Management of Women with Postmenopausal Bleeding

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Version changes: Update on new NICE guidance on initial investigations for suspected cancer – increasing investigation age to 55 in women without risk factors.
Introduction and Scope

It is the policy of the gynaecology department at York Hospitals NHS Trust to care for women in accordance with best available evidence along with regional/national guidance. The following guidance sets out the expected pathway for women presenting with Postmenopausal Bleeding (PMB) from primary through to tertiary care.

**PMB is defined as an episode of vaginal bleeding 12 months or more after the last period.**

PMB is a cardinal symptom of endometrial cancer and does require further investigation. Approximately 10% of women up to 60 years of age presenting and referred with post-menopausal bleeding have endometrial cancer and this rises to 13% over the age of 60. For women on HRT presenting with PMB or unscheduled bleeding this risk falls to 1%.

Other causes of bleeding from the genital tract also need to be considered such as cervical cancer, atrophy and HRT.

Endometrial cancer can also present with unexplained vaginal discharge or haematuria.
Cancer of vulva, vagina or cervix?

Refer Fast Track

Patient presents with PMB
- GP performs VE and urinalysis.

Age ≥55 or <55 with risk factors
send URGENT Ultrasound fast track scan form
- Clearly stating PMB
- Vaginal examination findings

Age ≥55 or <55 with risk factors
consider wait and see

Non-suspicious

GP to follow up and treat
any underlying conditions, e.g. atrophy.

Further bleeding despite
treatment / no known
cause within 6 months

Suspicious

GP to send Fast-track/2WW Referral Form

Direct Access Hysteroscopy

Histology results

Abnormal result
- Patient informed over the telephone or in clinic.
- Letter to patient including contact details of Clinical Nurse Specialist.
- Letter to GP to be faxed stating patient has been given diagnosis of cancer.

Normal.
- Patient sent a letter, copy to the GP.
- If further bleeding
GP to investigate after 6 months.

MRI or CT scan booked once abnormal result known by consultant and patient.
- MRI pelvis for endometrial adenocarcinoma and atypical hyperplasia.
- CT chest, abdo and pelvis for serous or clear cell adenocarcinoma plus carcinosarcomas.
- Others to be discussed at MDT first.

Discussed at MDT, no need to wait for MRI or CT if not available as plans for care can be made.

Patient to be informed of FU plans.

EXCEPTIONS

HRT
COIL
TAMOXIFEN

Stop for 6/52
Remove

Abnormal bleeding continues
Bleeding stops – GP FU

Non-suspicious

GP to follow up and treat
any underlying conditions, e.g. atrophy.

Further bleeding despite
treatment / no known
cause within 6 months

Suspicious

GP to send Fast-track/2WW Referral Form

Direct Access Hysteroscopy

Histology results

Abnormal result
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Patient to be informed of FU plans.
Guidance for GPs

Women should have a full history, gynaecological examination and urinalysis. If cancer of the genital tract other than endometrial is suspected then fast track/2WW referral should be made at this stage. If endometrial cancer is suspected then an urgent pelvic ultrasound scan within 2 weeks is first line.

New NICE guidance published in 2015 states women should be referred via a suspected cancer pathway aged 55 and over with PMB. For women younger than 55 then guidance states consideration for referral only. Those women who have no risk factors for endometrial pathology could be considered for a ‘wait and see’ approach. The risk factors include obesity, diabetes, PCOS, heavy or recurrent episodes of bleeding and current tamoxifen therapy.

Those aged 55 and over with unexplained discharge that are presenting for the first time or have thrombocytosis or haematuria should be considered for urgent referral for pelvic ultrasound scan.

Those aged 55 and over with visible haematuria and low haemoglobin levels or thrombocytosis or high blood glucose levels should be considered for urgent referral for pelvic ultrasound scan.

For women taking HRT then consideration should be given to stopping this. If bleeding continues after 6 weeks then they should be referred for a scan at this stage. If the woman is unwilling to stop HRT then they should be informed that if they have any abnormal endometrial pathology then HRT could worsen this and referral for an urgent/2WW scan should be on the basis of the following;

- Persistent unscheduled bleeding on tibolone or continuous combined HRT after the first 6 months of treatment or after amenorrhoea established.
- Breakthrough bleeding or heavy/prolonged bleeding at the end of the progestogen phase for sequential regimens.

For women currently taking tamoxifen then fast track referral straight to hysteroscopy should be made as endometrial assessment on scan in these women is difficult to interpret. This does not apply to those taking anastrozole.

For women with recurrent PMB occurring some months after a normal scan and following treatment of potential causes such as infection, referral for fast track /2WW Gynaecology referral for hysteroscopy should be made. For women who have had a normal hysteroscopy, then go on to have further bleeding, reinvestigation should be considered after 6 months with a scan initially. If the time period between episodes of PMB is greater than 6 months a further scan request can be made rather than direct referral to secondary care.

