An article taken from the **Menopause & You** online program

Perimenopausal Bleeding

Over their reproductive years, women have come to expect a certain degree of predictability with regard to their menstrual cycle. Whether it is timing, length or amount of flow, there is generally not much variation from month to month. As we approach menopause all of this changes. Some of these changes are manageable, some are not. Dr. James Kolter takes us through what can be expected and how to approach these new facts of life.

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As a woman approaches menopause, the function of her ovaries gradually declines. Once she completes a year without menstruation, she has arrived at menopause. The average age for this to occur is 51. However, it can occur anytime after the age of 40.

Perimenopause is a transitional time 3-5 years prior to menopause usually characterized by a change in the normal menstrual cycle.

To appreciate the changes that are occurring, it is helpful to understand the normal menstrual cycle. A woman releases estrogen in response to pituitary hormones in the first half of the cycle. After ovulation, progesterone is also produced. Estrogen and progesterone help prepare the lining of the uterus (endometrium) with a thick, lush layer to receive a fertilized egg. These hormones peak approximately 7-10 days after ovulation. If pregnancy does not occur, the lining sheds. Thus, a period takes place; and the cycle will then repeat.

What is Perimenopause?

Perimenopause is a transitional time 3-5 years prior to menopause usually characterized by a change in the normal menstrual cycle. The cycles may be shorter or longer, and the flow may vary from light to heavy. As ovarian function is declining, ovulation may not occur. The estrogen that has been released will cause the uterine lining to thicken. Without progesterone to oppose the estrogen, the lining will continue to build-up; and break-through bleeding can result. This abnormal, thickening of the endometrium is called hyperplasia, and in some instances, it may ultimately lead to endometrial cancer. Polyps and fibroids, which are benign, may also cause changes in bleeding pattern. Abnormal bleeding, especially bleeding that saturates a pad per hour for 24 hours or bleeding that lasts longer than two weeks, should be evaluated by a physician or healthcare provider.

Evaluating Perimenopausal Bleeding

The evaluation will often include a history and physical exam. Various tests may be ordered to diagnose the cause of the abnormal bleeding. These might include certain ho mone levels; and possibly, blood tests including coagulation studies to identify clotting abnormalities. Most women may need to have the endometrial lining assessed. This is commonly done in an office setting with a biopsy instrument with minimal discomfort.

If the diagnosis is still uncertain, vaginal pelvic ultrasound is useful. Finally, a hysteroscopy may be done to evaluate abnormal bleeding. A hysteroscope is a lighted instrument that is passed through the vagina into the uterus. This is commonly done in a hospital outpatient facility. A D&C may be performed at this time.

Fibroids and Polyps

A fibroid is a fibromuscular type of tumor that often grows within the muscular layer of the uterus. Most commonly, they are incidental findings on an examination, but if they're lo-cation is jutting into the endometrial cavity, abnormal bleeding can result. Polyps, on the other hand, are

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are benign growths comprised of the endometrial lining and contain no muscle tissue. Either can be a source of extra bleeding due to their location within the interior of the uterus.

Treatment

Treatment will be determined by the diagnosis. Growths, like fibroid tumors and endometrial polyps, are often removed in various ways in an operating room. This will be discussed by the healthcare provider.

If there is no pathologic cause for the bleeding, anovulation is a common aspect of the perimenopause. Continued observation and re-evaluation may be the best plan. For persistent abnormal bleeding, however, hormone therapy is often instituted. This will usually help not only the bleeding problem, but also alleviate the associated symptoms of the perimenopause, such as hot flashes and night sweats. Depending on the results of your evaluation, this could be an oral contraceptive type pill, or a hormone replacement alternative. Some women respond to a progesterone containing IUD call Mirena. This provides the endometrial lining with a boost in progesterone while not necessitating a systemic dose of hormones. This IUD is placed in a doctor's office with no need for anesthetics.

There are a variety of surgical therapies available to help women who either fail the hormonal approach, or who can not tolerate certain side effects, such as bloating or breast tenderness. The simplest of these procedures is endometrial ablation. With this technique, the endometrial lining is cauterized or resected in the operating room with light sedation, similar to the hysteroscopy procedure. Over 90% of women obtain a satisfactory result.

Finally, for persistent difficult bleeding, a hysterectomy may be suggested. This will certainly correct the bleeding completely but will involve a more aggressive surgery and a recovery period of 3-6 weeks. This decision is best made after thoughtful discussion with your physician.

In summary, persistent or excessive bleeding should be evaluated thoroughly. Treatment options are based on the results of the evaluation and are designed to help a woman cope with

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