

Promoting Menstrual Wellbeing

Third edition

CLINICAL PROFESSIONAL RESOURCE



Acknowledgements

This publication was originally developed in 2019 by an RCN Womens Health Forum project team. It was reviewed and updated in 2025 by Dr Wendy Norton RCN Fellow, Esther Kuria, Women's Health Forum Committee member and Clare Cook, Patient Blood Management Practitioner.

This document has been designed in collaboration with our members to ensure it meets most accessibility standards. However, if this does not fit your requirements, please contact corporate.communications@rcn.org.uk

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Published by the Royal College of Nursing, 20 Cavendish Square, London, W1G 0RN

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1: Introduction

The onset of menstruation is both a physiological and psychological milestone in a woman's reproductive life. Most females will have their first period between the ages of 10 and 14 (average 12 years) (Hall, 2021), and their periods will continue regularly (usually monthly) until the menopause, which occurs around the age of 51 years in the UK. On average, women have periods for around 40 years of their life, and therefore, menstrual health forms an integral part of wellbeing.

The Women's Health forum is committed to equality, diversity and inclusivity. Whilst using the terms "females" and "women and girls" throughout this document, the RCN also acknowledges that in our gender diverse society, some people who do not necessarily identify as female, may also experience menstruation.

Menstruation is a natural process that women need to feel empowered to talk openly about, yet this aspect of health is often still seen as a taboo subject. Such stigma may result in many girls and women tolerating unnecessary levels of bleeding, pain and other associated symptoms. This can have a significant impact on their lives which can include education and work, family life, social life and general quality of life. Additionally, lack of awareness of the long-term complications of a delayed diagnosis leads to the development of more advanced or complex cases which then become more difficult and expensive to treat. This has further implications for the affected woman, NHS resources, and the wider workplace economy (Wellbeing of Women, 2025).

Wellbeing of Women's (2025) *Just a Period* survey of 3,004 UK consumers (men aged 16-65 and women aged 16-50) found that women affected by heavy and painful periods took an average of 22 months from symptoms starting to seeking help. Whilst 86% of women have experienced a period mishap, only one in 10 women could correctly identify all the signs of heavy menstrual bleeding. Only one in two women correctly identified that passing large blood clots (54%), periods lasting more than seven days (51%), using two types of period products together (48%) are signs of heavy bleeding, with more than 6 in 10 women not knowing that avoiding daily activities because of bleeding can be a sign of heavy bleeding.

Despite 99% of women and girls surveyed reported experiencing period symptoms, 31% have never sought help from a health care professional for these symptoms. In the two-thirds of women who had sought help from a health care professional, 52% have felt their health care professional (eg, GP/nurse/gynaecologist) did not take them seriously in relation to their period; 42% received treatment to help manage their period symptoms, 12% were not given anything for their symptoms during their appointment(s) and only 16% received a diagnosis.

In terms of the ways in which period issues impact on women's daily lives (education, work, leisure and home life), 51% of women said that having a period negatively impacts their life, 55% of those surveyed had taken time off work, 60% had taken time off school/college/university in relation to their period. In terms of leisure, 87% of women and girls said their period had prevented, or made it more difficult, for them to enjoy hobbies or other activities, with 51% avoiding exercise when they are on their period. Half of the women surveyed (51%) have experienced strained family relationships, and 51% have experienced marriage or relationship issues in relation to their period.

Access the full survey results at: wellbeingofwomen.org.uk/what-we-do/campaigns/just-a-period/just-a-period-survey-results

The first ever *Women's Health Strategy for England*, launched in 2022, calls for a fundamental reset in how the health care system listens to women and strives to improve their health outcomes. This 10-year plan identifies key priorities including gynaecological conditions, fertility, menopause, menstrual health and mental health. The strategy includes a 6-point plan to transform the health care system in England and tackle the issues faced by:

1. ensuring women's voices are heard
2. improving access to services
3. addressing disparities in outcomes among women
4. better information and education
5. understanding women's health in the workplace
6. supporting more research and improving data.

The Faculty of Sexual and Reproductive Health (FSRH) Hatfield Vision (FSRH, 2022), is clear about the need for quality, safe and free access to care around menstrual health:

Access to menstrual health support

Goal 10. Women and girls have access to a practitioner who is able to provide support, diagnosis and treatment for their menstrual health including pain, heavy bleeding and premenstrual mood disturbance at their general practice, specialist SRH services and community gynaecology services.

Goal 11. Women and girls have universal access to free menstrual products within health services and schools."

(FSRH Page 7, 2022)

Whilst the need to normalise conversations around periods is evident, women also need education so they understand how their body works, what is a normal period at specific stages of their lifecycle, and are able to recognise symptoms or changes which may necessitate them seeking help. Public Health England (2018) has reported that women of all ages cited school as the place where they had gained most of their knowledge about their reproductive health but that information they had received had often been basic, and they frequently remained unaware of what to expect or how to manage their reproductive health needs throughout their lives. There is also a need to include men and boys in these conversations to help reduce stigma and taboo around the menstrual cycle, so they have more understanding about periods, and are supportive about the difficulties women and girls may face.

The Menstrual Health Coalition (MHC) is an alliance of stakeholders (parliamentarians, patient and advocate groups, life sciences industry, leading clinicians and individuals) who have come together to discuss and make recommendations around menstrual health. The coalition aims to raise the profile of menstrual health on the political and

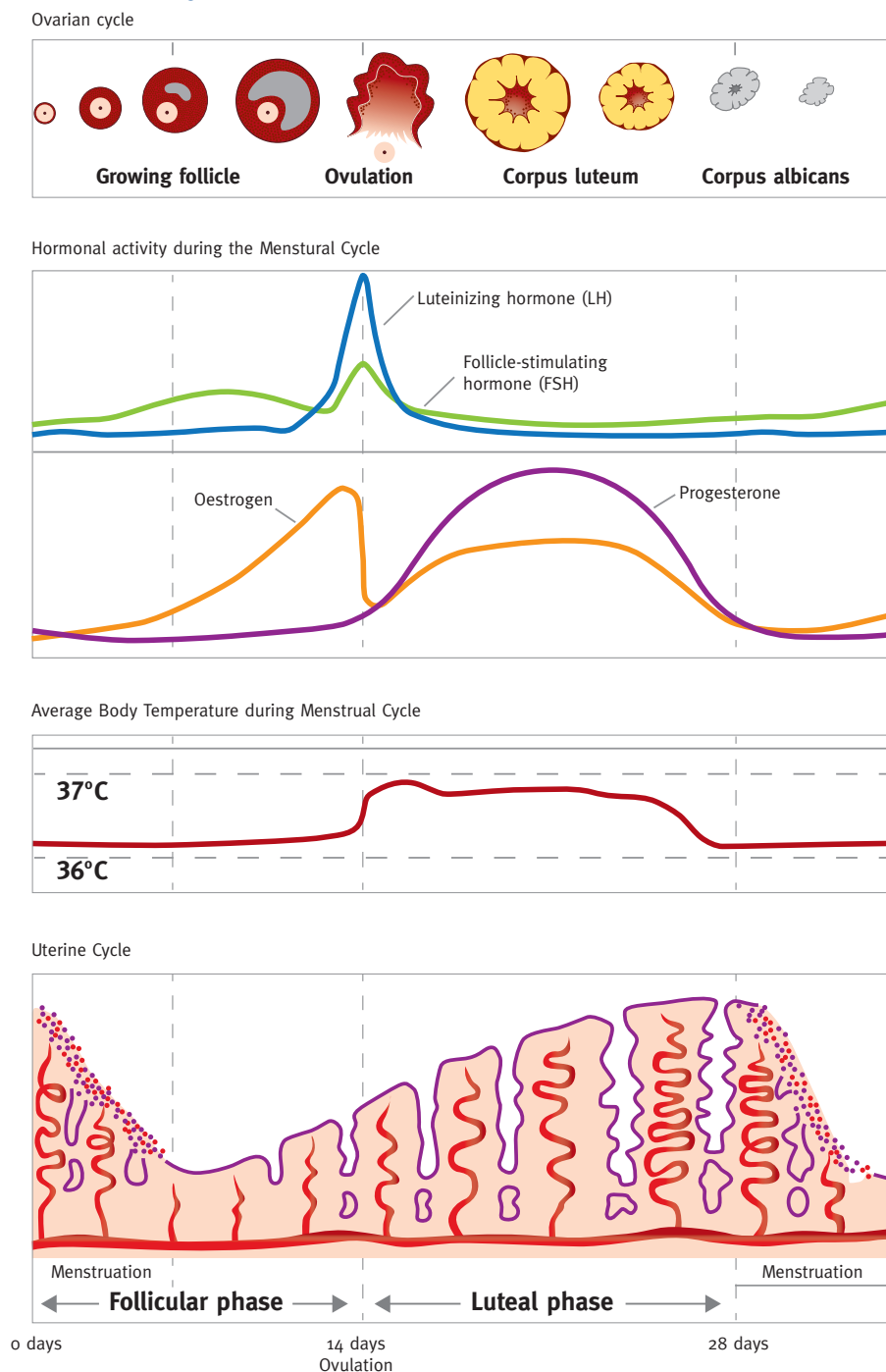
policy agenda, to reduce the stigma around talking about periods, and campaign for change to help women adversely affected by their menstrual health.

