Abnormal Uterine Bleeding

BELMATT
HEALTHCARE TRAINING

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Issues Covering:

- **Menorrhagia**
- **Endometriosis**

Menorrhagia

- **Definition of menorrhagia: Passing of more than 80mls of blood in each cycle**

- **Take a detailed clinical history:**
  - The nature of the bleeding (flooding, clots)
  - Her age
  - Cervical screening history
  - Details of the woman's normal menstrual cycle (such as length of the cycle, number of days of menstruation) and any variation of this pattern.
  - Sexual history — this should include current contraceptive use, contraceptive plans, and future plans for a family, as this may impact on the choice of treatment.

Menorrhagia

- The possibility of pregnancy should be considered and excluded
- Family history — particularly ask about endometriosis and coagulation disorders
- Medicines (for example hormonal contraceptives) — these may cause irregular bleeding.
- **Consider the possibility of an underlying systemic disease**. For example, look for signs of hypothyroidism (goitre) or PCOs (acne, hirsuitism)
- Other associated symptoms that might suggest an underlying cause for menorrhagia.

Further Investigations

- **Perform an abdominal and bimanual pelvic examination:**
  - To exclude an underlying cause, such as ascites, fibroids or gynaecological cancer.
  - **Perform a speculum examination of the vagina and cervix**
  - Swabs should be taken if infection is suspected.

- **Arrange a blood test to check for iron deficiency anaemia, Thyroid disorders and any other appropriate investigations.**

- **Consider referral for pelvic u/s scan if suspect any fibroids or other abnormal pathology**

Treatment – Non Hormonal

- Tranexamic acid 500mg tablets, one or two three times a day, for up to 4 days (max 8 a day)

- NSAIDs - Only mefenamic acid is specifically licensed for menorrhagia.
- The following doses are recommended:
  - Mefenamic acid — 500 mg three times daily.
  - Naproxen — 500 mg as the first dose, then 250 mg every 6–8 hours.
  - Ibuprofen — 400 mg three or four times daily

  - When menorrhagia coexists with dysmenorrhoea, NSAIDs should be prescribed in preference to tranexamic acid.

Treatment- Hormonal

- Consider initially stopping heavy menstrual bleeding by prescribing:
  - Oral Norethisterone 5 mg three times daily for 10 days — bleeding usually stops within 48 hours. Inform the woman that a withdrawal bleed will occur a few days after stopping treatment.
  - If bleeding is exceptionally heavy ('flooding'), 10 mg three times daily for 1 week, may provide more effective results. This should then be tapered to 5 mg three times daily for one week, once bleeding has stopped, depending on clinical judgement.

- Prescribe oral norethisterone longer term (5 mg three times daily) from days 5–26 of the menstrual cycle (the follicular and luteal phases) — this dose is off-label
- Note latest studies suggest Norethisterone carries similar clotting risks to CHC

Treatment - Hormonal

- Depending on the acceptability to the woman, consider treatments in the following order:
    - Levonorgestrel intrauterine system (LNG-IUS) provided long-term (at least 12 months) use is anticipated
    - Combined oral contraceptives (COCs).
    - Consider POP or Depo for those not suitable for above options

Treatment - Surgical

- For patients who do not respond to medical treatments, have other complicating factors, or when other methods are not suitable consider referral to gynaes for surgical options.
- Endometrial Ablation
- Fibroidectomy
- Hysterectomy

