Topic: Postmenopausal Bleeding

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Time: 17 minutes 51 seconds

Notes to accompany podcast:

5% of GP referrals relate to postmenopausal bleeding.

10% of postmenopausal bleeds will be due to endometrial cancer. The risk factors to consider are:

- Is the woman 12 month postmenopausal? i.e. vaginal bleeding occurring after twelve months of amenorrhoea
- Does she have any medical risk factors? e.g. diabetes
- Is she an obese patient?
- Is she on Tamoxifen?
- Does she have a family or personal history of hereditary non-polyposis colonic cancers?

These patients should be fast tracked using the 2 week wait process.

For young, fit and healthy patients with no risk factors, the patient should be examined for local causes.

An urgent ultrasound for endometrial thickness is recommended for women with post twelve months of amenorrhoea where no local causes are found, the cervix looks healthy and there is no cervical lesion. If the thickness is 4mm or less and there are no risk factors, the patient can be managed in primary care.

If there are further episodes and reoccurrences of bleeding, or her personal or family history changes, she will need to be referred to secondary care.

Fast track system

Patients referred through the two week process have an outpatient appointment with the oncology team to assess their history and risk factors. Their cervix is examined, their uterus is measured and an urgent scan is arranged.

If the scan suggests less than 4mm thickness, no further investigations are carried out.

If they have recurrent bleeding, more than 4mm thickness or any risk factors, the woman will have a hysteroscopy. Increasingly, hysteroscopies are being carried out in outpatients.

A diagnostic endoscopy is carried out to make an assessment at the time of the scan. If the endometrium looks healthy, there is no other benign cause of bleeding like polyps, the patient is reassured and written to with their histology results to prevent the need to return to a clinic.

If there is suspicion of pathology in the endometrium or any suspicion of cancer, patients will be called back to clinic within the next 10 days and a maximum of 2 weeks to get the results.

Treatment

The only treatment available for endometrium cancer is a hysterectomy with the removal of ovaries and tubes. Laparoscopic hysterectomy can be offered if appropriate for the patient.

Body mass index

Obese people have a conversion of testosterone to oestrogen in the fat cells and also the androstenedione from adrenal glands is converted to oestrogen so there is a double hit of extra oestrogen being produced in a different form to what is produced pre-menstrually which is causing a risk factor to the endometrium

Treatments of choice for endometrial cancer

Hormone replacement therapy (HRT) as a drug is not a risk factor directly for endometrial cancer unless you choose to give oestrogen unopposed to someone who has an intact uterus or monthly bleed combined HRT is given for more than 8 years.

Anyone with an intact uterus would get a combination of oestrogen and progesterone. The only role of the progesterone is to suppress the endometrium to prevent any stimulation from the oestrogen.

The combined HRT is creeping back into practice. The only indication for giving the combined HRT is the symptoms of the patient. There are no health benefits to HRT.

If HRT is being given for symptom control, within the first 12 months of a woman stopping her periods, a 'monthly bleed HRT' would be given. Monthly bleeds can be expected.

For those patients who start to have

- slightly prolonged bleeds in their breakthrough time or
- breakthrough bleeding in between their pill packet or
- bleeding that continues 6 weeks after stopping HRT

these patients should be considered to have suspicious features and referred for screening for endometrium cancer.

Continuous combined HRT is slightly different and is generally started 12 months post-menopause. It is not uncommon within the first three months to have slightly irregular bleeding or breakthrough bleeding. Within the first six months, as long as the patient has no other risk factors, you might choose to change the preparation three months into the treatment. However, if after six months, the patient is still showing breakthrough bleeding, or unexpected bleeding the patient should be referred.

Tamoxifen

Tamoxifen can behave as an oestrogen supplementation on the oestrogen receptors.

Tamoxifen is an independent risk factor for endometrial cancer but Tamoxifen use on its own does not require screening for endometrium cancer.

If the patient gets any breakthrough bleeding they require investigation and referral to secondary care immediately for hysteroscopy. Ultrasound scanning is not useful for Tamoxifen because it changes the appearance of the endometrium.

Support available

UHL provide two full time nurses to support patients from diagnosis to treatment to post-operative care and provide high quality information leaflets.

Cancer Research UK provides information www.cancerresearchuk.org/

The Royal College of Obstetrics and Gynaecology provide leaflets about symptology http://www.rcog.org.uk/womens-health/patient-information

Multi ethnic population

We provide an interpreting service for most of the common languages spoken in Leicester

Our two nurse specialists also speak a multitude of languages

The epidemiology of cancer can be different. For example, Asian, African and Sudan patients may never have had a cervical smear. They can have a high risk of cervical cancer or endometrial cancer and if they present with abnormal blood stained discharge or post-menopausal bleeding, their whole diagnosis could be slightly different to what we would expect.

Further information

Through SystmOne, GPs can access Map of Medicine which is an excellent source. There is a pathway for post-menopausal bleeding where you can click to find out history tips or risk factor tips or examination tips

The Royal College of Obstetrics and Gynaecology has useful information on post-menopausal bleeding and endometrial cancer

NICE provides information on who and when women should be screened for cancer

The Scottish Intercollegiate Guidelines Network (SIGN) Guidelines for postmenopausal bleeding have been recently updated and provide the evidence-base. They also produce a good telephone app http://www.sign.ac.uk/guidelines/fulltext/61/section2.html

Three key messages

1. Do a risk assessment including risk factors and appropriate examination. The aim is to do an appropriate referral to secondary care for urgent referrals.
2. Do an examination. NICE guidance states a pelvic examination should be considered. However an examination can change a referral pathway. For example, if you found a cervical pathology after examination, instead of sending the patient to a general two week wait clinic for endometrial cancer, you want them to be urgently seen for their cervix
3. Do not scan patients on Tamoxifen as it does not rule out anything. If a patient has recently had a normal cervical smear and presents with postmenopausal bleeding, she still warrants a biopsy