Currently, information on menstrual health is limited, fragmented and not easily accessible. In order to address this gap, this guidance has been designed for any member of the nursing community to use with women and girls. This publication can help provide understanding and knowledge to manage periods from teenage years to the menopause, and empower girls and women to ask for advice when needed. Nurses, midwives and nursing associates can use this guidance to initiate discussion with women and girls about normal menstruation and bleeding patterns throughout the lifecycle, and assess for menstrual cycle problems. The guidance includes information on the common causes of menstrual disorders, and describes initial investigations and early treatment management. Identifying potential problems in a timely manner can facilitate prompt referral to appropriate services to improve the long-term health of women, including their physical, psychological and social wellbeing.

2: Understanding the menstrual cycle

Girls are born with their full supply of ova (eggs). These ova lie dormant from birth until puberty; the age at which the female internal organs reach maturity. The commencement of the menstrual cycle, called the 'menarche', is the central event of female puberty, marking the physical change from adolescence to womanhood by signalling the possibility of fertility. Menarche occurs approximately two years after the first signs of puberty.

Figure 1: Menstrual cycle



The menstrual cycle is a series of changes taking place in the ovaries and the walls of the uterus, stimulated by the rise and fall of different hormone levels. The length of a menstrual cycle can vary from 23 days to 35 days.

The menstrual cycle consists of three phases:

Phase one: The menstrual phase

Menstruation is the shedding of superficial layers of the endometrium (lining of the uterus) and is initiated by a fall in circulating concentrations of progesterone hormone. The first day of the menstrual cycle is the first day of the period (day one); bleeding can last between two and seven days, with a varying menstrual flow.

Phase two: The proliferative/follicular phase – preparing for ovulation

At the beginning of the cycle, follicle stimulating hormone (FSH) is produced by the pituitary gland in the brain. FSH stimulates egg development in the ovaries. Each egg is contained within a fluid-filled sac known as a follicle. A number of follicles initially begin to develop, but normally one follicle becomes “dominant” and the egg matures within the enlarging follicle. As the follicle grows, oestrogen levels rise. The increasing level of oestrogen supports growth of the endometrial glands and new blood vessels form in a healthy endometrium. High levels of oestrogen also cause the cervical mucus to become thinner and clearer, making it penetrable for the sperm, which can survive for several days in this fertile mucus.

Once oestrogen levels reach a significant concentration in the blood, further secretion of FSH is blocked, and luteinizing hormone (LH) is released from the anterior pituitary in the brain. This LH surge leads to final maturation and rupturing of the dominant follicle (known as the graafian follicle), which releases the mature egg about 38 hours after the LH surge – a process known as ovulation. The day of ovulation will vary depending on the cycle length.

Phase Three: The secretory/luteal phase – preparing for implantation

This is the phase that follows ovulation. The egg travels along the fallopian tube toward the uterus to try to implant into the endometrium; this takes approximately five days. During this time the ruptured follicle fills with blood, and the theca and granulosa cells of the follicle luteinise and form the corpus luteum. The corpus luteum produces progesterone hormone, which helps the endometrium develop into secretory endometrium, ready for implantation. This phase of the cycle lasts for 14 days. During this time, some women may experience symptoms of pre-menstrual tension, which are physical and emotional symptoms that occur in the one to two weeks before a woman's period. Symptoms often vary between women and resolve around the start of bleeding. Common symptoms include acne, tender breasts, bloating, feeling tired, irritability, and mood changes.

If fertilisation has not occurred, the corpus luteum continues to shrink and levels of oestrogen and progesterone fall. Without the high levels of hormones to help maintain it, the endometrium starts to break down and sheds, resulting in menses; the beginning of the next menstrual cycle. If fertilisation and implantation has occurred, the developing embryo releases a hormone, known as human chorionic gonadotrophin (hCG), which

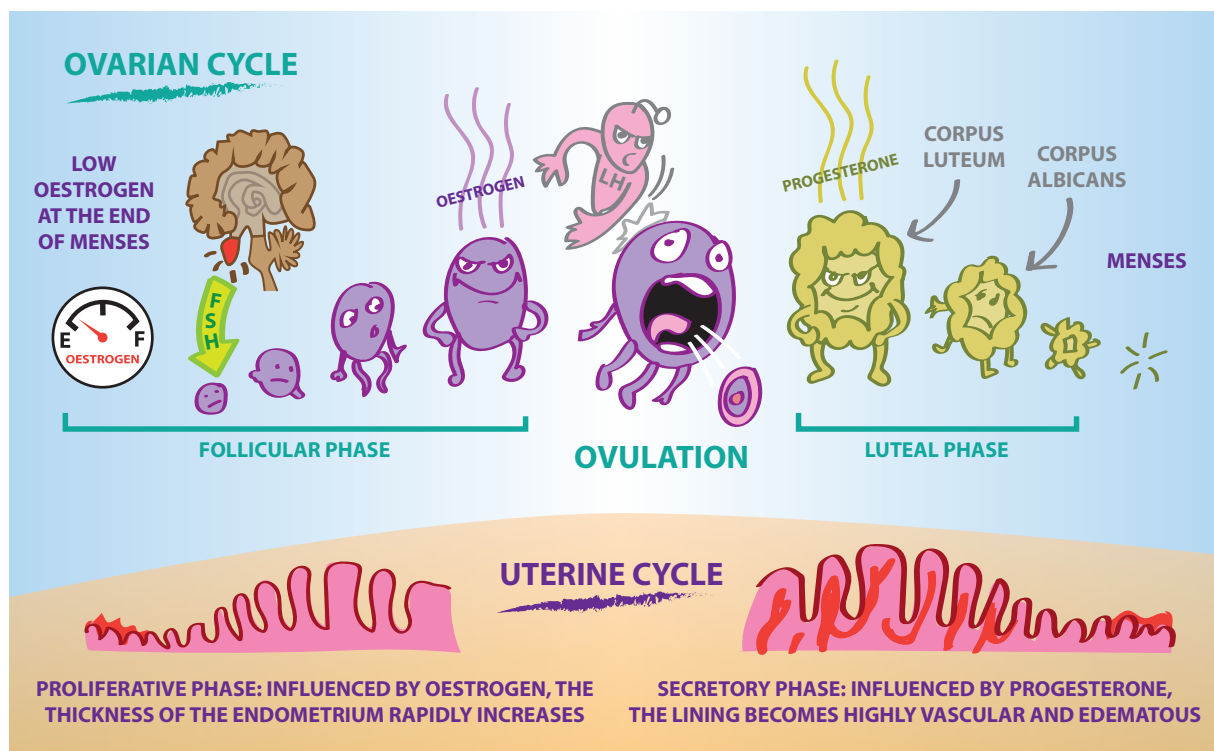
maintains the activity of the corpus luteum. The continuing production of oestrogen and progesterone prevent the endometrium from being shed, until the placenta can maintain the pregnancy.

A person-centred approach

It is really important not to assume knowledge when speaking to anyone about the menstrual cycle.

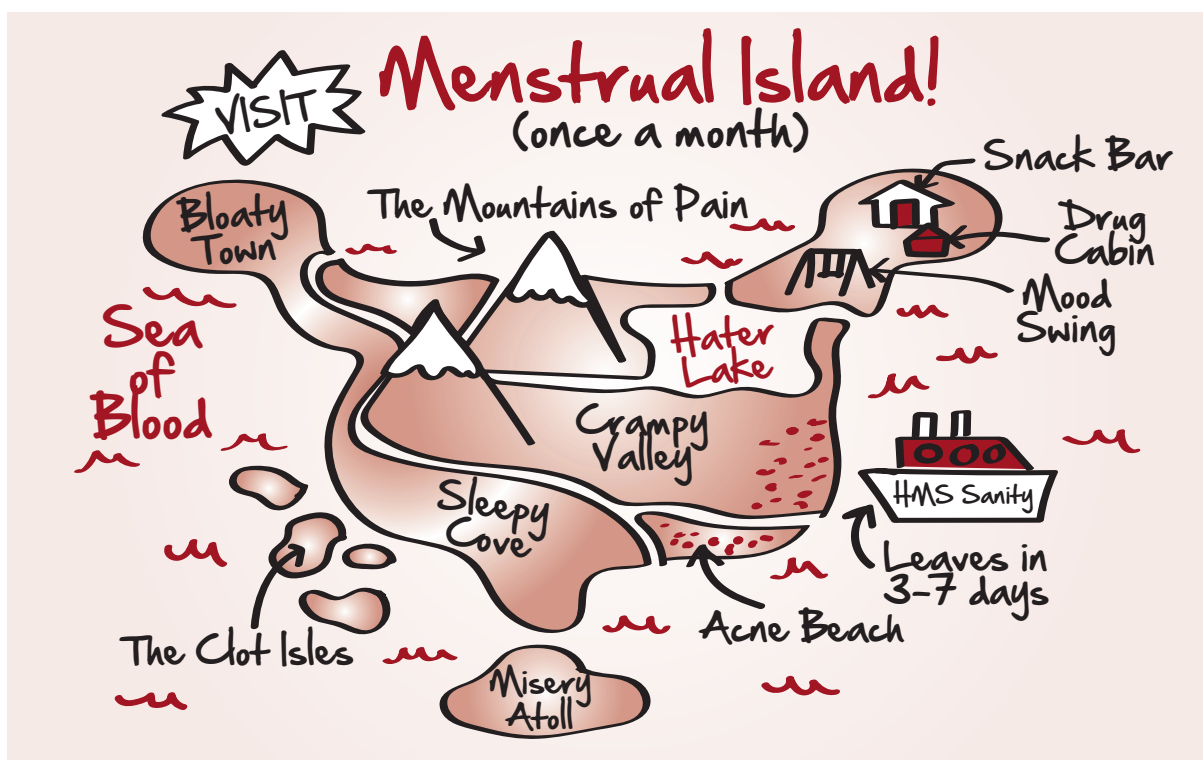
Nurses, midwives and nursing associates need to use appropriate and flexible communication methods to ensure that information on menstrual health is delivered in a format that is acceptable to everyone. The menstrual cycle can be a complex phenomenon to grasp and therefore alternative imagery and/or ways of describing the cycle, which are more age appropriate, may be useful (for example, see figure 2 below and 3 on [page 10](#)).

