

AUB • Abnormal Uterine Bleeding

A plain-English guide for you and your family

WHAT IS HAPPENING

Every month, two hormones work as a team. Estrogen builds the lining inside your uterus (the endometrium)—like stacking fresh layers of tissue. Around day 14, your ovary releases an egg. That egg's empty shell (corpus luteum) starts making progesterone, which locks the lining in place and gets it ready to shed neatly if no pregnancy happens. When both hormones drop, the lining falls away in a controlled bleed—your period. When something breaks that teamwork, bleeding turns chaotic. The most common break is anovulation: your ovary skips releasing an egg, so progesterone never shows up. Estrogen keeps building the lining thicker and more fragile—like stacking wet paper towels that eventually collapse in a messy flood. Growths can also disrupt shedding. A polyp (small bump), fibroid (benign muscle knot), or adenomyosis (lining tissue digging into the muscle wall) warps the surface and tears blood vessels. If you have a blood-clotting problem—like von Willebrand disease, low platelets, or use blood-thinning medicine—even a normal period becomes a flood because your body cannot seal the vessels fast enough. When you lose lots of blood over and over, you run out of iron and red blood cells faster than your bone marrow can replace them, causing anemia (low red-cell count). That is why you feel tired, dizzy, and short of breath—your muscles and brain are not getting enough oxygen. Your heart speeds up to try to push what little oxygen you have around faster, and in severe cases your blood pressure can drop dangerously low (shock). Every symptom traces back to one broken step—no ovulation, a growth, or a clotting problem—so your doctor can fix the root cause, not just patch the bleeding.

What you might feel

- Heavy menstrual bleeding (soaking through one or more pads or tampons every hour, passing clots bigger than a quarter, or losing more than 80 mL per cycle)
- Prolonged menstrual bleeding (periods lasting more than 7 days)
- Intermenstrual bleeding (bleeding between periods)
- Fatigue and weakness
- Shortness of breath with activity (dyspnea on exertion)
- Pale skin and mucous membranes (pallor, especially inside eyelids and under nails)

- Fast heart rate (tachycardia, often above 100 beats per minute at rest)
- Dizziness, lightheadedness, or fainting (syncope)
- Easy bruising, tiny red spots on skin (petechiae), or bleeding from gums or nose
- Pelvic pain or pressure

Call the doctor right away if...

- Fainting, severe dizziness, or blood pressure below 90/60 mmHg — means sudden heavy bleeding has dropped your blood volume so low that your body is going into shock (hypovolemic shock). You need IV fluids, possibly a blood transfusion, and hospital admission right away.
- Any vaginal bleeding more than 12 months after your last period (postmenopausal bleeding) — endometrial cancer until proven otherwise. Requires urgent endometrial biopsy or transvaginal ultrasound within days.
- Hemoglobin below 7 g/dL or severe anemia symptoms (chest pain, shortness of breath at rest, confusion) — your oxygen delivery is dangerously low. Requires blood transfusion and hospital admission.
- Positive pregnancy test with abnormal bleeding — ectopic pregnancy (pregnancy growing outside the uterus, often in a tube) or miscarriage must be ruled out immediately with a blood test (quantitative β -hCG) and ultrasound. An ectopic can rupture and cause life-threatening internal bleeding.
- Bleeding that will not stop despite medicine, or signs your circulation is failing (cold skin, rapid weak pulse, confusion) — may need an emergency procedure: D&C (scraping the lining out), uterine artery embolization (blocking the vessels that feed the uterus), or hysterectomy (removing the uterus).

What the care team will do

- Check vital signs immediately including blood pressure lying down and standing up, heart rate, and oxygen saturation, and repeat every 15 to 30 minutes if bleeding is heavy.
- Start two large-bore IV lines (18-gauge or bigger) and give isotonic crystalloid fluids like normal saline or lactated Ringer solution wide open if the patient shows any signs of shock.
- Draw blood for complete blood count (CBC measures red cells, hemoglobin, and platelets), type and crossmatch (prepares matched blood for transfusion), coagulation studies (PT/INR and aPTT measure clotting ability), and beta-hCG pregnancy test in all women of childbearing age.
- Count and weigh all blood-soaked pads, linens, and clots to measure exact blood loss every hour, and report immediately if the patient soaks through more than one pad per hour.

- Keep the patient on bedrest with the head of the bed flat or legs elevated if blood pressure is low, and help with all movement to prevent falls.
- Administer tranexamic acid 10 mg per kilogram IV over 10 minutes or 1,300 mg by mouth three times daily as ordered, and watch for signs of blood clots like chest pain, leg swelling, or sudden shortness of breath.
- Monitor for signs of worsening anemia including increasing fatigue, worsening shortness of breath, confusion, chest pain, or pale nail beds and inside of eyelids, and notify the provider immediately if any appear.
- Prepare for possible blood transfusion by verifying patient identification matches blood bank labels exactly, staying with the patient for the first 15 minutes of transfusion, and watching for transfusion reactions like fever, chills, back pain, dark urine, or trouble breathing.

Medicines you may be given — and why

First: Stabilize with IV fluids, transfuse packed red blood cells, high-dose IV estrogen or tranexamic acid for acute heavy bleeding. Second: Hormonal control with combined OCPs (birth control pills with estrogen plus progestin), progestin-only therapy, or levonorgestrel IUD (a small T-shaped device placed in the uterus that releases a hormone). Third: Tranexamic acid for ovulatory AUB (abnormal uterine bleeding—heavier or longer periods than normal) with heavy menses. Fourth: NSAIDs (drugs like ibuprofen that block inflammation and pain) reduce menstrual flow by 25 to 35 percent. Fifth: Surgical options include hysteroscopic resection (cutting out problem tissue through the cervix using a thin scope), endometrial ablation (destroying the lining of the uterus), or hysterectomy (removing the uterus). Sixth: Treat iron-deficiency anemia (low red blood cells from losing too much iron in blood) with oral or IV iron.

Every treatment fixes a specific broken step in AUB. Acute heavy bleeding happens when vessels in the uterus lining stay open and pour blood out—tranexamic acid stops the body from breaking down clots (like patching holes in a dam), and high-dose estrogen rapidly thickens the uterine lining so it seals off the bleeding vessels. Anovulation (not releasing an egg each month) means estrogen keeps growing the lining with no progesterone to stabilize it, so the lining gets thick and bleeds irregularly—giving progestin or OCPs mimics a normal cycle and thins the lining. Ovulatory heavy menses (heavy periods even with normal ovulation) are driven by high prostaglandins (chemicals that make vessels leak and the uterus contract hard)—tranexamic acid or NSAIDs block prostaglandins and reduce flow. Structural lesions like fibroids (muscle tumors) or polyps (overgrown tissue bumps) distort the uterus and must be removed surgically. Anemia develops because the gut cannot absorb iron fast enough to

replace what bleeds out every month—giving oral or IV iron refills the tank. Never use one drug for every AUB. Match each treatment to the exact cause: anovulatory versus ovulatory, structural versus functional, acute life-threatening bleeding versus chronic heavy periods.

Where this information comes from

- ACOG Practice Bulletin No. 128: Diagnosis of Abnormal Uterine Bleeding in Reproductive-Aged Women (reaffirmed 2023)
- FIGO Menstrual Disorders Committee: PALM-COEIN Classification System (2018)
- American College of Physicians: Evaluation and Management of Abnormal Uterine Bleeding (2021)
- CDC Heavy Menstrual Bleeding Guidelines (2023)

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