Health and Care Excellence, 2015):<br>• Non-steroidal anti-inflammatory agents<br>• Tranexamic acid<br>• Other hormone methods (injected progesterones, combined oral contraceptives, Gn-RH analogue)<br>**AND**<br>3. Surgical treatments such as endometrial ablation or myomectomy have failed to relieve symptoms, or are not appropriate, or are contra-indicated, or have been declined by the patient.<br><br>For more information please see: https://remedy.bnssgccg.nhs.uk/ |

Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy.

Individual cases will be reviewed at the ICB's Exceptional Funding Panel upon receipt of a completed application form from the patient's GP, Consultant or Clinician. Applications cannot be considered from patients personally.

## Due Regard

In carrying out their functions, the Bristol North Somerset and South Gloucestershire Commissioning Policy Review Group (CPRG) are committed to having due regard to the

Public Sector Equality Duty (PSED). This applies to all the activities for which the ICB is responsible, including policy development and review.

Consideration has been given to this policy and the development process of the above criterion following the recent NHSE Evidence-Based Interventions (EBI) recommendations.

Following this review, local consensus is that due to the robust development process which included a public consultation this policy should remain and be reviewed in line with the BNSSG published process.

If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Customer Services Team on: **0117 900 2655** or **0800 073 0907** or email them on **BNSSG.customerservice@nhs.net** .

## Connected Policies

N/A

## This policy has been developed with the aid of the following references:

Ash. (2016). *Ash.org.uk.* Retrieved Sept 24, 2018, from www.ash.org.uk: www.ash.org.uk/briefings

Hehenkamp WJ, V. N. (n.d.). Uterine artery embolization versus hysterectomy in the treatment of symptomatic uterine fibroids (EMMY trial): peri-and postprocedural results from a randomized controlled trial. *American Journal of Obstetrics and Gynecology* , 2005;193(5):1618–29.

Hurskainen R, T. J. (2004). Clinical outcomes and costs with the levonorgestrel-releasing intrauterine system or hysterectomy for treatment of menorrhagia: randomized trial 5-year follow-up. *JAMA: the journal of the American Medical Association*, 291(12):1456–63.

Learman LA, S. J. (2004). Hysterectomy versus expanded medical treatment for abnormal uterine bleeding: Clinical outcomes in the medicine or surgery trial. *Obstetrics and Gynecology*, 103(5 I):824–33.

Lethaby A, H. M. (n.d.). Endometrial destruction techniques for heavy menstrual bleeding. *Cochrane Database Syst Rev. 2005 Oct 19;(4):CD001501. Review. Update in: Cochrane Database Syst Rev. 2009;(4):CD001501. PubMed PMID: 16235284.*

National Institute for Health and Care Excellence. (2015, March). *National Institute for Health and Care Excellence*. Retrieved August 12, 2015, from http://www.nice.org.uk/guidance/cg44

NHS Choices. (2015, February 21). *www.nhs.uk*. Retrieved August 12, 2015, from NHS UK: http://www.nhs.uk/Conditions/Periods-heavy/Pages/Treatment.aspx

NHS UK. (n.d.). *www.nhs.uk*. Retrieved April 11, 2019, from NHS website: https://www.nhs.uk/conditions/heavy-periods/#Causes

NICE Guidance. (n.d.). *www.nice.org.uk*. Retrieved April 11, 2019, from NICE: https://www.nice.org.uk/guidance/ng88.

Pinto I, C. P. (n.d.). Uterine fibroids: uterine artery embolization versus abdominal hysterectomy for treatment – a prospective, randomized, and controlled clinical trial. . *Radiology*,

2003;226(2):425–31.

Thelwall, S. (2015). Impact of obesity on the risk of wound infection following surgery: results from a nationwide prospective multicentre cohort study in England. *Clinical microbiology and infection : the official publication of the European Society of Clinical Microbiology and Infectious Diseases*, vol. 21, no. 11, p. 1008.e1.

Zupi E, Z. F. (2003). Hysteroscopic endometrial resection versus laparoscopic supracervical hysterectomy for menorrhagia: a prospective randomized trial. *American Journal of Obstetrics and Gynecology*, 188(1):7–12.

## OPCS Procedure codes

Procedures challenged in this policy:
OPCS Codes for hysterectomy: Q07, Q070, Q071, Q072, Q073, Q074, Q075, Q076, Q077, Q078, Q079, Q08, Q080, Q081, Q082, Q083, Q084, Q085, Q086, Q087, Q088, Q089, Q101,Q102,Q103,Q108,Q109,R251
Relevant diagnoses for this policy:
ICD10 Code: None
Diagnoses for which the above procedures are permitted:
ICD10 Code: C54, C54X, C540, C55, C55X, C550, C56, C56X, C560, C57, C57X, C570, C58, C58X, C580, D25, D25X, D250 (with failure of conservative treatment); N80, N80X, N800 (with failure of conservative management); N92, N920, N921, N922, N924, N923, N925, N926 (with failure of conservative management) Audit required to determine failure of conservative treatments.