Figure 2: The menstrual cycle



Adapted from a diagram published on www.medcomic.com (originally by Jorge Muniz)

Figure 3: Visit Menstrual Island



Adapted from a diagram published on www.thenib.com (originally by Gemma Correll)

Staying well

The experience of a period varies from person to person. Periods can last between three to seven days, the average being five days. Periods lasting more than seven days are considered heavy (abnormal) (NHS 2022). The loss of blood is also variable but is usually between 20-60 mls per period; that is about 4-12 teaspoons of blood. Usually, the first two days are the heaviest and the bleeding then becomes lighter. The colour of period blood ranges from dark brown, bright red to dark red and will often change during the period. It is important that girls and women use period products that they feel comfortable with. There are a range of products available including; tampons, pads, reusable pads, disposable and reusable menstrual cups, as well as menstrual underwear, designed to function in the same way as a sanitary pad. It is important that girls and women recognise that there are a wide range of products available now, and they should be encouraged to find the right product for them (Holloway, 2019 www.bbc.co.uk/news/health-48988240)

Period pain (dysmenorrhoea) is very common; 50-90% of girls/women will experience it at some point during their period, often during the heavier days of bleeding. Although uncomfortable, it is normal and can be managed by taking over the counter pain relief such as paracetamol or ibuprofen at regular intervals according to the directions on the packet. Period pain can also be alleviated by taking gentle exercise, soaking in a warm bath, or by applying a heat pad or hot water bottle, or transcutaneous electrical nerve stimulation (TENS) to the lower abdomen.

It is also common for women to feel more emotional during their period. They may find themselves more sensitive and tearful with less resilience than normal. This is due to the changes in hormones and although it can be difficult, it is quite normal. It can be really helpful to talk about these feelings with family and friends so that they know what is happening and can offer support. Practising meditation, breathing exercises, mindfulness or simply making the most of downtime can also be an effective strategy.

3: What is normal bleeding, and what is not?

Menstrual cycle patterns change through the decades of a woman's lifecycle, due to normal age-related hormonal changes, as well as experiences such as pregnancy, contraception use, and certain medical conditions. By women and girls knowing what bleeding pattern and vaginal discharge is normal for them, and understanding how the cycle may change over time, they can be alerted to potential problems that require investigation.

There are a wide range of tools available to track menstrual cycles, a number of apps and paperbased diaries, such as the Wear White Again diary ([Appendix on page 42](#)) can help girls and women to better understand what normal is for them, and these can also be used when discussing cycles and concerns with health care professionals.

a) Pre-puberty/menarche and adolescence

The average age of the first period, or menarche, is 12.4 years but varies across populations. This age has been decreasing over the last 100 years and is most often attributed to improvements in child and adolescent nutrition. Exogenous hormones in the diet also may contribute to this earlier initiation of menarche. It is worth noting that menarche usually occurs following a growth spurt, development of pubic hair and breast development; with 95% of girls having started menstruation by the age of 15 years (Lacroix et al., 2021).

In adolescents, a typical menstrual cycle ranges from 21 to 45 days, and may last seven days or less. It is common for adolescents to present with heavy or painful periods. Around the menarche, 45% of cycles are anovulatory (no ovulation) or abnormal due to the immaturity of the hypothalamic-pituitary-ovarian (HPO) axis. It can take up to three years after menarche for the HPO axis to mature (Adeyemi-Fowode and Brander, 2022).

The language used to discuss normal menstruation is important particularly around the menarche and when communicating with adolescents. Treatment is not always required, sometimes just time and reassurance is needed.

Table 1: Overview of conditions, investigations and treatment options for adolescence

	Signs	Bleeding	Investigations	Treatment
Menarche	Age 10-13	Cyclical bleeding longer irregular cycle	Nil	Reassure
Precocious puberty	Before age 8	Slight vaginal bleeding or blood stained discharge	External examination of secondary sexual characteristics	Refer to secondary care
Primary amenorrhoea	Secondary sexual characteristics	No bleeding	Hormone profile Ultrasound Investigate by age 16	Refer to secondary care
	No secondary sexual characteristics	No bleeding	Hormone profile Ultrasound Investigate by 14	Refer to secondary care
Imperforate hymen	Cyclical severe pain Feverish Bulging hymen	No bleeding	Examination Pelvic ultrasound	Cruciate incision Refer to secondary care
Heavy menstrual bleeding	Missing school monthly and/or avoiding sports activities	Flooding, gushing or passing large clots	Full blood count (FBC) Suggest pictorial diary or app Consider pelvic ultrasound	Tranexamic acid Combined oral contraceptive pill (COCP) Cyclical progesterone Consider an intrauterine system
Dysmenorrhoea	Painful periods	Varies	Consider pelvic ultrasound	Regular over the counter analgesics Mefenamic acid
Secondary amenorrhoea	Secondary sexual characteristics	Bleeding stopped for six months or more	Hormone profile Pregnancy test Pelvic ultrasound	Depends on cause
Polycystic ovarian syndrome (PCOS)	Higher BMI Hirsutism Acne	Irregular bleeding usually heavy	Hormone profile Pelvic ultrasound	COCP, other treatments depend on symptoms
Premature ovarian insufficiency (POI)	Hot flushes	Periods stop	Rare Hormonal profile	Refer to secondary care COCP or hormone replacement therapy (HRT)
Pregnancy	Breast tenderness	Periods stop	Pregnancy test	Discuss options Refer according to decision
Stress	Any age	Irregular bleeding or periods stop	Pregnancy test Hormone profile Consider pelvic ultrasound	Depends on cause Reassure Monitor

b) Adult reproductive years

1) Secondary amenorrhoea

Secondary amenorrhoea refers to the absence of menstruation for three to six months with previous regular periods or six–12 months in a woman with preceding oligomenorrhoea (infrequent menstrual periods) (Thwaites et al., 2021).

Once pregnancy is ruled out, the common causes include:

- polycystic ovarian syndrome
- hypothyroidism
- premature ovarian insufficiency
- hypothalamic amenorrhoea
- hyperprolactinaemia
- eating disorders
- anatomical factors such as scarring post uterine surgery causing Ashermans Syndrome (Khan, 2023).

Investigations to be undertaken:

- clinical history
- physical examination
- imaging
- thyroid function
- follicle stimulating hormone and luteinising hormone
- prolactin
- oestradiol
- androgen concentration.

Secondary amenorrhoea should be treated in line with the diagnosis and referral to secondary service made as required, for instance, women who are concerned about their fertility.

For further information see: NICE (2025) *Management of secondary amenorrhoea; Clinical Knowledge Summary*. Available at: <https://cks.nice.org.uk/topics/amenorrhoea/management/secondary-amenorrhoea>

2) Bleeding patterns relating to contraception use

The use of hormonal contraception is likely to have an impact on bleeding patterns and it can be very useful in managing the experience of bleeding. Users of combined hormonal contraception are likely to experience shorter and lighter bleeds in the hormone free intervals, due to the suppression of ovulation and effect on the lining of the uterus. Combined methods can be used to control the timing of a bleed or used continuously to avoid it.

Approximately 20% of those who use a combined method (pill, patch or vaginal ring) will

have irregular bleeding in the first three months of using the method but this is likely to settle. Breakthrough bleeding with hormonal methods is common but should always be investigated and pregnancy, infection and cervical abnormalities should be excluded.

Bleeding is unpredictable when using the progesterone only pill. Approximately 50% of those using it are likely to have either very infrequent or no bleeding and 20% will experience prolonged spotting or bleeding (more than 14 days).

Bleeding is often lighter for users of the contraceptive implant, but the bleeding pattern can also be unpredictable. Approximately 20% of users will stop bleeding and 20% will have prolonged bleeding. The bleeding pattern experienced in the first three months of use is unlikely to change.

Bleeding disturbances are common for those who use the progesterone only injection and about 50% will stop bleeding in the first year of use. The return to a normal cycle can be delayed for up to one year after stopping this method.

Intrauterine systems (IUS – coils containing hormone) will usually reduce blood flow by approximately 85% and some users will stop bleeding and become amenorrhoeic. The levonorgestrel IUS (Mirena/Levosert) is licensed to treat heavy menstrual bleeding because of the effect on thinning the uterine lining. Bleeding patterns usually return to normal after removal of an IUS.

There is evidence that the non-hormonal copper intrauterine device (Cu-IUD) can cause a woman's periods to become heavier, longer, or more painful.