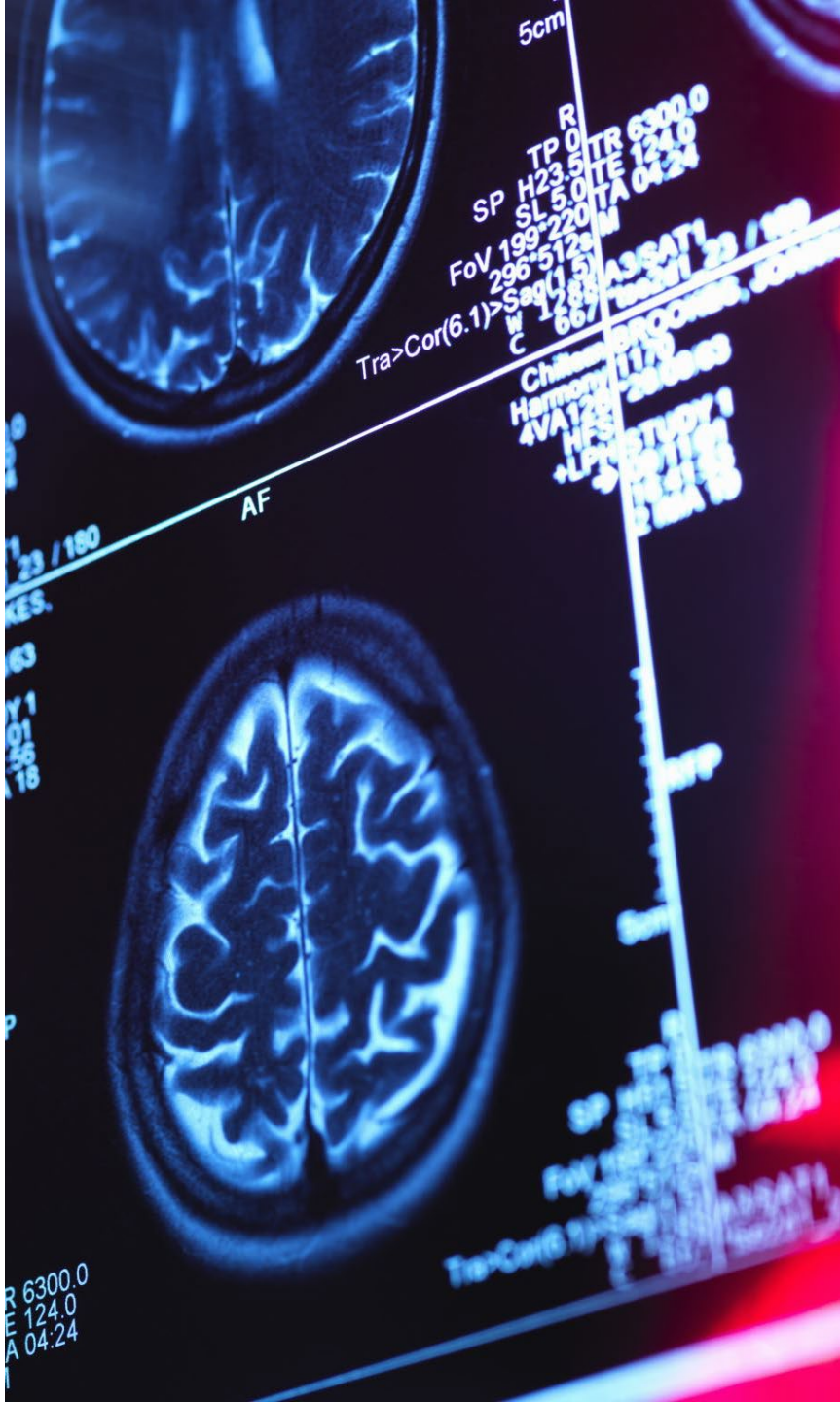
Endometriosis

- Long term condition where tissue similar to the endometrium grows in other places eg fallopian tubes, ovaries, bowel

- Aetiology is unknown

Symptoms include:

- pelvic pain often related to menstruation
- Dysmenorrhoea
- deep dyspareunia
- cyclical dysuria
- May result in infertility



Endometriosis Diagnosis

- A detailed history including menstrual history
- Physical examination- pelvic examination to check for pelvic tenderness and cervical excitation as well as any obvious pathology
- Laparoscopy often only way to confirm diagnosis –visual mapping of the lesions and histological confirmation

Endometriosis – Treatment Options

- Drug treatments induce atrophy of ectopic endometrium, either by altering the effect of oestrogen on endometriosis tissue or by reducing circulating oestrogen levels, which may reduce menstrual bleeding or induce amenorrhoea.
- **If the woman does not wish to conceive, consider prescribing a 3–6 month trial of hormonal contraception (off-label use).**
- Advise the woman to start a 3–month trial of a conventional regimen, or switch to tricycling or continuous use if this does not control symptoms.
- POP (desogestrel 75 micrograms), depot (Depo-Provera® or SAYANA PRESS®), subdermal implant (Nexplanon®) may all help
- Mirena IUS may also be considered, after a full discussion of the advantages and disadvantages.
- Surgery

Intermenstrual Bleeding

Among women with regular menses, intermenstrual spotting occurs in less than 3 percent of cycles and **may** simply represent physiological intermenstrual bleeding associated with ovulation. In these situations the bleeding is likely to be cyclical

Other causes include:

Cervical factors

Vaginal Factors

Endometrial factors

Hormonal/Iatragenic factors

Intermenstrual Bleeding – Cervical Factors

- Cervical Polyps
- Cervical Erosion
- Cervicitis

Intermenstrual Bleeding – Cervical Polyps

Cervical Polyps: treatment is removal. Note risk of bleeding and need to arrange a pelvic scan to exclude endometrial lesions

Smaller lesions can be removed in the community but larger ones require referral to gynaes

Cervical polyps should be avulsed and sent for histology.

