Bleeding after the menopause

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Postmenopausal bleeding (PMB)

Prevalence

- 5 per cent of office gynaecology presentations
- 4-11 per cent of postmenopausal women will experience bleeding
- Chance reduces as time since menopause increases

Definition

- Any bleeding from the genital tract occurring in the postmenopausal period

Causes of PMB

Table 1. Origin of PMB incidence.

Atrophy	60–80%
Exogenous oestrogen	15–25%
Polyps (endometrial/cervical)	2–12%
Endometrial hyperplasia	10%
Endometrial cancer	10%
Cervical cancer	<1%

Modified from Goodman A. Postmenopausal bleeding. UpToDate Accessed June 2014 and Brand A. The women with postmenopausal bleeding. *Aust Family Physician* 2007.

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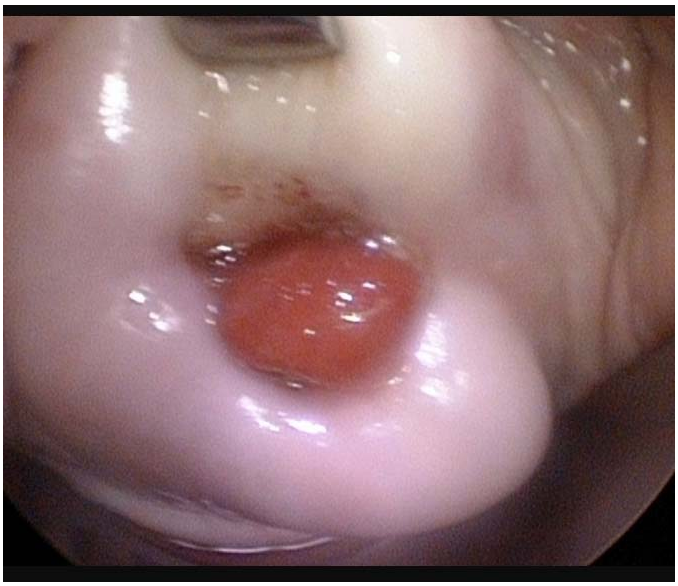
What to do?

Thorough history

- Bleeding history including:
  - when it started, duration, pattern, amount, frequency and any associated trauma
- Changes in bladder or bowel function
- Pain
- Weight loss
- Use of hormone replacement therapy (MHT)
  - the type of MHT (continuous, cyclical, oestrogen and progesterone or oestrogen only) duration of use
- Past gynaecological, obstetric, medical, surgical include, hysterectomy, medications and family history.

Examination

- **General appearance** and establishing **body mass index**
- **Abdominal examination** should focus on palpation for discernible masses
- **Pelvic examination** detailed inspection of the vulva and vagina, especially atrophy, suspicious lesions, trauma and a foreign body
- **Speculum examination** to evaluate the cervix for polyps and cancer. Cervical screening +/- chlamydia PCR
- **Bimanual examination** to evaluate uterine size, mobility and the adnexae plus a rectal examination.



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Investigations

- **Pelvic ultrasound** to determine endometrial thickness and pelvic pathology.
  - TVUS acceptable initial investigation.
- **3-mm cut-**off has high sensitivity for detecting endometrial cancer
- **Tissue biopsy**
  - **Biopsy** may be from the vulva, vagina, cervix, or an endometrial biopsy.

Wong AS BJOG. 2016 Feb;123(3):439-46

Vaginal Ultrasound

In postmenopausal women without vaginal bleeding:

- With endometrial fluid in the uterine cavity, if the endometrial thickness (ET) is 3 mm or less, endometrial sampling is not necessary. [1]
  - Incidence of endometrial cancer is low
- ET cutoff of 11mm or greater, need hysteroscopy assessment.[2]

1. Seckin B. J Obstet Gynaecol. 2016;36(2):230-3.
2. Laiyemo R. J Obstet Gynaecol. 2016;36(2):223-6.

What to do?