It is common to have some intra-menstrual spotting in the first three to six months after the fitting of an IUD/IUS however this spotting should always be investigated to rule out other causes such as pregnancy and infection. For further information please see:

[fsrh.org/Public/Standards-and-Guidance/Problematic-Bleeding.aspx](https://www.fsrh.org/Public/Standards-and-Guidance/Problematic-Bleeding.aspx)

3) Bleeding patterns relating to pregnancy

3.1 Early stages of pregnancy

Bleeding during early pregnancy is fairly common and does not always mean something is wrong. However vaginal bleeding during early pregnancy should be assessed and investigated. Women who are RhD negative need assessment for prophylactic anti-D immunoglobulin if they experience a potentially sensitising event, which includes bleeding in pregnancy. Bleeding may be caused by the following:

Implantation bleed: this is harmless light bleeding. This occurs when the developing embryo implants in the endometrial lining of the uterus. This bleeding often happens around the time the period would have been due.

Cervical changes: pregnancy can cause changes to the cervix and this may sometimes cause bleeding, for example, after sex (post-coital bleeding).

Miscarriage and ectopic pregnancy: bleeding and/or pain could be caused by a miscarriage or ectopic pregnancy. More information can be found in the RCN's *Women's Health Pocket Cards* at: rcn.org.uk/Professional-Development/publications/womens-health-pocket-guide-uk-pub-010-898

3.2 Later stages of pregnancy

Bleeding in later pregnancy is not common and should be assessed and investigated. Antepartum haemorrhage (APH) is defined as bleeding from or in the genital tract, occurring from 24 weeks of pregnancy and prior to the birth of the baby.

Cervical changes: these can lead to bleeding, particularly after sex. The cervix gets an increased blood supply and becomes softer thus can bleed.

A 'show': this is when the plug of mucus that has been in the cervix during pregnancy comes away, signalling that the cervix is getting ready for labour to start. It may happen a few days before contractions start or during labour itself.

Placental abruption: this is a serious condition in which the placenta starts to come away from the uterus. Placental abruption usually causes abdominal pain and this may occur even if there is no bleeding.

Placenta praevia: this is when the placenta is attached in the lower part of the uterus, near to or covering the cervix. Bleeding from a low-lying placenta can be very heavy and put the woman and her baby at risk.

Vasa praevia: this is a rare condition where the fetal blood vessels run through the placental membranes. When the membranes rupture, these vessels may be torn and cause vaginal bleeding. The baby can lose a life-threatening amount of blood. Vasa praevia is uncommon with a prevalence ranging between one in 1,200 and one in 5,000 pregnancies.

4) Post-partum bleeding

All women experience a time of post-partum bleeding following birth which is not considered a menstrual period. Bleeding can last around a month but up to six weeks is normal. If bottlefeeding, most mothers will have their first real period not long after this.

5) Periods during breastfeeding

Almost anything is considered normal when it comes to periods while breastfeeding. Breastfeeding does however suppress menstruation for some time after childbirth. For some mothers, there may be an absence of menstruation for weeks, months and even years while still breastfeeding. However, it is important to advise women that effective contraception should be initiated by both breastfeeding and non-breastfeeding women as soon as possible after childbirth, as sexual activity and ovulation may resume very soon afterwards (Faculty of Sexual and Reproductive Health, 2020).

Once menstruation returns it may continue to be irregular during breastfeeding. It is not uncommon to have a shorter or longer than normal period while breastfeeding. It is also not abnormal to skip a period or see the first period return and then find that months pass before the next one.

When the first period returns depends upon several factors:

- how frequently the baby is feeding
- how often feeds are supplemented with bottle feeds

- if the baby is using a dummy
- how long the baby is sleeping at night
- if solids have been introduced
- hormonal influences associated with breastfeeding.

Anytime the stimulation to the breast is decreased, especially at night, menstruation is likely to return soon after with the likelihood of pregnancy increasing.

6) Bleeding at the time of, and after miscarriage

Most miscarriages happen in the first trimester (under 13 weeks of pregnancy). The level of bleeding a woman might experience can be variable. A few women may get minimal or no bleeding as they miscarry, particularly in very early pregnancy. Most women however will experience bleeding, and for some this will be heavy. Women may also pass large clots at the time the pregnancy is being expelled from the uterus, which should then gradually taper off over the following one to two weeks. Women can expect their periods to resume within four to six weeks after a miscarriage.

If a woman is soaking two or more maxi-size sanitary towels per hour for two consecutive hours she should seek urgent medical advice.

If the bleeding does not taper off as expected and is problematic for the woman she should seek medical advice. In such cases, there may or may not be other signs and symptoms such as abdominal pain/cramping and/or signs of infection (for example high temperature, abdominal tenderness, feeling generally unwell, offensive vaginal discharge).

More information can be found in the RCN's *Women's Health Pocket Cards* at: [rcn.org.uk/Professional-Development/publications/womens-health-pocket-guide-uk-pub-010-898](https://www.rcn.org.uk/Professional-Development/publications/womens-health-pocket-guide-uk-pub-010-898)

7) Bleeding at the time of, and after, induced abortion

Induced abortion can be performed up to 24 weeks gestation (beyond, in certain very limited circumstances). The vast majority of induced abortions however, occur in the first trimester (under 13 weeks of pregnancy).

The level of bleeding a woman might expect will depend on a number of things, the first of which is whether she has a surgical or a medical abortion. In the case of surgical abortion, the contents of the uterus are removed; in the case of medical abortion, medications are used to cause the uterus to expel its contents.

After a surgical abortion, a small number of women will have minimal or even no bleeding. Most women will experience bleeding, rather like a period, which may include some small clots and should taper off over the following one to two weeks. Women may then experience some occasional spotting until their next period four to six weeks later.

During a medical abortion, the bleeding may be heavier than a period, significantly heavier in some cases, and the woman is likely to pass clots, some of them large. Once the pregnancy has been expelled, the heaviest bleeding should start to subside and similar to a surgical abortion, should taper off over the next one to two weeks, with occasional spotting until their next period four to six weeks later.

If a woman is soaking two or more maxi-size sanitary towels per hour for two consecutive hours she should seek urgent medical advice. If the bleeding does not taper off as expected and is problematic for the woman she should seek medical advice. In such cases, there may or may not be other signs and symptoms such as abdominal pain/cramping and/or signs of infection (for example high temperature, abdominal tenderness, feeling generally unwell, offensive vaginal discharge).

If periods do not resume after six weeks, a woman should do a pregnancy test and seek medical advice.

More information can be found in the RCN's *Women's Health Pocket Cards* at: rcn.org.uk/Professional-Development/publications/womens-health-pocket-guide-uk-pub-010-898 and the RCN Termination of Pregnancy clinical resources page at: rcn.org.uk/clinical-topics/womens-health/termination-of-pregnancy

8) Bleeding related to medical conditions and medication use

Many other medical conditions and medication can have an impact on the menstrual cycle and the amount of bleeding women may experience, see tables 2 and 3 below:

Table 2: Other conditions

Other conditions	Impact on menstruation
Raised prolactin	No periods
Under active thyroid	Heavier periods
Over active thyroid	No periods or light periods
Obesity	Either no periods or heavier periods
Anorexia	No periods
Stress	No periods
Bleeding disorders, such as von Willebrands	Heavier periods

Anaemia

Some women with heavy periods can experience anaemia.

Anaemia is defined as a reduced number of red blood cells (RBCs) or less than the normal amount of haemoglobin (Hb) in the blood. It can also be defined as a lowered ability of the blood to carry oxygen.

The most common cause of anaemia is iron deficiency. Many women will experience symptoms of iron deficiency before they become anaemic. Common symptoms of iron deficiency without anaemia are fatigue and poor concentration.

The following are the common signs and symptoms of anaemia. It is important to remember that they can be over looked or missed due to their vagueness and ability to be attributed to several causes. Patients rarely present with only one of the symptoms listed and often present them as part of a list of other symptoms, sometimes obscuring information:

- weakness
- shortness of breath
- dizziness
- fatigue
- fast or irregular heartbeat
- pounding or 'whooshing' in the ears
- headache
- cold hands or feet
- pale or yellow skin
- chest pain
- lack of concentration
- mouth ulcers or cracks at the corners of the mouth
- slow or poor wound healing
- tinnitus.

Table 3: Medications

Contraceptive injection (Intramuscular depoprovera or subcutaneous sayana press)	No periods, irregular bleeding, continuous bleeding
Progestogen only pill (POP)	
Contraceptive implant	
Intrauterine system (IUS)	
Combined oral contraceptive pill (COCP)	Lighter bleeding
Anti-coagulants	Heavier bleeding
Steroids	Irregular spotting
Antipsychotics	May stop periods

9) Bleeding around the time of the menopause

Peri-menopause: during the peri-menopause menstruation can become irregular. The perimenopausal stage leads up to menopause and continues for 12 months after the final period. The peri-menopause is also known as the menopausal transition or climacteric. Menopausal symptoms can occur during the peri-menopause.

Menopause: this is a biological stage in the lifecycle that occurs when menstruation stops at the end of a person's reproductive life. Menopause is usually defined as having occurred when a woman has not had a period for 12 consecutive months (for women reaching menopause naturally). The changes associated with menopause occur when the ovaries stop maturing eggs and secreting oestrogen and progesterone.