A systematic review and meta-analysis found that the incidence of cancer within an endometrial polyp in women of reproductive age was only 1.7%, compared with 5.4% in postmenopausal women[12].

Intermenstrual Bleeding -Cervical ectropions

Common in teenagers, patients taking the CHC, and pregnancy as often hormone induced

These may resolve spontaneously if the COC pill is stopped

They can be treated conservatively or cauterised with silver nitrate.

Other treatment options include thermal cautery and diathermy, cryosurgery, laser or microwave therapy

Intermenstrual Bleeding – Cervicitis

- Usually related to infection of some kind
- Treatment should be tailored towards the results of the swab taken.
- Chlamydia or GC consult local GUM clinic for latest treatment regimens
- Bacterial vaginosis (Metronidazole 400mg BD for 7 days)

Intermenstrual Bleeding: Endometrial Factors

Endometrial polyps – usually diagnosed on U/S scan

Endometrial hyperplasia or carcinoma or, rarely, uterine sarcoma – Usually diagnosed on endometrial biopsy taken at hysteroscopy

Endometritis or PID

Intermenstrual Bleeding – Hormonal/Iatragenic factors

- Tamoxifen
- Following Smears or treatment to the cervix
- Drugs that alter clotting parameters eg antivoagulants, SSRIs steroids
- Hormonal contraception break through bleeding

Post Coital Bleeding

Within General Practice approximately 6% of patients will present with post coital bleeding.

·PCB occurs in 0.7-39% of women with cervical cancer.

The incidence of finding a woman in the community presenting with PCB who has cervical cancer is 1 in 44,00- of 20-24 year olds and 1 in 2,400 of 45- 54 year olds.

Abnormal Vaginal Bleeding – History key points

- Menstrual Hx – LMP, cycle length and regularity
- Duration of abnormal bleeding and any cyclical pattern
- Sexual history, recent partners and any previous screening hx
- Associated symptoms eg pain, discharge, fever, dyspareunia
- Aggravating factors eg SI, exercise
- Obstetric Hx
- Contraception Hx
- Any current pregnancy risk
- Medical Hx and current medications

Abnormal Vaginal Bleeding - Examination

- Bimanual PV exam and speculum exam to exclude any pelvic mass, cervical excitation, obvious abnormal vaginal or cervical pathology
- BMI if high is an independent risk factor for endometrial Ca
- Abdominal exam to exclude any obvious abdominal mass
- Pregnancy test
- If relevant can consider bloods for Thyroid, clotting, FBC, FSH/LH

Investigations and Examination

ALWAYS exclude the possibility of the patient being pregnant. If this is positive then the patient requires urgent referral to early pregnancy clinic for an ultrasound +/- serial serum β-HCG. This will help to exclude an ectopic pregnancy.

Screening for STIs – This can be performed by a self-obtained low vaginal swab. This swab will allow for the patient to be tested for Chlamydia and Gonorrhoea.

Cervical Smear – A speculum examination will allow for you to have a look at the vaginal wall for any evidence of vaginitis, an abnormal cervix, an ectropion or any obvious mass. A smear is not routinely performed unless the patient is due for a smear. A negative smear, with persistent post coital bleeding should be investigated

Bimanual examination – Feeling for a palpable mass consistent with a polyp or carcinoma, or cervical excitation/tenderness, which would indicate pelvic inflammatory disease.

Abnormal Vaginal Bleeding- Investigations

Transvaginal ultrasound is the investigation of choice to look for structural abnormality.

Ultrasound should ideally be done immediately postmenstrually, as the endometrium at its thinnest and polyps and cystic areas tend to be more obvious.

Evidence of endometrial thickening (more than 10mm in postmenopausal but can be up to 20mm in menstruating women) should prompt referral for biopsy.

Women with PMB (bleeding after more than 12 months of amenorrhoea if 50yrs and after 24 months <50yrs) require an **urgent** 2ww referral to gynaes for endometrial biopsy to exclude endometrial Ca, unless bleeding is likely to be HRT related

Key Points for Referral

Any features suggestive of an abnormal looking cervix or cervical cancer must be referred urgently

Cervical polyps not easily removed in primary care

Endometrial polpys require hysteroscopy

Any pelvic mass on examination or significant abnormality on U/S scan

High risk of endometrial Ca – FH, tamoxifen, high BMI, over 45yrs with IMB/HMB, under 45yrs with persistent symptoms

POST MENOPAUSAL BLEEDING IS ENDOMETRIAL CANCER UNTIL PROVEN OTHERWISE!

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