Menorrhagia is the medical term for menstrual periods with abnormally heavy or prolonged bleeding. Although heavy menstrual bleeding is a common concern among premenopausal women, most women don't experience blood loss severe enough to be defined as menorrhagia.

With menorrhagia, every period you have causes enough blood loss and cramping that you can't maintain your usual activities. If you have menstrual bleeding so heavy that you dread your period, talk with your doctor. There are many effective treatments for menorrhagia.

The signs and symptoms of menorrhagia may include:

- Soaking through one or more sanitary pads or tampons every hour for several consecutive hours
- Needing to use double sanitary protection to control your menstrual flow
- Needing to wake up to change sanitary protection during the night
- Bleeding for longer than a week
- Passing blood clots with menstrual flow for more than one day
- Restricting daily activities due to heavy menstrual flow
- Symptoms of anemia, such as tiredness, fatigue or shortness of breath

When to see a doctor

Seek medical help before your next scheduled exam if you experience:

- Vaginal bleeding so heavy it soaks at least one pad or tampon an hour for more than a few hours
- Bleeding between periods or irregular vaginal bleeding
In some cases, the cause of heavy menstrual bleeding is unknown, but a number of conditions may cause menorrhagia. Common causes include:

- **Hormone imbalance.** In a normal menstrual cycle, a balance between the hormones estrogen and progesterone regulates the buildup of the lining of the uterus (endometrium), which is shed during menstruation. If a hormone imbalance occurs, the endometrium develops in excess and eventually sheds by way of heavy menstrual bleeding.

- **Dysfunction of the ovaries.** If your ovaries don't release an egg (ovulate) during a menstrual cycle (anovulation), your body doesn't produce the hormone progesterone, as it would during a normal menstrual cycle. This leads to hormone imbalance and may result in menorrhagia.

- **Uterine fibroids.** These noncancerous (benign) tumors of the uterus appear during your childbearing years. Uterine fibroids may cause heavier than normal or prolonged menstrual bleeding.

- **Polyps.** Small, benign growths on the lining of the uterus (uterine polyps) may cause heavy or prolonged menstrual bleeding. Polyps of the uterus most commonly occur in women of reproductive age as the result of high hormone levels.

- **Adenomyosis.** This condition occurs when glands from the endometrium become embedded in the uterine muscle, often causing heavy bleeding and painful menses. Adenomyosis is most likely to develop if you're a middle-aged woman who has had children.

- **Intrauterine device (IUD).** Menorrhagia is a well-known side effect of using a nonhormonal intrauterine device for birth control. When an IUD is the cause of excessive menstrual bleeding, you may need to remove it.

- **Pregnancy complications.** A single, heavy, late period may be due to a miscarriage. If bleeding occurs at the usual time of menstruation, however, miscarriage is unlikely to be the cause. An ectopic pregnancy — implantation of a fertilized egg within the fallopian tube instead of the uterus — also may cause menorrhagia.

- **Cancer.** Rarely, uterine cancer, ovarian cancer and cervical cancer can cause excessive menstrual bleeding.

- **Inherited bleeding disorders.** Some blood coagulation disorders — such as von Willebrand's disease, a condition in which an important blood-clotting factor is deficient or impaired — can cause abnormal menstrual bleeding.

- **Medications.** Certain drugs, including anti-inflammatory medications and anticoagulants, can contribute to heavy or prolonged menstrual bleeding.

- **Other medical conditions.** A number of other medical conditions, including pelvic inflammatory disease (PID), thyroid problems, endometriosis, and liver or kidney disease, may be associated with menorrhagia.

Menorrhagia is most often due to a hormone imbalance that causes menstrual cycles
without ovulation. In a normal cycle, the release of an egg from the ovaries stimulates the body's production of progesterone, the female hormone most responsible for keeping periods regular. When no egg is released, insufficient progesterone can cause heavy menstrual bleeding.

Menstrual cycles without ovulation (anovulatory cycles) are most common among two separate age groups:

- **Adolescent girls who have recently started menstruating.** Girls are especially prone to anovulatory cycles in the first year after their first menstrual period (menarche).
- **Older women approaching menopause.** Women ages 40 to 50 are at increased risk of hormonal changes that lead to anovulatory cycles.

