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Clinical Spotlight for Primary Care: Five Things to Know About Women and Girls with Bleeding Disorders

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1. Heavy menstrual bleeding (HMB) may be the first sign of a bleeding disorder.

Although common, HMB is often an underrecognized symptom, and affects up to 39% of individuals diagnosed with a bleeding disorder.[1] Taking a structured medical history is key. Tools such as the Pictorial Blood Assessment Chart[2] and the Menorrhagia Screening Tool[3] can aid in identifying HMB. Screening for iron deficiency, even in the absence of anemia, is essential, as low iron can impact cognition, energy, and quality of life.[4]

2. Bleeding assessment tools (BATs) aid diagnosis but are not definitive.

BATs are useful for identifying individuals who may need further evaluation; however, a normal score does not exclude a bleeding disorder, particularly in those without surgical or obstetrical challenges or in those who have a positive family history.[5] The self-administered BAT (**https://letstalkperiod.ca/self-bat/**) can facilitate early detection. An abnormal score should prompt further clinical assessment.

3. Tranexamic acid is effective for HMB and compatible with hormonal therapy.

Tranexamic acid, an antifibrinolytic agent, is a first-line therapy for HMB. Despite common misconceptions about thrombotic risk, it is safe for use with combined hormonal contraceptives.[4] While it is contraindicated in cases of active thromboembolism, and should be used with caution in those with thrombotic risk factors or prior thrombosis, routine avoidance is unnecessary. Provider unfamiliarity, concerns about off-label use, and access barriers continue to limit its uptake.[4]

4. Routine coagulation tests cannot definitely exclude a bleeding disorder.

Routine tests—such as prothrombin time, activated partial thromboplastin time, fibrinogen levels, and von Willebrand factor levels—may yield normal results, necessitating specialized testing guided by a hemostasis expert. Hemostatic testing must be interpreted in the context of female physiology—pregnancy can elevate factor levels, and hormonal therapies may influence test outcomes.

5. Multidisciplinary care optimizes outcomes.

Effective management of HMB and pregnancy requires collaboration between hematology and obstetrics and gynecology. Both specialties contribute to diagnosis, bleeding risk assessment, and treatment planning. Coordinated care supports fertility planning, pregnancy management, and counselling on fetal bleeding risks, ensuring timely and effective treatment.

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References

1. Comishen KJ, Bhatt M, Yeung K, Irfan J, Zia A, Sidonio RF Jr, James P. Etiology and diagnosis of heavy menstrual bleeding among adolescent and adult patients: a systematic review and meta-analysis of the literature. J Thromb Haemost. 2025;23(3):863-876. doi: 10.1016/j.jtha.2024.11.014.
2. Higham JM, O'Brien PM, Shaw RW. Assessment of menstrual blood loss using a pictorial chart. Br J Obstet Gynaecol. 1990;97(8):734-739. doi: 10.1111/j.1471-0528.1990.tb16249.x.
3. Philipp CS, Faiz A, Dowling NF, Beckman M, Owens S, Ayers C, Bachmann G. Development of a screening tool for identifying women with menorrhagia for hemostatic evaluation. Am J Obstet Gynecol. 2008;198(2):163.e1-163.e1638. doi: 10.1016/j.ajog.2007.08.070.
4. VanderMeulen H, Tang GH, Sholzberg M. Tranexamic acid for management of heavy vaginal bleeding: barriers to access and myths surrounding its use. Res Pract Thromb Haemost. 2024;8(3):102389. doi: 10.1016/j.rpth.2024.102389.
5. Rodeghiero F, Tosetto A, Abshire T, Arnold DM, Coller B, James P, et al. ISTH/SSC bleeding assessment tool: a standardized questionnaire and a proposal for a new bleeding score for inherited bleeding disorders. J Thromb Haemost. 2010;8(9):2063-2065. doi: 10.1111/j.1538-7836.2010.03975.x.