Post-menopause: the time after menopause has occurred, starting when a woman has not had a period for 12 consecutive months. Bleeding or spotting after this 12 month timeframe is classed as post-menopausal bleeding (PMB) which is a clinical red flag.

Women experiencing PMB should be referred on a fast track pathway to gynaecology for further investigations.

PMB is defined as unscheduled bleeding that occurs a year after the last natural menstrual period, or any breakthrough bleeding on cyclical hormone replacement therapy (HRT) or breakthrough bleeding after six months on continuous combined therapy (CCT) after amenorrhoea has been established.

PMB is a common reason for referral to gynaecology services, representing about 5% of referrals. The majority of women with PMB will have either no cause or it will be a benign cause but about 10% of women will have endometrial cancer. Endometrial cancer accounts for one in 18 of every female cancer and the rate is increasing.

PMB should be managed as a suspected cancer until proved otherwise. The *Suspected Cancer: recognition and referral guideline NG12* (NICE, 2023) provides guidance for the referral, and treatment times for a suspected cancer as well as recommended care pathways. Once referred, women will undergo:

- pelvic examination with cervical screening and infection screening if needed
- pelvic or abdominal ultrasound – the endometrium should be under 4-5mm dependent on local guidelines. It should also be regular in outline
- hysteroscopy and endometrial biopsy – hysteroscopy for a thickened endometrium, irregular endometrium, repeated bleeding or bleeding on tamoxifen and combined with a biopsy as needed.

Possible causes of PMB include:

- other sources of bleeding such as vaginal or bladder
- endometrial cancer
- cervical, vaginal, vulva cancers and precancerous changes
- tamoxifen use
- endometrial hyperplasia
- cervical polyps
- endometrial polyps
- fibroids
- vaginal atrophy
- bleeding on HRT
- oestrogen secreting tumours.

In some cases no cause will be found.

More information can be found in the RCN's *Women's Health Pocket Cards* at: rcn.org.uk/Professional-Development/publications/womens-health-pocket-guide-uk-pub-010-898

4: Assessment

Language used around periods can be difficult as it is a sensitive and subjective topic. Whilst nurses, midwives and nursing associates should encourage girls and women to feel comfortable to use proper terms for menstruation, they must also be aware of some of the colloquial language that may be used to describe periods.

Questions need to be open-ended to start to allow someone to describe the problem and then use more specific language that all can understand; sometimes the use of apps or charts can give a visual picture.

Figure 4: An example of questioning

Referral to see a woman who has inter-menstrual bleeding (IMB).

Questions in clinic

Nurse: "Are you bleeding in between your period?"

Woman: "No"

Nurse: "What is happening with your cycle?"

Woman: "I'm having two periods a month"

Further questioning

Nurse: "So it would appear you are having a period at the beginning of the month and then one at the end, so a shorter cycle of 21 days but regular, and no bleeding in between these periods is that correct?"

Woman: "Yes".

Euphemisms for periods

Mother nature

Time of the month/monthlies

Lady time/lady friend

Aunt Flo

Code red

My friend is visiting

Granny's stuck in traffic (South Africa)

Eve's curse

Cousin red

Have the decorators in

I'm on

On the blob/blobbering

On the rag

Jammy dodger

Women's troubles

Terminology for menstruation in different languages

Chinese: 月经

Croatian: menstruacija

Czech: menstruace

Dutch: menstruatie

French: règles

Greek: εμμηνόρροια

Hindi: अवधि

Japanese: 月経

Korean: 생리

Polish: menstruacja

Romanian: menstruatie

Russian: менструация

Somalia: muddo

Thai: การมีประจำเดือน

Turkish: regl

Urdu: مدت

Possible assessment questions:

DO NOT ASK	DO ASK
How are your periods?	When was your last period? Are your periods regular? How regular are your periods? How many days from the first day of bleeding to the last day of bleeding?
Is your bleeding ok?	Do you think your periods are heavy? How heavy is your bleeding? How many days of bleeding in total? How many days of heavy bleeding? On your heaviest day, how often do you change your pads or tampons or moon cup? What size/type of product are you using? Do you ever leak through your clothes during the day or at night? Do you have clots, what size? Do you plan your journeys around toilets on your period? Are you able to leave the house on your period? Do you think your periods are manageable? Are you missing social activities or work?
Do you have pain?	Is there any pain with your period, when you are bleeding, or before the bleeding starts? Do you have pain when you have sex; all the time, at different times in the month, and in different positions? Do you have any pain when you have your bowels open or pass urine? Is your pain manageable?
Have you taken any medication?	Have you been prescribed any medication for your periods or hormone treatments? Which ones, and did they help? Do you take any over the counter medication to help?
Any other bleeding?	Do you have any bleeding in between your periods? If yes, can you describe the frequency, amount, colour, and what brings this on? Do you ever have any bleeding when you have sex? If yes, what are the frequency, amount and colour? Any blood in the urine or after opening your bowels?
How do you feel?	Ask for any signs of iron deficiency or anaemia – have you any shortness of breath, tiredness? Check if any bloods have been taken including serum ferritin for iron stores
	Are your periods a problem to you?
What do you want?	What is the aim of treatment; to reduce, stop the bleeding? What is needed in the way of contraception and future pregnancy?
	Are you taking any hormones, either HRT or contraceptive? Are you up-to-date with your cervical screening/sexual health screening?

Other considerations

Cultural and religious influences

Women's experiences of menstruation, while it is a normal physiological process, are shaped by the sociocultural environment in which they live. Most girls learn about the menarche and menstruation from family and friends. Within different cultures girls are directly or indirectly instructed to behave in ways that uphold these beliefs and this perpetuates many of the menstrual taboos that persist in the present day. How young girls are prepared for menstruation can directly affect their menstrual experiences during their reproductive years in a positive or negative way and will shape their attitudes towards seeking advice and help on menstruation problems from health care providers.

Menstruation is surrounded by myths and cultural perceptions that are associated with good and bad practices that include the belief in some ethnic groups that menstrual blood is 'leakage' and 'dirty'. As a result, a woman may be viewed as 'unclean' and 'impure' and therefore untouchable during menstruation by their communities. During this time restrictions may be placed on their religious, social, sexual and domestic activities by isolating them sometimes away from the community in a menstrual hut. In many cases they are required to perform a cleansing ritual before returning to the fold of the community or family. In some religions even to touch a menstruating woman would not be allowed. Conversely in other belief systems menstrual blood is seen as magical or powerful and a strong flow of menstrual blood is seen as desirable. Consequently, women with this belief may delay seeking help for heavy bleeding resulting in a risk of anaemia or late diagnosis of uterine disorders. Due to the cultural etiquette, the discussion of menstruation particularly in the presence of a male, even a male relative, will be a challenge for some women. Nurses need to find innovative ways to allow a woman to speak freely during a consultation. Perceptions of vaginal bleeding as shameful and something to be concealed is more prevalent in women from low resource countries and restricts even further the ability of asylum seekers or refugees for example to raise or discuss menstrual problems in the presence of interpreters.

In today's multi-ethnic society it is therefore necessary that all those involved in caring for women have an understanding of the influences of culture and religion on a woman's attitudes towards her menses so she can be provided with culturally sensitive and medically appropriate therapies, health promotion and health education. For further information regarding the impact of taboos on sexual and reproductive health, refer to *Forbidden conversations: A comprehensive exploration of taboos in sexual and reproductive health*. Cureus, 16(8) which is available at: https://assets.cureus.com/uploads/review_article/pdf/282156/20240813-69208-vrxlmk.pdf

Female genital mutilation (FGM)

FGM is child abuse and the practice is illegal in the UK. FGM is usually carried out on girls before puberty. When seeing girls from cultures where FGM is practised, nurses and midwives should take the time for sensitive questioning. It is important to consider recent FGM when young girls are presenting with sudden heavy bleeding, pain or urinary retention. Nurses and midwives have a mandatory duty to report cases of FGM (DHSE, 2016).

More information can be found at: rcn.org.uk/clinical-topics/female-genital-mutilation and unicef.org/documents/accelerating-action-towards-fgm-elimination-lessons-evidence-effective-interventions

Trans and non-binary people

The experience of a period can be extremely distressing for transgender men, non-binary and gender fluid people. It can be a painful reminder of the incongruent gender assigned at birth. Period pain and emotional sensitivity can be amplified because of this. It is important that each individual is listened to with sensitivity and treated with compassionate respect using the pronoun of their choice, to avoid misgendering which can escalate distress. It is very important to use the terminology for body parts that the person elects to use, to ensure that care is person centred.

Those who are assigned female at birth who retain a uterus may wish to discuss options for controlling bleeding and should be given accurate information about all methods of contraception for which they are medically eligible and given help to decide which would best suit their needs. In general, use of combined hormonal contraceptives (CHC) containing oestrogen and progestogen by trans men and non-binary people undergoing testosterone treatment are not recommended as the oestrogen component of CHC will counteract the masculinising effects of testosterone therapy. Progestogen-only contraceptives are not thought to interfere with the hormone regimens used in the treatment of trans and non-binary people and may be helpful in reducing or stopping vaginal bleeding. All options, including risks and benefits should be discussed on an individual basis. Further information is available at: [thelancet.com/pdfs/journals/lansea/PIIS2772-3682\(23\)00037-9.pdf](https://thelancet.com/pdfs/journals/lansea/PIIS2772-3682(23)00037-9.pdf) and <https://jdc.jefferson.edu/cgi/viewcontent.cgi?article=1092&context=obgynfp>

Care for trans and non-binary people

Providing care for people from diverse backgrounds should include creating a safe and welcoming environment for all. As some trans and non-binary patients report poor experiences of health care settings, an individual's approach can have a significant impact in ensuring better health outcomes.