Excessive or prolonged menstrual bleeding can lead to other medical conditions, including:

- **Iron deficiency anemia.** In this common type of anemia, your blood is low in hemoglobin, a substance that enables red blood cells to carry oxygen to tissues. Low hemoglobin may be the result of insufficient iron.

  Menorrhagia may decrease iron levels enough to increase the risk of iron deficiency anemia. Signs and symptoms include pale skin, weakness and fatigue. Although diet plays a role in iron deficiency anemia, the problem is complicated by heavy menstrual periods.

  Most cases of anemia are mild, but even mild anemia can cause weakness and fatigue. Moderate to severe anemia can also cause shortness of breath, rapid heart rate, lightheadedness and headaches.

- **Severe pain.** Along with heavy menstrual bleeding, you might have painful menstrual cramps (dysmenorrhea). Sometimes the cramps associated with menorrhagia are severe enough to require prescription medication or a surgical procedure.

If your periods are so heavy that they limit your lifestyle, make an appointment with your doctor or other health care provider.

Here's some information to help you prepare for your appointment and know what to expect from your provider.

**What you can do**

To prepare for your appointment:

- **Ask if there are any pre-appointment instructions.** Your doctor may ask you to track your menstrual cycles on a calendar, noting how long they last and how heavy the bleeding is.

- **Write down any symptoms you're experiencing,** and for how long. In addition to the frequency and volume of your periods, tell your doctor about other symptoms that
typically occur around the time of your period, such as breast tenderness, menstrual cramps or pelvic pain.

- **Write down key personal information**, including any recent changes or stressors in your life. These factors can affect your menstrual cycle.

- **Make a list of your key medical information**, including other conditions for which you're being treated and the names of medications, vitamins or supplements you're taking.

- **Write down questions to ask your doctor**, to help make the most of your time together.

For menorrhagia, some basic questions to ask your doctor include:

- Are my periods abnormally heavy?
- Do I need any tests?
- What treatment approach do you recommend?
- Are there any side effects associated with these treatments?
- Will any of these treatments affect my ability to become pregnant?
- Are there any lifestyle changes I can make to help manage my symptoms?
- Could my symptoms change over time?

Don't hesitate to ask any other questions that occur to you during your appointment.

**What to expect from your doctor**

Your doctor is likely to ask you a number of questions, such as:

- When did your last period start?
- At what age did you begin menstruating?
- How have your periods changed over time?
- Do you experience breast tenderness or pelvic pain during your menstrual cycle?
- How long do your periods last?
- How frequently do you need to change your tampon or pad when you're menstruating?
- Do you experience severe cramping during your period?
- Do you experience fatigue during your period?
- How much do you exercise?
- Has your body weight recently changed?
- Have you recently experienced significant stress or emotional difficulty?
- Are you sexually active?
- Are you using any type of birth control?
Do you have a family history of bleeding disorders?

Do your symptoms limit your ability to function? For example, have you ever had to miss school or work because of your period?

Are you currently being treated or have you recently been treated for any other medical conditions?

**What you can do in the meantime**

While you wait for your appointment, check with your family members to find out if any relatives have been diagnosed with bleeding disorders. In addition, start jotting down notes about how often and how much you bleed over the course of each month. To track the volume of bleeding, count how many tampons or pads you saturate during an average menstrual period.

Your doctor will most likely ask about your medical history and menstrual cycles. You may be asked to keep a diary of bleeding and nonbleeding days, including notes on how heavy your flow was and how much sanitary protection you needed to control it.

Your doctor will do a physical exam and may recommend one or more tests or procedures such as:

- **Blood tests.** A sample of your blood may be evaluated for iron deficiency (anemia) and other conditions, such as thyroid disorders or blood-clotting abnormalities.
- **Pap test.** In this test, cells from your cervix are collected and tested for infection, inflammation or changes that may be cancerous or may lead to cancer.
- **Endometrial biopsy.** Your doctor may take a sample of tissue from the inside of your uterus to be examined by a pathologist.
- **Ultrasound scan.** This imaging method uses sound waves to produce images of your uterus, ovaries and pelvis.

Based on the results of your initial tests, your doctor may recommend further testing, including:

- **Sonohysterogram.** During this test, a fluid is injected through a tube into your uterus by way of your vagina and cervix. Your doctor then uses ultrasound to look for problems in the lining of your uterus.
- **Hysteroscopy.** This exam involves inserting a tiny camera through your vagina and cervix into your uterus, which allows your doctor to see the inside of your uterus.

