INDIAN HEALTH SERVICE
National Pharmacy and Therapeutics Committee
Formulary Brief: *Abnormal Uterine Bleeding*
-August 2026-

Background:

The Indian Health Service (IHS) National Pharmacy and Therapeutics Committee (NPTC) provided a review of Abnormal Uterine Bleeding (AUB) and therapeutic agents, focusing on updated treatment guidelines from the American College of Obstetrics and Gynecology (ACOG) and the International Federation of Gynecology and Obstetrics (FIGO).[1-6] Medications on the IHS National Core Formulary (NCF) relevant to this condition include medroxyprogesterone acetate, levonorgestrel IUD, progestins, depot medroxyprogesterone (IM and SC), and several nonsteroidal anti-inflammatory drugs. Following clinical review and analysis, the NPTC made **no modifications** to the NCF.

Discussion:

One third of outpatient visits to gynecologists are for abnormal uterine bleeding.[1] FIGO-AUB System 1 defines normal duration of menstrual flow as eight days or less and normal cycle frequency as 24-38 days.[3] Terms used to describe bleeding patterns include frequency, regularity, duration, volume, and intermenstrual bleeding. Heavy menstrual bleeding (previously known as *menorrhagia*) is defined as excessive menstrual blood loss which interferes with the patient's physical, social, emotional and/or material quality of life.

FIGO System 2 uses the PALM–COEIN classification to categorize causes of AUB.[3] PALM represents structural causes: polyp (AUB-P), adenomyosis (AUB-A), leiomyoma (AUB-L), and malignancy and hyperplasia (AUB-M). COEIN represents nonstructural causes: coagulopathy (AUB-C), ovulatory dysfunction (AUB-O), endometrial (AUB-E), iatrogenic (AUB-I), and not otherwise classified (AUB-N). Ovulatory dysfunction ranges from amenorrhea to irregular heavy periods related to unopposed estrogen. Iatrogenic causes include medications such as anticoagulants/antiplatelet agents and hormonal therapies, as well as devices such as copper intrauterine devices (IUD).

The diagnosis of AUB requires a thorough history including menstrual cycle, personal or family history of bleeding, medication review, physical examination, laboratory studies, and imaging as appropriate. Lab testing should include pregnancy testing in reproductive-aged patients and a complete blood count. Additional testing as appropriate may include iron studies, coagulation studies, endocrine testing, and sexually transmitted infections screening. Age-appropriate cancer screening should also be completed. Endometrial sampling should be performed as a first-line test in patients older than 45 years with AUB. In younger patients, sampling should be considered with persistent AUB, failed medical management, or risk factors for unopposed estrogen exposure (e.g., obesity or Polyendocrine Metabolic Ovarian Syndrome [PMOS]).[1,2] Most patients with postmenopausal bleeding should undergo initial evaluation with transvaginal ultrasonography and endometrial tissue sampling, with gynecologic evaluation/referral as clinically appropriate.[7]

For acute AUB in the emergency or acute care setting, rapidly assess hypovolemia and hemodynamic instability, stabilize the patient, and initiate medical treatment when clinically appropriate.[2] Medical management options include intravenous conjugated estrogen, multidose combined oral contraceptives, multidose oral progestins, and tranexamic acid (TXA). Providers are advised to refer to the U.S. Medical Eligibility Criteria (MEC) for Contraceptive Use when considering therapy with hormones[9]. One studied oral regimen is a monophasic combined oral contraceptive containing norethindrone 1 mg/ethinyl estradiol 35 mcg, one tablet three times daily for 7 days, followed by one tablet daily for 3 weeks.[8] High-dose estrogen-containing regimens may cause nausea; an antiemetic may be considered as needed. If estrogen is contraindicated, one studied regimen is medroxyprogesterone acetate 20 mg three times daily for 7 days, followed by 20 mg once daily for 3 weeks.[8] A non-hormonal option for patients who desire fertility or prefer to avoid hormonal therapy is TXA. Urgent procedural or surgical management should be considered in patients who are clinically unstable, are not candidates for medical therapy, or fail to respond adequately to medical management.[2]

For AUB due to structural causes (i.e., "PALM"), referral to Gynecology and surgical management may be indicated. For chronic AUB in patients who desire contraception, the 52mg levonorgestrel (LNG) IUD is a highly effective long-term medical treatment for heavy menstrual bleeding (HMB). The 52mg LNG IUD is FDA approved for treatment of HMB for up to five years and for contraception for up to eight years.[10] Patients may experience irregular bleeding for the first 3-6 months, 50% experience amenorrhea after one year and 60% at five years.[4] If regulation of menstrual cycle is preferred, combined hormonal contraception (e.g., pill, patch, ring) can be used. If estrogen is contraindicated per the MEC, oral progestins can be taken with cyclic or continuous use and strict daily adherence. Depot medroxyprogesterone 150 mg IM or 104 mg SQ can be used with a 68-71% amenorrhea rate at two years.[4] If a non-hormonal method is preferred, TXA can be given orally 1300 mg three times daily for up to 5 days during menstruation with a 30-55% reduction in

bleeding.[2] Dose reduction is required in patients with renal impairment; refer to prescribing information for renal-function-based dosing.[11] Use is contraindicated with concomitant use of combined hormonal contraceptives and in patients with active thromboembolic disease or a history/intrinsic risk of thrombosis. Nonsteroidal anti-inflammatory drugs (NSAIDs) can reduce menstrual blood loss and are particularly useful when dysmenorrhea is present. The 68-mg etonogestrel implant may improve dysmenorrhea but commonly causes irregular bleeding; approximately 22% of users achieve amenorrhea.[4] Iron deficiency and iron-deficiency anemia should be treated with appropriate iron replacement, with laboratory monitoring to document hematologic response and iron repletion.

Findings:

1. Evaluation of abnormal uterine bleeding requires a thorough history including menstrual cycle and identification of etiology.
2. Treatment options depend on the patient's clinical goals: If long-term treatment and contraception are desired, consider the 52mg levonorgestrel IUD. If cycle regulation is desired, consider combined hormonal contraception. If estrogen is contraindicated by the U.S. Medical Eligibility Criteria for Contraceptive Use, consider progestins and depot medroxyprogesterone. If contraception is not desired or a nonhormonal option is preferred, consider tranexamic acid. If relief of dysmenorrhea is desired, consider NSAIDs.
3. Most patients with postmenopausal bleeding should undergo initial evaluation with transvaginal ultrasonography and endometrial tissue sampling, with gynecologic evaluation/referral as clinically appropriate.

If you have any questions regarding this document, please contact the NPTC at IHSNPTC1@ihs.gov . For more information about the NPTC, please visit the NPTC website.

References:

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