Original Article

PATIENT SATISFACTION WITH MIRENA IN PATIENTS AGED 35 TO 45 WITH HEAVY MENSTRUAL BLEEDING REFERRED TO MARDAN MEDICAL COMPLEX FROM JAN 2014 TO DEC 2016

Hemasa Gul[1], Nuzhat Amin[1], Muhammad Hussain[2]

[1]Department of Gynecology, Bacha Khan Medical College, Mardan, Pakistan

[2]Department of Surgery, Bacha Khan Medical College, Mardan, Pakistan

ABSTRACT

Background: *Less blood loss in menstrual cycles builds a woman's perception of gravity and indicates an influence on their judgment about treatment success. Many of the world's women are fed up with undergoing surgery and less satisfied with the medical treatment of HMB. Mirena provides a non-surgical alternative, which is reversible and fertility-sparing. The study's primary aim was to determine the satisfaction level of women using Mirena within the reproductive age of 35-45 years.*

Methods: *A total of 50 patients with mirena induction were included in the study. Women less than 35 and above 45 years of age, with a uterus larger than 12 weeks, those with pelvic inflammatory disease, and women with implants other than Mirena were excluded from the study. The women were inspected for the principal complaints, duration of complaints, and ultrasound findings. The satisfaction level was assessed for all patients using Mirena with symptoms controlling, like blood reduction.*

Results: *The study constituted a total of 50 females ranging from 35 to 45 years old. The majority of them were aged 35-40 years. The use of the Mirena technique has subsequently not only reduced the heavy menstrual blood loss but also controlled symptoms like Amenorrhea and spotting. The satisfaction level of the women using it is very high. These women highly recommended the option to other women.*

Conclusion: *Mirena is an effective treatment option for HMB among women 35-45. It achieved high satisfaction of patients after insertion.*

Keywords: *Mirena, Amenorrhea, spotting, satisfaction level, Quality of life*

INTRODUCTION

Heavy menstrual bleeding (HMB) is defined as excessive menstrual blood loss and is a common problem [1] among women with the age between 35-45 years. Almost 1.5 million women are affected by HMB in England and Wales.[2] The HMB condition causes women of reproductive age to consult gynecologists and GPs. This might be one of the leading reasons for distress among women as it affects their social life, social activity, and, more importantly, performance at work. HMB also leads to a measurable reduction in Quality of life (QoL). [3] The definitive cause for HMB is not found yet; this condition is also labeled as dysfunctional uterine bleeding (DUB).[4] The less blood loss in menstrual cycles builds a woman's perception of gravity and indicates an influence on their judgment about treatment success.[5] Many of the world's women are fed up with undergoing surgery and less satisfied with the medical treatment of HMB.[6] Hysterectomy was and is the most popular surgical treatment for HMB.[7] But it has many side effects on women's health. In the recent past, a second generation of nonhysteroscopic techniques has become available. These techniques are easy to perform, including device siting

Correspondence:
Hemasa Gul
Specialist Registrar
Department of Gynecology, Bacha Khan Medical College, Mardan, Pakistan
Cell: 0300-5952933
Email: hemasadr@hotmail.com
Date Received: Jan-17-2020
Date Accepted: Feb-18-2020
Date Revised: Mar-28-2020
Available Online: April-05-2020

and activation like Mirena. The under-study technique to control HMB, Mirena, provides an anon-surgical alternative, which is reversible and fertility-sparing.[8] The study's primary aim was to determine the satisfaction level of women using Mirena within the reproductive age of 35-45 years.

MATERIAL AND METHODS

This was an observational study where 50 patients were enrolled during one year starting from January 2014. The study venue was the patients' department (OPD), Mardan Medical Complex. The exclusion criteria include women less than 35 and above 45 years of age, a uterus size larger than 12 weeks, pelvic inflammatory disease, and women with other implants than Mirena. The women were inspected for the principal complaints, duration of complaints, and ultrasound findings. Complete blood count, thyroid stimulating hormone (TSH) levels, and pap smear, if carried out, were noted down. The date of insertion for Mirena and other histopathology results were recorded. A proper follow-up was maintained at 3, 6, and 12 months. The satisfaction level was assessed for all patients with symptoms controlling, like blood loss reduction.

Statistical analysis: All the collected data was stored electronically & analyzed later by using SPSS version 20. Descriptive statistics were applied to calculate the mean and standard deviation. Frequency distribution and percentages were calculated for qualitative variables. Over a P, a value less than 0.05 was considered statistically significant.

RESULTS

The study constitutes 50 females with a mean age of 40 ± 4.5 years, ranging from 35 to 45 years. 35 (70%) females were aged 35-40, whereas 15 (30%) were 41-45. Symptomatic relief post-treatment was summarized in Table 1. 80% of the women were with Menorrhagia, 10% with Menorrhagia and dysmenorrhea, 8% with menometrorrhagia, and 2% with post-menopausal bleeding. The post-treatment evaluation was made at different durations for indicative relief and summarized in Table 1: The satisfaction level of all the women with Mirena was high, as shown in Table 2.

Overall, 85% of all the women recommended that other women use Mirena as they were highly satisfied with the usage. The dismissal rate was 6%, constituting one patient during the first month of insertion, one within thirteen, and one within 12 months of insertion. High dismissal rates were observed in women with thick endometrium.