Doctors can be certain of a diagnosis of menorrhagia only after ruling out other menstrual disorders, medical conditions or medications as possible causes or aggravations of this condition.

Specific treatment for menorrhagia is based on a number of factors, including:

- Your overall health and medical history
The cause and severity of the condition
Your tolerance for specific medications, procedures or therapies
The likelihood that your periods will become less heavy soon
Your future childbearing plans
Effects of the condition on your lifestyle
Your opinion or personal preference

Drug therapy for menorrhagia may include:

- **Iron supplements.** If you also have anemia, your doctor may recommend that you take iron supplements regularly. If your iron levels are low but you’re not yet anemic, you may be started on iron supplements rather than waiting until you become anemic.

- **Nonsteroidal anti-inflammatory drugs (NSAIDs).** NSAIDs, such as ibuprofen (Advil, Motrin IB, others) or naproxen (Aleve), help reduce menstrual blood loss. NSAIDs have the added benefit of relieving painful menstrual cramps (dysmenorrhea).

- **Tranexamic acid.** Tranexamic acid (Lysteda) helps reduce menstrual blood loss and only needs to be taken at the time of the bleeding.

- **Oral contraceptives.** Aside from providing birth control, oral contraceptives can help regulate menstrual cycles and reduce episodes of excessive or prolonged menstrual bleeding.

- **Oral progesterone.** When taken for 10 or more days of each menstrual cycle, the hormone progesterone can help correct hormone imbalance and reduce menorrhagia.

- **The hormonal IUD (Mirena).** This intrauterine device releases a type of progestin called levonorgestrel, which makes the uterine lining thin and decreases menstrual blood flow and cramping.

If you have menorrhagia from taking hormone medication, you and your doctor may be able to treat the condition by changing or stopping your medication.

You may need surgical treatment for menorrhagia if drug therapy is unsuccessful. Treatment options include:

- **Dilation and curettage (D&C).** In this procedure, your doctor opens (dilates) your cervix and then scrapes or suctions tissue from the lining of your uterus to reduce menstrual bleeding. Although this procedure is common and often treats acute or active bleeding successfully, you may need additional D&C procedures if menorrhagia recurs.

- **Uterine artery embolization.** For women whose menorrhagia is caused by fibroids, the goal of this procedure is to shrink any fibroids in the uterus by blocking the uterine arteries and cutting off their blood supply.

During uterine artery embolization, the surgeon passes a catheter through the large artery in the thigh (femoral artery) and guides it to your uterine arteries, where the
blood vessel is injected with microspheres made of plastic.

- **Focused ultrasound ablation.** Similar to uterine artery embolization, focused ultrasound ablation treats bleeding caused by fibroids by shrinking the fibroids. This procedure uses ultrasound waves to destroy the fibroid tissue. There are no incisions required for this procedure.

- **Myomectomy.** This procedure involves surgical removal of uterine fibroids. Depending on the size, number and location of the fibroids, your surgeon may choose to perform the myomectomy using open abdominal surgery, through several small incisions (laparoscopically), or through the vagina and cervix (hysteroscopically).

- **Endometrial ablation.** Using a variety of techniques, your doctor permanently destroys the lining of your uterus (endometrium). After endometrial ablation, most women have much lighter periods. Pregnancy after endometrial ablation can put your health at risk — if you have an endometrial ablation, you should use reliable or permanent contraception until menopause.

- **Endometrial resection.** This surgical procedure uses an electrosurgical wire loop to remove the lining of the uterus. Both endometrial ablation and endometrial resection benefit women who have very heavy menstrual bleeding. Pregnancy isn't recommended after this procedure.

- **Hysterectomy.** Hysterectomy — surgery to remove your uterus and cervix — is a permanent procedure that causes sterility and ends menstrual periods. Hysterectomy is performed under anesthesia and requires hospitalization. Additional removal of the ovaries (bilateral oophorectomy) may cause premature menopause.

Except for hysterectomy, these surgical procedures are usually done on an outpatient basis. Although you may need a general anesthetic, it's likely that you can go home later on the same day.

When menorrhagia is a sign of another condition, such as thyroid disease, treating that condition usually results in lighter periods.

**References**


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Original article: http://www.mayoclinic.org/diseases-conditions/menorrhagia/basics/definition/con-20021959

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