Appendix 4: Auditable topics

1. Women prescribed stand-alone estradiol products (oral / transdermal) with concurrent issue of appropriate dose and total days per month progestogen or progesterone (100%)

2. Women prescribed stand-alone estradiol products (oral / transdermal) in the presence of an 'in-date' 52 mg LNG–IUD (five or less years since insertion) (100%)

3. Women who started HRT ≥ 45 years of age switched to ccHRT after 5 years of sequential HRT or by age 54 (whichever occurs first) (100%)

4. Percentage of women presenting with unscheduled bleeding meeting criteria for USCP referred by a USCP (100%)

5. Percentage of women presenting with unscheduled bleeding on HRT meeting the criteria for referral on USCP meeting 28-day faster diagnosis target (85%)

6. Percentage of women referred for urgent (6 week) TVS seen by 6 weeks (85%)

7. Percentage of women referred on an urgent (6 week) pathway, with endometrial assessment by 6 weeks (85%)

Appendix 5: Research Priorities

1. Assessment of endometrial cancer risk in women who have unscheduled bleeding on ccHRT including variables relating to moderate / high dose estrogen and/or micronised progesterone.

2. Assessment of endometrial cancer risk in perimenopausal women who have unscheduled bleeding on sHRT including variables relating to moderate / high dose estrogen and/or micronised progesterone.

3. Acquire evidence assessing endometrial cancer risk dependent upon total duration of HRT use. This should be stratified by progestogen type and dose (with priority given to micronised progesterone).

4. Assessment of endometrial protection with LNG IUD as progestogenic component of HRT:
   a. When lower dose (13.3 and 19.5 mg) LNG IUD is used
   b. When 52 mg LNG IUD is sited in the lower endometrial cavity (more than 2 cm from the fundus)
   c. When 52 mg LNG IUD is used in conjunction with estrogen use above high dose.

5. Acquire evidence correlating endometrial thickness (ET) with endometrial disease (hyperplasia with / without cytological atypia and endometrial cancer) in women who have unscheduled bleeding on HRT. Priority should be given to women taking sequential HRT; assessment of ultrasonographic variation at different intervals in the cycle, with histological correlation, may enable higher cut-offs at the end of the progestogen phase which would reduce the number of women offered invasive testing.

6. Assessment of optimal interval for endometrial reassessment (ultrasound or biopsy) in women who have recurrent unscheduled bleeding, despite progestogen adjustments, and a normal biopsy and / or hysteroscopy.

7. Assessment of the prevalence of endometrial hyperplasia / cancer in hysteroscopically diagnosed focal endometrial pathology in women with unscheduled bleeding on HRT.

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