- Referral to gynaecologist
  - Depends on GP expertise, available of appropriate radiology, pathology or gynaecological services before referral.
- Complete history
  - Check for adherence to therapy
  - Other medical history
- Examination check for visual signs of bleeding and site
- Repeat vaginal US – tertiary
- Endometrial biopsy
- Hysteroscopy D&C

Endometrial biopsy

- **Gold standard** for evaluation of PMB.
- Endometrial biopsy can be obtained with:
  an **endometrial pipelle** in the outpatient setting,
  or
  by **hysteroscopy and curettage** (with or without dilatation) in either the **outpatient or inpatient** setting.

The sensitivity of the pipelle endometrial sampling in the detection of endometrial hyperplasia and cancer was 99.6 and 81 per cent, respectively, in postmenopausal women.
Feldman S. Evaluation of the endometrium for malignant and premalignant disease. UpToDate. Accessed online June 2014.

Review of the literature on Pipelle biopsy for diagnosis of endometrial lesions

Year	References	Cases	Curettage or hysterectomy	Pipelle	Specimen satisfaction (%)	Pathological accuracy (%)
2015	Sanam and Majid (2015)	130	130	130	88.0	94.0
2014	Rauf et al. (2014)	203	101	102	98	–
2014	Gungorduk et al. (2014)	267	189	78	–	62.0
2013	Leng et al. (2013)	200	200	200	93.0	85.0
2012	Kazandi et al. (2012)	82	82	82	93.0	66.0
2008	Fakhar et al. (2008)	100	100	100	98.0	94.0
2003	Machado et al. (2003)	1535	168	1535	73.9	96.9
1995	Guido et al. (1995)	65	65	65	97.0	83.0
1994	Zorlu et al. (1994)	26	26	26	100	95.0
1994	Ben-baruch et al. (1994)	269	97	172	90.6	95.5

Du J. J Cancer Res Clin Oncol. 2016

Management: what to do next?

- **Cervical or endometrial cancer**, endometrial hyperplasia with atypia or endometrial intraepithelial neoplasia(**EIN)**.
  - Prompt referral to a gynaecological oncology service.
- Endometrial hyperplasia **without** atypia may be treated with progestogens

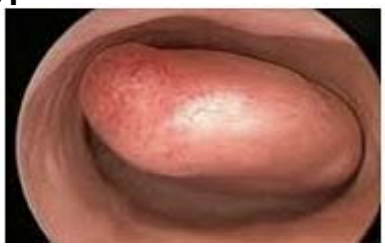
Zito A RANZCOG O&G Magazine Vol 16 No 3 Spring 2014

Management: what to do next?

- Gynaecologist & patient's general practitioner manage other causes

Cervical or endometrial polyps

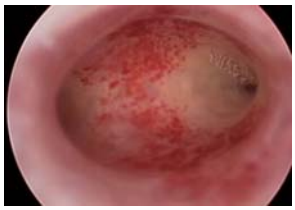
- Removed in the work up.
  - Cervical polyp
    - During examination
  - Endometrial polyp
    - During hysteroscopy
    - Recommended by resection to remove base of the polyp



- If benign histopathology is confirmed, no further investigation or treatment is required.

Atrophy / atrophic endometrium

- Vulvovaginal or urogenital atrophy treatment if symptomatic
  - Lubricants, moisturisers, natural oils
  - Vaginal oestrogens including:
    - Oestriol vaginal pessaries or cream
    - Oestradiol vaginal tablets



Summary

- PMB is endometrial cancer until the diagnosis is excluded
- Atrophy most common cause
- ET 3mm or less does not require biopsy
- Recurrent episodes even if endometrium <3mm require evaluation
- Pipelle has reasonably high specificity/sensitivity for endometrial cancer but not for polyps or submucous fibroids
- Referral to gynae-oncology service if malignant.

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