General Commissioning Policy

Treatment	**Hysterectomy (vaginal or abdominal surgical excision of uterus)**
For the treatment of	**Menorrhagia (Heavy Menstrual Bleeding [HMB])**
Background	From April 2013 NHS England took over responsibility for commissioning activity in primary care, where initial conservative treatment takes place. NHS Hull CCG is responsible for commissioning activity in secondary care, and this policy sets out the treatment pathway for hysterectomy for heavy menstrual bleeding and the threshold at which surgical treatment in secondary care will be commissioned. This policy aims to ensure women have tried less invasive alternative treatments first, in line with NICE Clinical Guideline CG44.
Commissioning position	NHS Hull CCG will not routinely commission hysterectomy for HMB, with or without fibroids, except where: • There has been a prior 3 month trial with levonorgestrel intrauterine system (Mirena® unless contraindicated*) which has not relieved the symptoms. AND • Other treatments (such as non-steroidal anti-inflammatory agents [NSAIDs], tranexamic acid, a combined oral contraceptive pill or endometrial ablation) have not successfully relieved symptoms after 3 months or are not appropriate or are contra-indicated in line with NICE CG44. (The care pathway for Menorrhagia in shown in the Appendix). Requests that fall outside the criteria above must be considered via the Individual Funding Request (IFR) process. * Contraindications to the levonorgestrel system are: • Severe anaemia, unresponsive to transfusion or other treatment • Distorted or small uterine cavity (with proven ultrasound measurements) • Genital malignancy • Active trophoblastic disease • Pelvic Inflammatory Disease • Established or marked immuno-suppression It is recommended the insertion and removal of Mirena® coils as a treatment for menorrhagia takes place in primary care, unless there is a clear clinical reason why the procedure should be conducted in a secondary care setting. NHS Hull CCG will commission hysterectomy for appropriate patients with a diagnosis of: • cancer of the cervix / fallopian tubes / uterus and/or ovaries

Notes

1. This Policy will be reviewed in the light of new evidence, or guidance from NICE.
2. General Commissioning Policies are agreed by the Planning and Commissioning Committee on behalf of NHS Hull CCG.

	• severe and debilitating endometriosis or adenomyosis that cannot be managed by non-surgical interventions • uterine prolapse, where non-surgical options are inappropriate or have failed to manage the woman's symptoms • complicated and persistent pelvic inflammatory disease that has not responded to conventional treatment In all instances, women offered hysterectomy should: • have a full discussion of the implication of the surgery before a decision is made. The discussion should include: fertility impact; bladder function; need for further treatment; treatment complications; sexual feeling; the woman's expectations; alternative surgery; and psychological impact; • be informed about the increased risk of serious complications (such as intraoperative haemorrhage or damage to other abdominal organs) associated with hysterectomy when uterine fibroids are present; • be informed about the risk of possible loss of ovarian function and its consequences, even if their ovaries are retained during hysterectomy.
Effective from	December 2013 *(This policy supercedes Hull PCT policy T33/11 dated June 2011)*
Summary of evidence / rationale	Menorrhagia is excessive (heavy), cyclical menstrual bleeding over several cycles that can occur at any age between menarche and menopause. Each year this condition prompts one in twenty women aged 30-49 to consult their GP. If severe, menorrhagia can seriously disrupt day-to-day activity. It is the commonest cause of iron deficiency anaemia in women of reproductive age in the UK. In many women, the underlying cause of menorrhagia is not known. In others, the excessive bleeding could be secondary to a gynaecological, hormonal or haematological disorder. NICE states hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding. A Cochrane systemic review concluded that levonorgestrel intrauterine system/Mirena® coil improved the quality of life of women with menorrhagia as effectively as hysterectomy. A number of effective conservative treatments are available as second line treatment after failure of Mirena®.
Date	June 2017
Review Date	June 2018
Contact for this policy	Karen Billany, Head of Acute Care, NHS Hull Clinical Commissioning Group. Karen.billany@nhs.net

References:

1. Lethaby A, Farquhar C: Treatments for heavy menstrual bleeding – BMJ November 2003;327:1243–4 http://www.bmj.com/content/327/7426/1243.full.pdf
2. Marjoribanks J, Lethaby A, Farquhar C: Surgery versus medical therapy for heavy menstrual bleeding – Cochrane Database of Systematic Reviews 2006, Issue 2. http://onlinelibrary.wiley.com/o/cochrane/clsysrev/articles/CD003855/pdf_fs.html
3. NICE (Jan 2007). Heavy menstrual bleeding. Investigation and treatment. http://guidance.nice.org.uk/CG44
4. NICE pathway http://pathways.nice.org.uk/pathways/heavy-menstrual-bleeding

APPENDIX - Referral Pathway for Menorrhagia