For women with an IUCD in-situ these should be removed before requesting a scan as the endometrium cannot be assessed with a IUCD in-situ. If the women is unwilling to have her IUCD removed or it is felt necessary clinically to leave it in-situ and endometrial pathology is suspected then referral to direct access hysteroscopy can be made as a fast track/2WW referral. It should be noted that these women are supposed to be post-
menopausal. If the diagnosis of the menopause is in doubt due to a mirena IUS being in situ, the IUS could be removed to see if menstruation returns.

All women should be made aware that further investigations could lead to a diagnosis of cancer.

**Guidance for GPs once scan result is available**

For those with a non-suspicious scan result (endometrial thickness less than or equal to 4mm) then the woman needs to be informed of the result and plans made for treatment if necessary. This could include topical oestrogens for atrophy or adjustments to HRT.

**Fibroids** are very common and in the presence of a normal endometrium do not require any action.

**Atrophic Vaginitis** is one of the commonest non-malignant causes of PMB and is appropriate to manage in primary care with topical estrogens (e.g. A 3 month course of Vagifem).

**Lichen Sclerosus** may also be found at examination in post-menopausal women. It can be managed in primary care with topical steroids and routine annual examinations to exclude any suspicious changes. There is a 2-4% lifetime risk of vulval malignancy with this condition. The CCG RSS guidance has some useful tips on managing this problem.

For those with a **suspicious scan fast track/2WW referral** should be made and the women will be informed by telephone or sent an appointment for out-patient hysteroscopy. The woman needs to be informed of the scan results and the intention to refer for urgent hysteroscopy. An information leaflet regarding out-patient hysteroscopy is sent with each appointment letter.

If the woman is not sure she wants an out-patient hysteroscopy she still needs to attend this appointment to discuss the alternatives – most women tolerate the procedure well and the instruments are no bigger than pipelle samplers which have been used in out-patients for many years.

The scan result should include a statement as to whether the result is suspicious or not and if referral is recommended.
Guidance for Hysteroscopy Clinic

Women should be given an appointment within 14 days from the fast track/2WW referral date.

All women should have a history and BMI performed.

If an out-patient hysteroscopy is not possible then urgent day unit procedure should be booked within 14 days.

If hysteroscopy possible and cause for bleeding seen such as a polyp, a biopsy should be taken even if the polyp is too large for removal. The woman can be down graded from fast track only with normal histology.

If out-patient hysteroscopy not possible in a woman with multiple medical problems then consultant opinion needs to be sought before booking in-patient procedure. Risk assessment of cancer Vs risk of anaesthetic is required.

It should be discussed with the patients how they would like to be informed of their results. If abnormal this would usually be a choice between a telephone call or an urgent clinic appointment. Those with normal results would usually receive a letter. Their decision should be documented in the notes.

Patients should be informed as soon as possible via their chosen route. If abnormal then letters to the patient confirming diagnosis and possible further treatments should be sent urgently once they have received their diagnosis. This should include contact details of the clinical nurse specialist.

A copy of the patient letter should be sent to the GP with a separate letter informing them the patient has received a diagnosis of cancer. These should be faxed / electronically sent to the surgery, backed up by a telephone call to the surgery so that they are expecting the letters and the GP’s can take timely appropriate action.

There is no need to wait for the MDT if histology is endometrial adenocarcinoma, atypical hyperplasia, serous or clear cell adenocarcinoma plus carcinosarcomas. An MRI or CT scan should be booked (as per guidance in the pathway above) and U+E’s checked if not done recently.

The woman needs to be discussed at the next MDT meeting even if MRI or CT not yet available as a plan or care can be made.

Once a treatment plan is made by the MDT, the woman needs to be informed by letter which may include an appointment with CLO, CJB, RWH or TB. This could be a pre-operative appointment.
Implementation

GPs informed via the Vale of York CCG. The pathway was initially presented at the January 2012 GP Forum and full paper briefing to all practices followed. Pathway implementation date was the 05/03/12.

Updated versions will be shared with GPs via the Vale of York monthly Update and also via the weekly communication.

Information regarding this guideline will be disseminated via the gynaecology MDT and teaching programme of junior doctors. A copy of this document will be available on the gynaecology X-drive and on horizon.

Monitoring and Audit

Stages of the pathway are audited on an annual basis as part the Yorkshire cancer network peer review audit and York Cancer work programme.

Consultation

This policy has been written by Miss Claire Oxby in liaison with the Vale of York CCG clinical lead for Women’s Health, Dr Emma Broughton and Dr Joan Meakins. It has been reviewed by the gynaecology MDT. Approved with the Gynaecology MDT and official gynaecology clinical governance approval on 13.05.16.

Review Arrangements

The authors and owners of this procedure will review the contents every two years, or earlier if new evidence comes to light. The review will include consultation with relevant clinical leads and those involved in delegating or undertaking the advanced practice. The results of the review will be submitted to the Gynaecology MDT, gynaecology clinical governance and GP forum for approval.

Supporting Evidence

1) Yorkshire Cancer Network, Going further on cancer waits – A quick guide for MDTs.

2) Yorkshire Cancer Network. Network endometrial cancer pathway, Version 1.0 – August 2009


4) Investigation of Post-menopausal Bleeding. SIGN publication No.61. Modified 16/09/11