DISCUSSION

In peri-menopausal and reproductive-age women, heavy menstrual bleeding (HMB) is a very common and serious issue. Pathologies like fibroids, adenomyosis, and endometriosis are the major causes of HMB. Literature reports that HMB affects the quality of life, and in several females, this situation leads to hysterectomy. The side effects of hysterectomy are well-known and enormous. The insertion of Mirena (as a treatment option) is very effective and controlled in published literature.[9,10] It reduced the blood loss comparably less to any other drug or treatment.[11] In our study, we report that most women belong to reproductive age

Table 1: Symptoms after Mirena insertion

Symptoms	Three months	Six months	Twelve months	P value
Bleeding reduced	13(26%)	23(46%)	30(60%)	0.003*
Heavy bleeding	10(20%)	4(8%)	1(2%)	0.009*
Amenorrhea	1(2%)	6(12%)	8(16%)	0**
Spotting	30(60%)	15(30%)	9(18%)	0.004*

Table 2: Satisfaction scores for post treatment with Mirena

Findings	Satisfaction score	P-value
Fibroids (n=11)	72%	0.01
Adenomyosis (n=11)	80%	0.01
Endometriosis (n=6)	70%	0.6
thick endometrium (n=12)	58%	0.03
Normal findings (n=13)	80%	0.45

(35-40 years), and HMB is the most common among them. This may indicate the need for a less effective treatment option other than a hysterectomy. We report in our study almost half of the women with fibroids and adenomyosis. The HMB, or heavy blood loss, was a major symptom among all women. We also observed a very low number of women with dysmenorrhea. These two situations were majorly involved with heavy blood loss. Similar results were found in other studies. [12] This requires medical help and a better mode of treatment to prevent blood loss. Many women suffered from HMB for almost one year before presenting to a doctor in the Outpatient department (OPD). Several among them use conservative methods, including hormones, but no relief. Various studies show that women using Mirena were likely to have less menstrual blood loss after insertion.[13]

The use of Mirena resulted in the achievement of oligomenorrhea during one year in almost 95% of the females in Menorrhagia due to fibroids.[14,15] In our study, predominant symptoms, like spotting, decreased a year after Mirena insertion. Other symptoms are reduced to a minimal level or controlled by achieving Amenorrhea due to Mirena. The overall satisfaction level for the women using Mirena is quite expressive and high. Other studies reported similar results.[14] These were the ones who highly recommend this treatment modality to other women. We present a small number of patients with an expulsion rate after insertion. It is more frequent in women with thick endometrium. Interestingly, expulsion or removal was not found to be related to uterine pathology. The study's results recommend using Mirena in patients with HMB with greater satisfaction rates from the understudy population. The use is also safe with limited side effects. It proved itself a good replacement for other surgical or complex hormonal treatments and surgical procedures.

CONCLUSION

Mirena is an effective treatment option for HMB among women 35-45 years of age. It achieved high satisfaction of patients after insertion.

REFERENCES

1. Abbott J, Hawe J, Hunter D, Garry R. A double-masked randomized trial comparing the Cavaterm and the NovaSure endometrial ablation systems for treating dysfunctional uterine bleeding. FertilSteril2003;80:203–8.
2. Aberdeen Endometrial Ablation Trials Group. A randomized trial of endometrial ablation versus hysterectomy for the treatment of dysfunctional uterine bleeding: outcome at four years. Br J ObstetGynaecol1999;106:360–6.
3. Coulter A, Peto V, Jenkinson C. Quality of life and patient satisfaction following treatment for Menorrhagia. FamPract1994;11:394–401.
4. Lethaby A, Hickey M. Endometrial destruction techniques for heavy menstrual bleeding.Cochrane Database Syst Rev 2002;2:CD001501.
5. Fraser IS, McCarron G, Markham R. A preliminary study of factors influencing the menstrual blood loss volume perception. Am J ObstetGynecol1984;149:788–93.
6. Lethaby A, Farquhar C. Treatments for heavy menstrual bleeding. BMJ 2003;327:1243–4.
7. Maresh MJ, Metcalfe MA, McPherson K, Overton C, Hall V, Hargreaves J, et al. The VALUE national hysterectomy study: description of the patients and their surgery. BJOG 2002;109:302–12.
8. Lethaby AE, Cooke I, Rees M. Progesterone or progestogen-releasing intrauterine systems for heavy menstrual bleeding. Cochrane Database Syst Rev 2005;4:CD002126.
9. Stewart A, Cummins C, Gold L, Jordan R, Phillips W. The effectiveness of the levonorgestrel-releasing intrauterine system in Menorrhagia: A systematic review. BJOG. 2001;108:74–86.
10. Desai RM. Efficacy of levonorgestrel-releasing intrauterine system for the treatment of Menorrhagia due to benign uterine lesions in perimenopausal women. J Midlife Health. 2012;3:20–3.
11. Farquhar CM. Management of dysfunctional uterine bleeding. Drugs. 1992;44:578–84.
12. Robinson R, China S, Bunkheila A, Powell M. Mirena intrauterine system in treating menstrual disorders: A survey of UK patients' experience, acceptability, and satisfaction. J ObstetGynaecol. 2008;28:728–31.
13. Zapata LB, Whiteman MK, Tepper NK, Jamieson DJ, Marchbanks PA, Curtis KM. Intrauterine device use among women with uterine fibroids: A systematic review. Contraception. 2010;82:41–55.
14. Sokolov D, Blidaru I, Tamba B, Miron N, Boiculese L, Socolov R. Levonorgestrelreleasingintrauterine system for the treatment of Menorrhagia and frequent irregular uterine bleeding associated with uterine leiomyoma. Eur J ContraceptReprod Health Care. 2011;16:480–7.
15. Haimovich S, Checa MA, Mancebo G, Fusté P, Carreras R. Treatment of endometrial hyperplasia without atypia in peri and postmenopausal women with a levonorgestrel intrauterine device. Menopause. 2008;15:1002–4.