The following tips are recommended:

- be positive and proactive in your approach to welcoming trans and non-binary patients to your care. Always treat trans and non-binary patients in a respectful way, as you would any other patient or client
- if you are unsure about how to address a person you are supporting or caring for, start off by introducing yourself with your name and gender pronoun. You can then, politely and discreetly, ask the person for their name and pronouns.
- avoid disclosing a patient's trans or non-binary status to anyone who does not explicitly need to know
- discuss issues related to a patient's gender identity in private and with care and sensitivity.

(RCN, 2020)

Women with disabilities

Girls and women with disabilities may face greater challenges in managing their menstruation hygienically and with dignity, often facing a double stigma due to both social norms around gender and menstruation and having a disability (UNICEF, 2019). This may range from every month self-care, to menstruation impacting on existing conditions, to needing sensitive support and care to understand what is happening and how to manage the challenges faced with daily living. Girls and women with severe physical disabilities have little choice of privacy, and many have bowel and urinary challenges too.

A learning disability is a lifelong condition which may result in reduced intellectual ability which can lead to difficulty with everyday tasks such as managing health needs and accessing health care. Many individuals with cognitive disabilities do not receive adequate education about menstrual health, leading to confusion and anxiety when they experience menstruation for the first time (Pinkishe Foundation, 2024). The start of periods for young people with physical disabilities and learning disabilities can affect their independence and become a concern for their families and carers. Menstrual management may need the support of families/carers to minimise hygiene issues, pre-menstrual symptoms and heavy, painful and/or irregular periods. The options available for menstrual management vary, depending upon the required outcome, which range from cycle regulation to amenorrhoea.

Young people with learning disabilities follow a similar pattern of puberty to young people without disabilities. Earlier development may occur in girls with neurodevelopmental disabilities, girls with autism spectrum disorders may experience a slight delay. Young people with disabilities that compromise their nutrition or are linked to chronic inflammation may have a later onset. Public Health England (2022) report that epilepsy is common in people with learning disabilities and seizure frequency can be related to the menstrual cycle (catamenial epilepsy). Hypothyroidism may contribute to heavy bleeding and this may be a contributing factor for young women with Down Syndrome who experience heavy periods. Menstrual discomfort may be associated with behavioural problems. Conversely, changes in a young woman's behaviour may be attributed to the menstrual cycle, whether or not this is actually the case.

Girls and women with physical and/or learning disabilities should be given support to manage their own periods. Menstruating girls and women with different types of disabilities may have different needs. Those with physical impairments in their upper body and arms may have difficulties placing their sanitary protection materials in the correct position and washing themselves, their clothes and the menstrual materials. Those with vision impairments (blind or low vision) may face challenges knowing if they have fully cleaned themselves, and those with intellectual and developmental impairments may need accessible and easy-to-read materials tailored to support them to communicate about pain and their needs and to learn menstrual health and hygiene (UNICEF, 2020). The decision of choice of support must engage the girl and her parents or carers, who should be given the opportunity to discuss options, including advantages and disadvantages of each method.

Period poverty

Stigma, as well as affordability, are key challenges for women and girls in the UK, significantly affecting their hygiene, health and wellbeing. Period poverty is a term used to refer to a lack of access to sanitary products due to financial constraints. According to ActionAid (2022), 3 in 10 girls in the UK are experiencing period poverty, which means they cannot afford to buy safe, hygienic menstrual products. This is within the context of austerity, homelessness and rising use of food banks.

In 2019, the UK government committed to tackling period poverty. In that year, NHS England pledged to providing free sanitary products to women and girls in hospitals. Local authorities across England started to offer free sanitary products for staff and all students at schools, colleges, and universities to have access to free products by the end of 2020. The scheme continues to run for the academic year 2024-2025, and it is hoped that the UK government will extend the scheme beyond the current timeframe. Local authorities also received funding to help tackle period poverty in areas of high deprivation.

In 2020, Scotland became the first country in the world to make period products completely free. In November that year, the Period Products (Free Provision) (Scotland) Bill, was unanimously approved by MPs. There is now a legal duty on local authorities to ensure that free items such as tampons and sanitary pads are available to “anyone who needs them”.

In 2021, Northern Ireland launched a three-year pilot programme to make free period products available to all pupils who menstruate, in primary, secondary and special schools and EOTAS (Education Otherwise Than at School) settings. The successful pilot scheme closed in 2024 to make way for wider provision under new legislation.

The Welsh government’s *Period Proud Wales* action plan aims to tackle period poverty by improving access to period products and ensuring period dignity, by removing any sense of stigma or shame associated with periods. In 2022, the Welsh government increased funding to ensure that period products could be accessed free of charge by learners in schools, further education institutions and to those in need in communities to £3.7m. The government has already implemented a free period product scheme to ensure that individuals have access to the menstrual products they need. There are also free period products in schools, public buildings and leisure and sports centres.

An ActionAid poll (2023) found that 21% (more than one in five) women and people who menstruate in the UK were struggling to afford period products – up from 12% in just one year. This equates to an estimated 2.8 million people, putting around 1 million more people into period poverty since the previous year. Of those affected by period poverty, 41% kept sanitary pads or tampons in for longer, and 8% re-used disposable pads, which can increase the risk of infection. In addition, 37% said they had used tissues or cotton wool instead of sanitary products in the last 12 months. 13% used socks or other clothing, and 9% resorted to using paper or newspaper.

More information can be found at: rcn.org.uk/clinical-topics/womens-health/promoting-menstrual-wellbeing/period-poverty

How can we all help?

Many initiatives now provide free period products to local schools and communities to help women and girls in the UK who can't afford them, such as:

- The Red Box project redboxproject.org
- Bloody Good Period bloodygoodperiod.com
- The Trussell Trust trusselltrust.org/get-help/emergency-food/non-food-items
- Food banks in many areas are also grateful for donations of products to distribute to those who are unable to afford them.

5: Possible causes of menstrual problems and irregularities

Menstrual problems and irregularities can be caused by a variety of factors.

Pre-menstrual syndrome (PMS)

PMS is a chronic cyclical condition with multiple symptoms that occurs in the luteal phase (second half) of the menstrual cycle. Approximately 40% of women experience PMS symptoms and of these 5-8% will suffer severe PMS.

Symptoms may be psychological and physical:

- depression and anxiety
- loss of confidence
- mood swings
- food cravings
- irritability
- mastalgia
- bloating
- changes in sleep pattern.

More information can be found in the RCN's *Women's Health Pocket Cards* at: rcn.org.uk/Professional-Development/publications/womens-health-pocket-guide-uk-pub-010-898

Premenstrual Dysphoria Disorder (PMDD)

PMDD is a hormone-based severe mood disorder occurring in the luteal phase of the menstrual cycle. It affects an estimated one in 20 women of reproductive age, with disabling symptoms of poor mental health and physical pain every cycle. It can have a devastating impact on relationships and daily life; 30% of those with PMDD have attempted suicide. PMDD is often under-recognised and underdiagnosed.

Symptoms include:

- feelings of sadness and despair
- anxiety and panic attacks
- suicidal thoughts
- anger
- insomnia
- headaches
- joint pain
- bloating
- menstrual cramps.

More information can be found in the RCN's *Women's Health Pocket Cards* at: rcn.org.uk/Professional-Development/publications/womens-health-pocket-guide-uk-pub-010-898 and rcn.org.uk/Professional-Development/publications/rcn-what-are-pms-and-pmdd-uk-pub-011-822

Endometriosis

Endometriosis is defined as the presence of endometrial-like tissue outside the uterus, which induces a chronic, inflammatory reaction.

It is estimated that one in 10 women of reproductive age suffer from endometriosis (estimates range from 2-10% of the general female population, but up to 50% in infertile women). It takes an average of eight years from the onset of symptoms for women to get a diagnosis.

The cause is uncertain but may include:

- genetics/family history
- retrograde menstruation
- immune dysfunction.

Signs and symptoms:

- dysmenorrhea
- dyspareunia
- chronic pelvic pain
- painful caesarean section scar or cyclical lump
- infertility
- cyclical or premenstrual symptoms with or without abnormal bleeding and pain
- chronic fatigue
- depression
- less commonly: dysuria, dyschezia, haematuria
- pain in back, legs, and/or chest.

More information can be found in the RCN's *Women's Health Pocket Cards* at: rcn.org.uk/Professional-Development/publications/womens-health-pocket-guide-uk-pub-010-898 and: rcn.org.uk/clinical-topics/Womens-health/Endometriosis and *What is Endometriosis?* available at: rcn.org.uk/Professional-Development/publications/rcn-what-is-endometriosis-uk-pub-011-851

Adenomyosis

Adenomyosis is a condition characterised by the abnormal presence of endometrial tissue within the myometrium. When endometrial tissue is abnormally present entirely outside the uterus, it is considered to be a similar, but distinct medical condition from endometriosis. The two conditions are found together in many cases, but often occur separately. Adenomyosis can cause menstrual cramps, lower abdominal pressure and bloating before

menstrual periods and can result in heavy periods. Treatment for adenomyosis is similar to the treatment for uterine fibroids, discussed later in this section.

