

Original Article

# Clinical Practice Guideline for Abnormal Uterine Bleeding: Hysterectomy versus Alternative Therapy

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**ABSTRACT** **Study Objective:** To develop recommendations in selecting treatments for abnormal uterine bleeding (AUB).

**Design:** Clinical practice guidelines.

**Setting:** Randomized clinical trials compared bleeding, quality of life, pain, sexual health, satisfaction, the need for subsequent surgery, and adverse events between hysterectomy and less-invasive treatment options.

**Patients:** Women with AUB, predominantly from ovulatory disorders and endometrial causes.

**Interventions:** On the basis of findings from a systematic review, clinical practice guidelines were developed. Rating the quality of evidence and the strength of recommendations followed the Grades for Recommendation Assessment, Development, and Evaluation system.

**Measurements and Main Results:** This paper identified few high-quality studies that directly compared uterus-preserving treatments (endometrial ablation, levonorgestrel intrauterine system and systemically administered medications) with hysterectomy. The evidence from these randomized clinical trials demonstrated that there are trade-offs between hysterectomy and uterus-preserving treatments in terms of efficacy and adverse events.

**Conclusion:** Selecting an appropriate treatment for AUB requires identifying a woman's most burdensome symptoms and incorporating her values and preferences when weighing the relative benefits and harms of hysterectomy versus other treatment options. Journal of Minimally Invasive Gynecology (2012) 19, 81–88 © 2012 AAGL. All rights reserved.

**Keywords:** Endometrial ablation; Guideline for uterine bleeding; Hysterectomy; Medical treatment; Levonorgestrel-releasing intrauterine system

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Annually, 5% to 10% of women of reproductive age seek medical care for abnormal uterine bleeding (AUB), which negatively impacts quality of life (QoL) [1]. Most women with AUB report that their leisure activities are at least mod-

erately affected by their bleeding [2]. Compared with women without AUB, women with AUB work almost 4 fewer weeks per year in the United States [3]. Approximately 600 000 hysterectomies are performed annually in

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**Table 1**

Categorization of quality of evidence and balance of potential benefits and harms

Quality of evidence	
High	Further research is unlikely to change the confidence in the estimate of the effect
Moderate	Further research is likely to have an important impact on the confidence in the estimate of effect and may change the estimate
Low	Further research is very likely to have an important impact on the confidence in the estimate of effect and is likely to change the estimate
Very low	Any estimate of effect is very uncertain
Balance of potential benefits and harms	
Net benefits	The intervention clearly does more good than harm
Trade-offs	There are important trade-offs between the benefits and harms
Uncertain trade-offs	It is not clear whether the intervention does more good than harm
No net benefits	The intervention clearly does not do more good than harm

the United States, and many of these are performed to treat AUB [4]. AUB has several causes [5], but for patients with AUB caused by ovulatory disorders (AUB-O) or endometrial hemostatic disorders (AUB-E) uterine-preserving treatments include endometrial ablation, levonorgestrel releasing intra-uterine system (LNG-IUS), and systemically administered medical management (which includes numerous medical therapy options).

Deciding who may benefit from less-invasive options and who would benefit from an expeditious hysterectomy could optimize patient care and health care efficiency. The Society for Gynecologic Surgeons (SGS) Systematic Review Group (SRG) set out to develop a clinical practice guideline to assist health care providers in delivering evidence-based counseling about the relative advantages and disadvantages of various treatment options for women with AUB predominately from ovulatory disorders (AUB-O) or endometrial causes (AUB-E) who would consider having a hysterectomy. These clinical practice guidelines are based on a systematic review of the literature [6].

## Materials and Methods

The SRG includes SGS members with clinical and surgical expertise and methods consultants with expertise in the conduct of systematic reviews and guideline development [7]. For recommendations on treatment of AUB, in women with either AUB-O or AUB-E, the SGS-SRG conducted a systematic review of trials for AUB that included hysterectomy as one of the treatment assignments. The full description of methods and findings of this systematic review can be found in the companion publication to this guideline [6]. Briefly, a literature search was performed in Medline (inception to January 14, 2011) for randomized controlled trials comparing hysterectomy with other treatments for premenopausal women with AUB. We included RCTs that compared hysterectomy (via any route) to endometrial ablation, LNG-IUS, or systemically administered medical therapies as treatments of AUB caused by presumed ovulatory

disorders or disorders of endometrial hemostasis (AUB-O and AUB-E) and reported an outcome of interest. We excluded RCTs that included only participants with AUB attributed to fibroids (AUB-L).

In the process of reviewing eligible randomized trials for AUB-O and AUB-E, the SGS-SRG identified numerous reported clinical outcomes that were categorized into 7 groups: (1) bleeding; (2) quality of life; (3) pain; (4) sexual health; (5) patient satisfaction; (6) need for additional treatments; and (7) adverse events. The importance of each outcome for clinical decision making was determined by consensus in the SGS-SRG [8]. The systematic review for this guideline included only outcomes of critical or high importance. In each study, the methodologic quality of the data for each outcome was scored as good, fair, or poor.

To grade the overall quality of evidence and the strength of the recommendations, we followed the Grades for Recommendation, Assessment, Development and Evaluation system [9]. For each set of studies evaluating a given treatment comparison, we graded the quality of evidence for each specific outcome across studies, including methodologic quality, consistency across studies, directness of evidence, and other factors such as imprecision or sparseness of evidence. We then evaluated the balance between benefits and harms of the given treatments and assessed the overall quality of evidence across all outcomes of interest (Table 1).

Guideline recommendations were assigned a grade for the strength of the recommendation on the basis of the quality of the supporting evidence, the size of the net medical benefit, and other considerations including values and preferences applied in judgments.

The strength of a recommendation indicates the extent to which one can be confident that adherence to the recommendation will do more good than harm. For this guideline, we graded the strength of each recommendation as either "strong" or as "weak." The wording and its implications for patients, physicians, and policy makers are detailed in Table 2. This system differs from the 3-level system used in the previous SGS guideline on vaginal repair of pelvic

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