ABNORMAL UTERINE BLEEDING

What's New:

Information on abnormal bleeding in gender patients on hormonal treatments has been added (page 4 of 7)

Abnormal uterine bleeding describes any symptomatic variation from normal menstruation (eg: regularity, frequency, volume or duration) and may include:

- Post-coital bleeding (PCB)
- Intermenstrual bleeding (IMB)
- Heavy menstrual bleeding (HMB)
- Oligomenorrhoea
- Dysmenorrhoea

Possible Causes:

Structural	Non-Structural
Polyps (cervical or endometrial)	Coagulopathy
Adenomyosis	Ovulatory disorder
Leiomyoma (fibroids)	Endometrial
Malignancy (cervix or endometrium) or hyperplasia	Iatrogenic (ie: associated with hormonal contraception or HRT)
	Not yet classified

- Infection e.g. cervicitis, salpingitis, endometritis
- Benign causes e.g.cervical ectropion,
- Others e.g. Origin from bladder, urethra or rectum, trauma, vulval or vaginal lesions.

All patients should have

- A full history of bleeding including timing, nature of bleeding and impact on quality of life.
- A full sexual and contraceptive history
- Pregnancy test if premenopausal / menopausal status uncertain and any risk of pregnancy
- Screening for sexually transmitted infection as appropriate
- Cervical cytology if due
- Where appropriate consider initial medical management

An examination is warranted to visualise the external genitalia and cervix:

- For persistent bleeding beyond the first 3 months* of use of hormonal contraception (try medical management first if appropriate/acceptable and no significant risk factors for malignancy or infection).
- After a failed trial of medical management (Appendix 1).

- For new symptoms or a change in bleeding after at least 3 months of use (if the woman has a coil or implant that is due to expire advise replacement of method and then investigate if the bleeding persists beyond 3 months).
- If cervical screening overdue or defaulted from screening programme
- If requested by patient:
  If there are other symptoms such as pelvic pain, dyspareunia or symptoms of pelvic pressure or post-coital bleeding please also do bi-manual examination

*The 3-month cut-off is arbitrary and is not evidence based so is given as a guide only. Some methods, in particular the LNG-IUS or progestogen-only implant, may commonly cause persistent bleeding after the first 3 months of use.

Additional Investigations
- Consider FBC if there is a history of HMB

Referral criteria:
- If visual inspection of the cervix is suspicious (suggestive of cancer), refer urgently to Colposcopy.
- If age <40 with persistent symptoms following initial medical management as below please refer to SRH Complex for further investigations.
- If >40 years or <40 with additional risk factors for endometrial pathology (ie PCOS, BMI >40 or current/past use of Tamoxifen) please refer urgently to SRH
- If pelvic mass identified on examination
- If symptoms suggestive of breakthrough (BTB), before referral consider changing contraception or additional treatment as recommended by FSRH guidance on Problematic Bleeding With Hormonal Contraception (Appendix 1). Women should be made aware that such treatment may be outside the product licence, and this discussion should be documented.

Heavy Menstrual Bleeding

Initial Management Options:
Pharmacological
- Non- hormonal
  - Tranexamic Acid
  - Regular NSAIDs

- Hormonal
  - LNG-IUS
  - COCP/ POP
  - Injectable progestogen

Post Coital Bleeding

Is defined as bleeding from the genital tract occurring after intercourse. PCB after the menopause should be regarded as PMB and referred as this for further investigation.

Postmenopausal Bleeding

This is defined as any vaginal bleeding following a period of amenorrhoea lasting 12 months or longer in the post-menopausal patient, or irregular bleeding in a patient taking an HRT product for 6 months or longer.

PMB is a red flag symptom as 5-10% of women will have endometrial cancer.

Causes:

- Atrophic vaginitis
- Side effects of HRT
- Infection
- Carcinoma – vulva, cervix, endometrium, ovary

At initial consultation, all patients require:

- A full medical and gynaecological history
- A cervical smear, if due and if still in cervical screening programme
- Examination to visualise the vulva, vagina and cervix
- GC/CT NAAT if infection is suspected.
- Urgent SCI GW referral to Acute gynaecology. If an internal referral form is completed, please also telephone the medical secretaries to inform them of the referral.

References:

- Faculty of Sexual & Reproductive Health. (2015). Problematic Bleeding With Hormonal Contraception: http://www.fsrh.org/pdfs/CEUGuidanceProblematicBleedingHormonalContraception.pdf (accessed November 2023)
- NICE: Heavy Menstrual Bleeding: Assessment and Management. 2018. https://www.nice.org.uk/guidance/ng88/resources/heavy-menstrual-bleeding-assessment-andmanagement-pdf-1837701412549 (Accessed November 2023)

Management of Bleeding on Testosterone Treatment

Patient is established on testosterone.
If patient desires to stop menses quickly, they can prescribe GnRH analogue e.g. Triptorelin 11.25mg 3 monthly Imiquimod.
Menses will usually stop once established on testosterone (with level of testosterone lower to mid of normal local male testosterone).
If continued bleeding after 6 months.

1. Consider sexual health screen /cytology as indicated.
2. Consider examination to exclude e.g. vaginal atrophy/ cervical abnormality.
3. Discuss with patient use of progestogen only pill or injectable Medroxyprogesterone Acetate to control bleeding (this will not affect masculinising changes on testosterone).
4. Is patient regularly using testosterone gel / having injections regularly (?supply issues/ issues getting prescriptions/ appointments).

Guidelines suggest any new / abnormal bleeding on testosterone should be investigated as per standard guidelines for cis women.

Appendix 1

Medical therapy options for women using hormonal contraception with problematic bleeding.

NOTE: Use of additional hormonal treatment may be outside the product licence.

Medical therapy options for women using hormonal contraception with problematic bleeding

Combined hormonal contraception users	Progestogen-only pill	Progestogen-only implants, injectable or intrauterine system
In general continue with the same pill for at least 3 months as bleeding may settle in this time. Use a COC with a dose of EE to provide the best cycle control. Could consider increasing the EE dose up to a maximum of 35ug. Could try a different COC but no evidence one better than any other in terms of cycle control. No evidence changing progestogen dose or type improves cycle control but may help on an individual basis. CVR may offer better cycle control than COC. There are no data on managing bleeding associated with the patch. Continue for at least 3 months as bleeding may settle in this time.	Could try a different POP. Women may experience different bleeding patterns with the traditional POP and suggest switching to Desogestral as a treatment option. No evidence to support the use of two POPs per day to improve bleeding. Although regimens such as estrogen supplementation or tranexamic acid may help to reduce bleeding induced by progestogen-only contraceptives in the short term, evidence does not support routine use of such regimen particularly for a long term effect.	A first line COC (30-35ug EE with LNG or norethisterone) can be considered for up to 3 months continuously or in the usual cyclical regimen (unlicensed). No evidence that reducing injection interval for DMPA improves bleeding. However, DMPA may be given after a 10 week interval. To reduce the duration of bleeding episodes in DMPA users, mefenamic acid 500mgs twice (or as licensed use up to three times) daily or tranexamic acid 1gm four times daily for 5 days may be effective in the short term, but confers no long term benefit.