Cervical and endometrial polyps

Cervical polyps are generally benign overgrowths of tissue at the external os, or just inside the internal cervical canal. They are common and the exact cause is unknown.

Symptoms may include:

- none, as it may only be found on examinations and at cervical screening
- intermenstrual bleeding (IMB)
- post-coital bleeding (PCB)
- vaginal discharge
- post-menopausal bleeding (PMB).

Endometrial polyps are dense, fibrous tissue, with blood vessels and glands lined with endometrial epithelium and can reoccur after removal. They are a common finding on ultrasound, and will regress if small.

More information can be found in the RCN's *Women's Health Pocket Cards* at: rcn.org.uk/Professional-Development/publications/womens-health-pocket-guide-uk-pub-010-898

Uterine fibroids

Uterine fibroids are benign tumours of myometrium with a clinically relevant prevalence in 30% women of reproductive age and can:

- be single or multiple
- their growth is influenced by oestrogen and progesterone
- enlarge during pregnancy and they shrink post-menopausally.

Symptoms (50% will be asymptomatic):

- heavy menstrual bleeding; possible intermenstrual/post-coital bleeding
- anaemia (due to heavy menstrual bleeding)
- dysmenorrhoea associated with heavy bleeding
- pressure symptoms (bowel, bladder, dyspareunia)
- pelvic pain and swelling (large uterus)
- reproductive dysfunction (subfertility, pregnancy loss).

More information can be found in the RCN's *Women's Health Pocket Cards* at: rcn.org.uk/Professional-Development/publications/womens-health-pocket-guide-uk-pub-010-898

Heavy menstrual bleeding

Heavy menstrual bleeding is a common debilitating problem affecting one in three women at some stage in their life, particularly over the age of 35. It can have a major impact on a woman's quality of life.

Causes:

- dysfunctional uterine bleeding (60%) – often no known cause
- pelvic pathology (35%) – includes fibroids, endometriosis, adenomyosis, polycystic ovarian disease, endometrial hyperplasia, malignancy, infection and trauma
- systemic disorders (5%) – includes coagulation disorders.

More information can be found in the RCN's *Women's Health Pocket Cards* at: rcn.org.uk/Professional-Development/publications/womens-health-pocket-guide-uk-pub-010-898 and: rcn.org.uk/clinical-topics/Womens-health/Promoting-menstrual-wellbeing/heavy-menstrual-bleeding

Bleeding disorders

Women can have bleeding disorders that can impact on menstruation. In such disorders, for example von Willebrand's, which is the most common one, there can be a reduction in the factor that is involved with clotting, or the factor is defective. Women who are carriers of haemophilia can be symptomatic as well and have low factor VIII levels and so have a tendency to bleed more. The next most common disorder is platelet function disorder.

Questions to note in a patient history would be:

- heavy periods from menarche
- family history of surgery for heavy menstrual bleeding
- history of unexpected bleeding after routine operations, childbirth or tooth extractions
- bruising easily.

If a woman is suspected of having a bleeding disorder then she needs to be referred to a haematologist for a diagnosis, which is best done in non-pregnant women who are not taking any hormonal contraception. Once a diagnosis is made the normal range of treatments for periods can be offered.

More detail is available at: <https://haemophilia.org.uk/bleeding-disorders/women-with-bleeding-disorders>

Polycystic ovarian syndrome (PCOS)

PCOS is an endocrine condition (affects ovaries, uterus, liver and adrenals) with multiple presentations affecting up to 10% of women of reproductive age.

- Harder to diagnose in young girls who have just started periods.
- Unknown causes, possible genetic link, fetal exposure to androgens.

- Multiple small follicles with persistently high luteinising hormone (LH), which inhibits ovulation, leading to high androgens.

Signs and symptoms:

- none
- irregular/no periods-(70%)
- infertility
- increase in hair-hirsutism (70%)
- male pattern baldness (5-10%)
- acne (15-25%)
- weight gain and obesity (45%).

More information can be found in the RCN's *Women's Health Pocket Cards* at: rcn.org.uk/Professional-Development/publications/womens-health-pocket-guide-uk-pub-010-898 and: rcn.org.uk/clinical-topics/Womens-health/Promoting-menstrual-wellbeing/Polycystic-Ovarian-Syndrome

6: Early investigations and initial treatments

Examination

- Pelvic and speculum examination:
 - speculum examination to assess the cervix and look for cervical polyps, ectropion and cancer
 - pelvic examination may identify a mass such as fibroids and pain that may indicate other pathology.
- Check infection screen and cervical screening.

Investigations

- A full blood count for all women with heavy menstrual bleeding. Consider a serum ferritin or iron if any symptoms of iron deficiency are present, although do not carry out routinely (NICE, 2018).
- If irregular bleeding, may carry out thyroid stimulating hormone, follicle-stimulating hormone (FSH), luteinising hormone, and oestradiol assessments. But not to diagnose menopause (NICE, 2019).
- NICE (2021) – hysteroscopy is suggested as the first line investigation for bleeding and ultrasound is the first line diagnostic tool for identifying other abnormalities such as fibroids and in the presence of pain.
- Dependent on age and presenting complaint, a hysteroscopy and biopsy and treatment may be needed to investigate any cavity pathology and a colposcopy to investigate any cervical abnormality.
- Women may present with similar symptoms that have different causes. For example, women with PCOS may have irregular, heavy bleeding with spotting and post-coital bleeding but these symptoms could apply equally to women with a sub-mucosal fibroid.
- Confirm women's recollection of cervical screening with the medical records.

Initial treatments would depend on the cause

- For heavy menstrual bleeding – follow the NICE (2021) guidelines with IUS, tranexamic acid, progestogens.
- For PCOS – it would depend on the desired outcome:
 - fertility concerns may need referral
 - lack of periods would need adequate progestogen cover for the endometrium.

Table 4 Referrals, symptoms and treatments

CAUSE OF BLEEDING	SYMPTOMS	TREATMENTS/REFERRALS
Heavy menstrual bleeding (HMB)		
Endometrial polyps	HMB, IMB or PCB	Hysteroscopic resection*
Adenomyosis	HMB and pain	Hormonal medication, IUS, tranexamic acid, non-steroidal anti-inflammatory drugs (NSAIDs) such as mefenamic acid. Referral if medical treatment fails. Embolisation* or hysterectomy*
IUCD/ medroxyprogesterone acetate injection	Irregular bleeding, HMB	Change contraception
PCOS	HMB, irregular, spotting or continuous bleeding	Depends on patient's needs. Can use hormones to control cycle if patient does not want to get pregnant If pregnancy is desired consider referral to secondary care/fertility services*
Simple hyperplasia	HMB, irregular, spotting or continuous bleeding	Treatment with progestogens*, LNG-IUS*
Endometritis	HMB, irregular, spotting or continuous bleeding	Treatment with antibiotics
Cancer	HMB, IMB, PCB or discharge	Referral to gynaecology oncology team*
No cause found	HMB, IMB or PCB	Treatment with tranexamic acid, NSAIDs (eg, mefenamic acid), LNG-IUS Endometrial ablation (if completed family)* Referral if failed medical treatment*
Fibroids – treatment dependant on size and locations	HMB, IMB or PCB	Medical (unless submucosal) ie, Ulipristal acetate (Esmya) or GnRH analogues Surgical/procedural* ie, hysterectomy, myomectomy, uterine artery embolisation (UAE) hysteroscopic resection, transcervical radiofrequency ablation (Sonata)
Intra cavity/sub mucosal fibroids	HMB, spotting, IMB or PCB	Hysteroscopic resection*
Post-coital bleeding (PCB)		
Cervical polyps	IMB or PCB	Removal – primary or secondary care
Cervical ectopy	IMB or PCB	Change contraception Secondary care – can be treated with cold coagulation* following normal biopsy
Sexually transmitted infection	IMB or PCB	Treatment in accordance with guidelines
Vaginal atrophy	PMB or pain with sex	Vaginal oestrogens
Endometrial polyps	IMB or PCB	Hysteroscopic resection* (once cause for PMB has been investigated)
Cervical cancer	IMB or PCB	Referral to gynaecology oncology team* (once cause for PMB has been investigated)

*only available in secondary care

CAUSE OF BLEEDING	SYMPTOMS	TREATMENTS/REFERRALS
Inter-menstrual bleeding (IMB)		
Cervical and endometrial polyps	IMB or PCB	Removal* (cervical polyps may be removed in primary or secondary care)
Submucosal fibroids	HMB, IMB or PCB	Hysteroscopic resection*
Cervical and endometrial cancer	HMB, IMB, PCB or PMB	Referral to gynaecology oncology team*
Sexually transmitted infection	IMB or PCB	Treatment in accordance with guidelines
Post-menopausal bleeding (PMB)		
Vaginal atrophy	PMB or PCB	Vaginal oestrogens
Cervical and endometrial polyps	PMB	Removal*
Submucosal fibroids	PMB	Hysteroscopic resection*
Cervical and endometrial cancer	PMB	Referral to gynaecology oncology team*
Simple hyperplasia	PMB	Treatment with progestogens*, LNG-IUS*
Abnormal bleeding on HRT	PMB	Investigate if 6 months more*, change HRT*, IUS*
Atypical hyperplasia		Hysterectomy* and referral to gynaecology oncology

*only available in secondary care

For further guidance on treatment options and shared decision making please visit:
[nice.org.uk/guidance/ng88/resources/endorsed-resource-shared-decision-making-aid-for-heavy-menstrual-bleeding-6540669613](https://www.nice.org.uk/guidance/ng88/resources/endorsed-resource-shared-decision-making-aid-for-heavy-menstrual-bleeding-6540669613)

7: Conclusion

This RCN guidance can be used with women and girls to:

- discuss normal bleeding patterns throughout the menstrual lifecycle
- undertake a detailed history and assessment
- explore how their periods impact on different aspects of their lives
- consider individual circumstances that may impact on menstrual wellbeing
- discuss health promotion interventions to promote menstrual wellbeing
- recognise specific signs and symptoms indicative of a menstrual disorder
- arrange initial investigations
- discuss early treatment options
- signpost to other support services
- recognise conditions requiring early referral to secondary care.

