

Standardizing the descriptive terminology of abnormal menstrual bleeding: it is time we talk the same talk

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The movement towards international standardization of the terminology used to describe abnormal uterine bleeding and of the definition that sets the boundaries of normal menstrual bleeding will greatly benefit clinicians and researchers. (*Fertil Steril*® 2007;87:477–8. ©2007 by American Society for Reproductive Medicine.)

The authors and their collaborators should be applauded for their work that finally provides clarity to the confusing terminology that has been used for years to describe abnormal uterine bleeding. This is direly needed, because abnormal uterine bleeding is one of the most common reasons a woman presents to her gynecologist. After a patient presents with this complaint the first decision that the physician has to make is whether the amount, duration, and/or timing of the bleeding is out of the norm, but to date, there is no such standard in place to judge what bleeding should be considered normal or abnormal. To further add to the confusion about the terminology there are 11 different diagnoses in the ICD-9-CM manual that describe some type of abnormal uterine bleeding. Most clinicians do not have time to review all of the diagnostic terms for each individual patient, so many patients are labeled as having menorrhagia or dysfunctional uterine bleeding. A standard definition that describes the boundaries of normalcy and a refinement in the descriptive diagnostic terms would be of great benefit to clinical medicine. The other benefit of standardization of the terminology is in the realm of research. Standardization will allow researchers to succinctly define the study group that is being investigated. Uniformity would result in better interpretation of the data, and would also allow similar clinical trials to be compared so more substantive conclusions can be drawn. As emphasized by the authors, the end result of all of this is better patient care.

The authors set out to accomplish an ambitious feat—to develop a clinical standard that would be accepted globally. To develop a standard, one needs to first bring together a group of experts that provide a resource of knowledge. To this end they assembled a group of 35 experienced clinicians and scientists from around the world. The other required element to achieve a workable standard is that a legitimate

process needs to be in place to develop consensus among the panel of experts. The study group utilized the modified Delphi technique, which is a formal group consensus method. The Delphi technique was first described in the 1950s, and has been used in the study of issues in public policy, science, and technology, and in the business field. The process starts with an open questionnaire given to a group of experts in a selected area. With subsequent rounds the participants are asked to rate the relative importance on specific items. Following feedback to the participants and subsequent rounds, consensus is finally developed. Group consensus development has been important in developing medical guidelines for the treatment of HIV, gynecologic cancers, and in other medical specialties such as cardiology. The importance of group processes for the establishment of consensus was the topic of a recent publication by the World Health Organization Advisory Committee on Health Research (1).

The authors set out initially to develop a consensus on terminologies and definitions of uterine bleeding. They focused on three commonly used terms—abnormal uterine bleeding, menorrhagia, and dysfunctional uterine bleeding. The initial survey of the participants provided concrete evidence about the confusion over these terms. There was no absolute agreement whether these terms were considered a symptom, diagnosis, or a descriptive term. The largest discrepancy was over the meaning of dysfunctional uterine bleeding (DUB)—59% felt it was a diagnostic term, 33% felt that it could be considered a diagnosis or a descriptive term, and the remaining 8% viewed it as a sign or symptom but not a diagnosis. Although there was divergence in opinions, the Delphi technique brought order to the confusion, and the consensus was to drop the terms menorrhagia and DUB.

The second accomplishment of the study group was to start the development of a framework to describe the boundaries of normal menstrual bleeding. There was agreement that four key terms would be used to characterize normal and abnormal bleeding, including frequency of menses, regularity of menses, duration of flow, and volume of monthly blood

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loss. A normal range for each term was established based on previous studies. Although the first three key terms can be accurately measured, the authors do take note that the amount of blood loss perceived by any woman is highly subjective. Previous studies have confirmed that the perceived loss of menstrual blood is many times not correlated with actual blood loss (2,3). In a prior study the actual loss was better correlated with poor iron status, the size of the clots, the rate of change, and the total number of sanitary products used during the menses (3). Therefore, one cannot rely solely on the patient's perception of her degree of blood loss. Rather, a detailed history along with laboratory testing to rule out anemia is necessary to adequately assess the degree of menstrual bleeding.

In conclusion, there are two significant achievements from this group's work—refinement of the terms used to describe

abnormal uterine bleeding, and the development of a standard that sets the parameters of normal and abnormal uterine bleeding. I look forward to future investigations that will expand this initial work and take the bold step of classifying the types of abnormal uterine bleeding.

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