Menstruation is a natural biological process and an integral part of female wellbeing. However, menstrual cycles are surrounded by varying degrees of stigma, silence and shame in many contexts. Women and girls are often uninformed about what constitutes a 'normal' period at different stages of their lifecycle. This may lead to delays in women accessing help, as they may perceive their bleeding and associated symptoms to be normal and something to be tolerated. Equally, nurses may not recognise these symptoms as requiring further investigation, which may result in a late diagnosis of conditions such as heavy menstrual bleeding, endometriosis or gynaecological cancers. Conversations about menstruation need to be normalised so women feel more comfortable seeking advice and have access to the information they need to make informed choices about their health.

All health and social care professionals working across a range of settings, such as schools, children and young people's services, primary care settings, sexual health clinics, urgent care, and gynaecology services are in a prime position to promote an open dialogue about menstrual health. Initiating early conversations with young girls and boys is fundamental to alleviating social stigma and promoting positive attitudes about periods. It is important to make every contact count by ensuring that women and girls have information about the physical, psychological, social and personal aspects of periods. Nurses can be instrumental in recognising period problems and associated symptoms, and understanding the impact these may be having on girls' and women's academic achievements, employment prospects, social and family lives. A holistic and sensitive approach to care is imperative to empower women to feel able to discuss their needs and preferences.

References and further reading

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Brook (2022) Healthy lives for young people: Periods. brook.org.uk/your-life/periods

Easy Read information about common health conditions for people with a learning disability; including *Keep Yourself Healthy: A Guide To Having A Period*: easyhealth.org.uk

Endometriosis support and/or information:

- Endometriosis UK endometriosis-uk.org
- NICE Guidance on Endometriosis (including patient decision aid for treatment) nice.org.uk/guidance/ng73
- ESHRE Guidelines (2022) eshre.eu
- RCN (2024) *What is Endometriosis?* rcn.org.uk/Professional-Development/publications/rcn-what-is-endometriosis-uk-pub-011-851
- RCN (2024) *Clinical Nurse Specialist in Endometriosis* rcn.org.uk/Professional-Development/publications/rcn-what-is-endometriosis-uk-pub-011-851
- The British Society for Gynaecological Endoscopy www.bsge.org.uk
- Royal College of Obstetricians and Gynaecologists www.rcog.org.uk
- European Society of Human Reproduction and Embryology www.eshre.eu
- The World Endometriosis Society endometriosis.ca

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Faculty of Sexual and Reproductive Healthcare *FSRH Clinical Guideline: Problematic Bleeding with Hormonal Contraception* fsrh.org/standards-and-guidance/documents/ceuguidanceproblematicbleedinghormonalcontraception

Faculty of Sexual and Reproductive Healthcare *FSRH CEU Clinical Statement: Contraceptive Choices and Sexual Health for Transgender and Non-Binary People* fsrh.org/Public/Documents/fsrh-ceu-statement-contraceptive-choices-and-sexual-health-for-non-binary-people.aspx

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National Association for Pre-Menstrual Syndromes pms.org.uk

NHS Mindfulness nhs.uk/mental-health/self-help/tips-and-support/mindfulness

NHS Choices Fibroid Treatment nhs.uk/conditions/fibroids/treatment

National Institute for Health and Care Excellence. Clinical knowledge summary for uterine fibroids. [nice.org.uk/Guidance/IPG367](https://www.nice.org.uk/Guidance/IPG367)

National Institute for Health and Care Excellence. Amenorrhoea. cks.nice.org.uk/topics/amenorrhoea

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Verity: a self-help group for women [verity-pcos.org.uk](https://www.verity-pcos.org.uk)

Wear White Again, Period diary and resources on heavy menstrual bleeding
[wearwhiteagain.co.uk](https://www.wearwhiteagain.co.uk)

Appendix: Wear White Again diary

Download the period diary here: wearwhiteagain.co.uk



My Diary

Since heavy bleeding can develop gradually, you may get used to it, or at least manage it. Often women do not realise that continuous heavy periods are a treatable medical condition (called menorrhagia). There are a number of treatment options available that can help give you back control of your life.

How to track

Tracking your periods

Use this **period diary** to help you and your doctor understand your periods and the symptoms you experience. Your doctor can then discuss potential treatment options with you.

Symptoms

Tiredness

If you experience extreme tiredness (fatigue), tick the box on the relevant day.

Blood loss

Heavy or strong flow during menstruation can cause blood to accumulate within the womb faster than the body can completely and properly expel it. When this happens blood pools and clots. If you experience a blood clot larger than a 10p coin and/or experience pooling/flooding, tick the box.

When do I need to change my sanitary products?



Light Flow

Changing sanitary products every 3-5 hours



Medium Flow

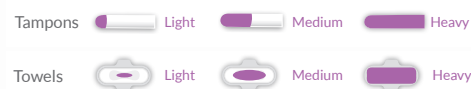
Changing sanitary products every 2-3 hours



Heavy Flow

Changing sanitary products every 1-2 hours*

Flow Gauge



*Doubling up using multiple sanitary products at the same time.

1 in 5 women
SUFFER WITH
HEAVY PERIODS*

*Royal College of Obstetricians and Gynaecologists. National Heavy Menstrual Bleeding Audit (May 2011). Last accessed August 2017, available https://www.rcog.org.uk/globalassets/documents/guidelines/research-audit/nationalhmbaudit_1stannualreport_may2011.pdf

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How to use this diary in 5 easy steps



Add the month



Tick the box that best describes your blood loss during the day – description opposite



If you experience any pain, rate your highest pain score over the day, according to the pain score chart on the next page



Add any additional information about symptoms you are feeling



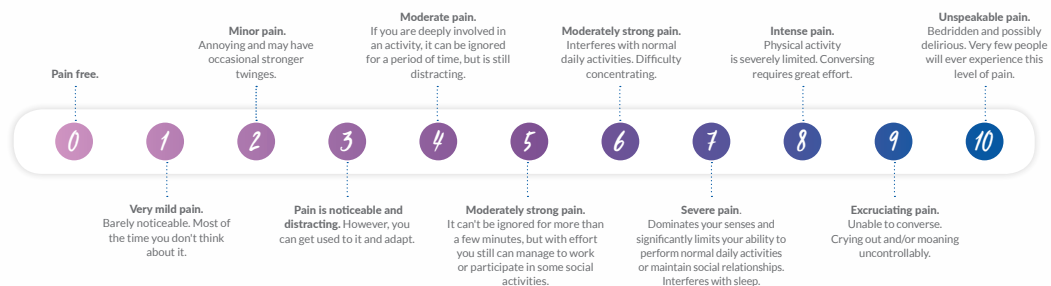
Return to your GP when agreed for further advice on your best treatment options

Month 1

Month:

Days	e.g.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
HEAVY																																
Flow																																
MEDIUM		✓																														
LIGHT																																
PAIN (0-10)		6																														
CLOTS		✓																														
TIREDNESS		✓																														

Pain score chart



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Month 2

Month:

Days	eg.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Flow	HEAVY																															
	MEDIUM	✓																														
	LIGHT																															
PAIN (0-10)		6																														
Symptoms	CLOTS	✓																														
	TIREDFNESS	✓																														

Month 3

Month:

Days	eg.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Flow	HEAVY																															
	MEDIUM	✓																														
	LIGHT																															
PAIN (0-10)		6																														
Symptoms	CLOTS	✓																														
	TIREDFNESS	✓																														

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RCN quality assurance

Publication

This is an RCN practice guidance. Practice guidance are evidence-based consensus documents, used to guide decisions about appropriate care of an individual, family or population in a specific context.

Description

Menstruation is both a physiological and psychological milestone in a woman's life. This updated publication has been developed to help nurses breakdown the stigma that can be associated with what is a completely natural process. It is important to use appropriate and flexible communication methods to ensure information on the menstrual cycle is delivered in an accessible format for women.

Publication date: July 2025 Review date: July 2028

The Nine Quality Standards

This publication has met the nine quality standards of the quality framework for RCN professional publications. For more information, or to request further details on how the nine quality standards have been met in relation to this particular professional publication, please contact **publications.feedback@rcn.org.uk**

Evaluation

The authors would value any feedback you have about this publication. Please contact **publications.feedback@rcn.org.uk** clearly stating which publication you are commenting on.

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Published by the Royal College of Nursing
20 Cavendish Square
London
W1G 0RN

020 7409 3333
www.rcn.org.uk

July 2025
Publication code: 012 123

