

Abnormal Vaginal Bleeding – Primary Care Pathway

This document sets out flowcharts for management of:

- 1 **Menorrhagia**
- 2 a&b **Irregular bleeding**
- 3 **Postmenopausal bleeding**

Key Messages

1 Menorrhagia

Regular Menorrhagia with normal examination can be managed without hysteroscopy in most circumstances

Referral to Gynaecology should be considered if:

- Unacceptable flow
and
- Medical management and levonorgestrel IUS has failed.
- High index of suspicion of underlying malignancy eg abnormal pelvic exam

2 Irregular Bleeding

- Irregular bleeding is more likely to need a hysteroscopy referral, in particular >40 years. Irregular bleeding in patients >40 years should be managed according to the SIGNIFICANCE of bleeding – see irregular bleeding (2b) and explanatory notes
- Prior to a referral a pelvic examination should be the norm
- An ultrasound scan with a normal pelvic exam is not recommended. Pelvic ultrasound has limited clinical usefulness in adding to a diagnosis of menorrhagia.

3 Postmenopausal Bleeding

- Post menopausal bleeding needs urgent referral for hysteroscopy

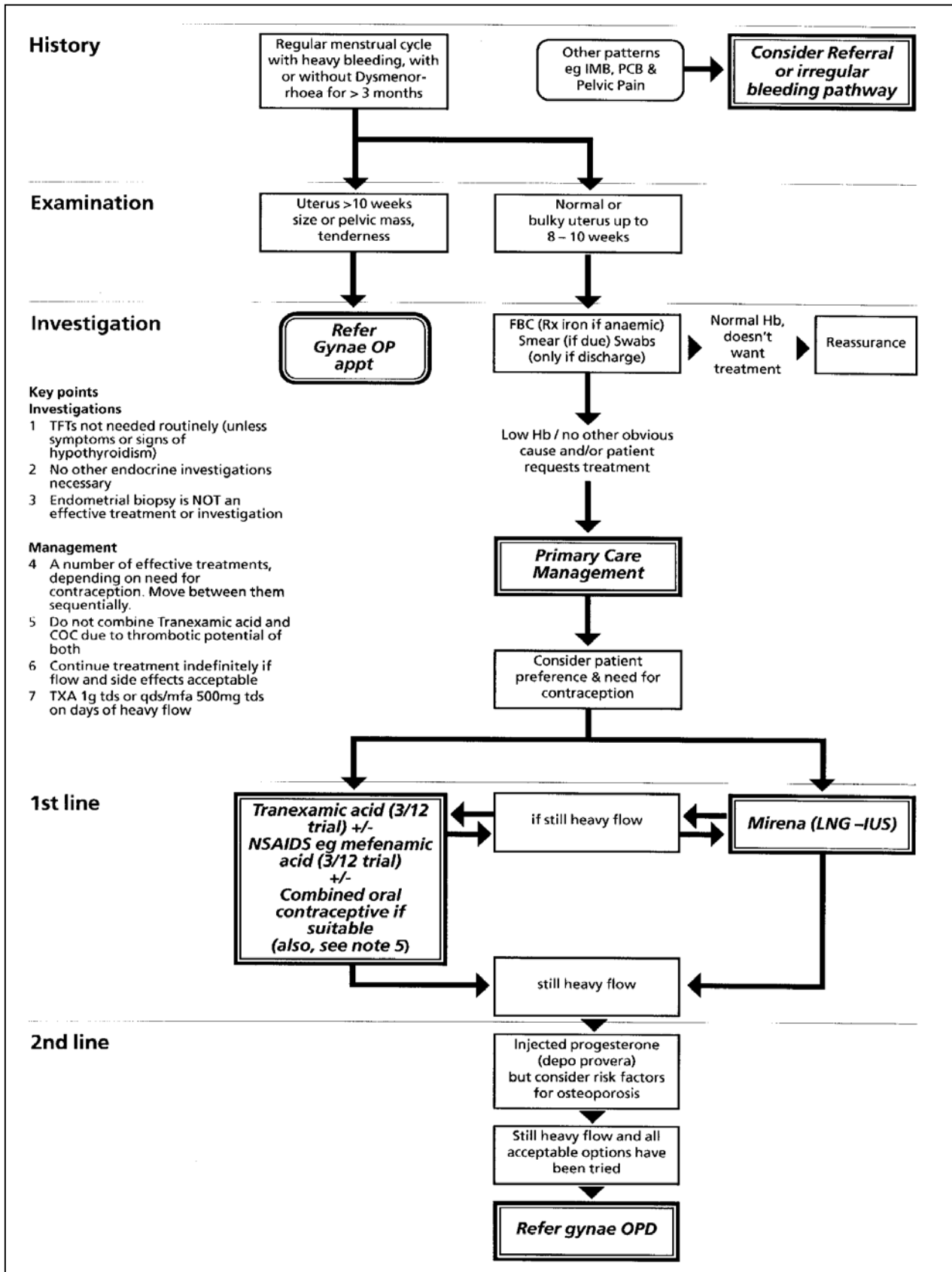
References

The Initial Management of Menorrhagia

RCOG. <http://www.rcog.org.uk/index.asp?PageID=698>

NICE guidance: *Heavy Menstrual Bleeding January 2007-02-26 Calderdale and Huddersfield NHS Trust. Draft Guidelines for the initial management of Menorrhagia*

1 Menorrhagia – Initial management in primary care



2 Management of irregular bleeding – explanatory notes to the guidelines

Definitions

Polymenorrhoea (too frequent)

Intermenstrual bleeding / (PCB – post intercourse)

Oligomenorrhoea (infrequent)

Post menopausal bleeding (>1 year from cessation of menses)

Causes

- 1 Younger patient <40 yrs – chart 2a
infection / contraception / cervical causes / PCOS
- 2 Older patient > 40yrs – chart 2b
Perimenopause / HRT / cancer (especially endometrial cancer)

Further important points

SIGNIFICANCE OF BLEEDING

You may need to decide significance of bleeding pattern – see chart 2b

Significant – consider if there is:

- IMB
- Unscheduled bleeding
- Continual bleeding
- No recognisable cycle
- Flow and loss different to menses

Not significant – consider if there is:

- Cyclical bleeding
- Scheduled bleeding (including flooding)
- Period like loss, even if irregular cycle length,

Suspect CA OVARY in women with abdominal distension, abdominal pain and palpable mass on examination. Ca125 may be performed in these circumstances.

RISK FACTORS for endometrial hyperplasia and endometrial Ca

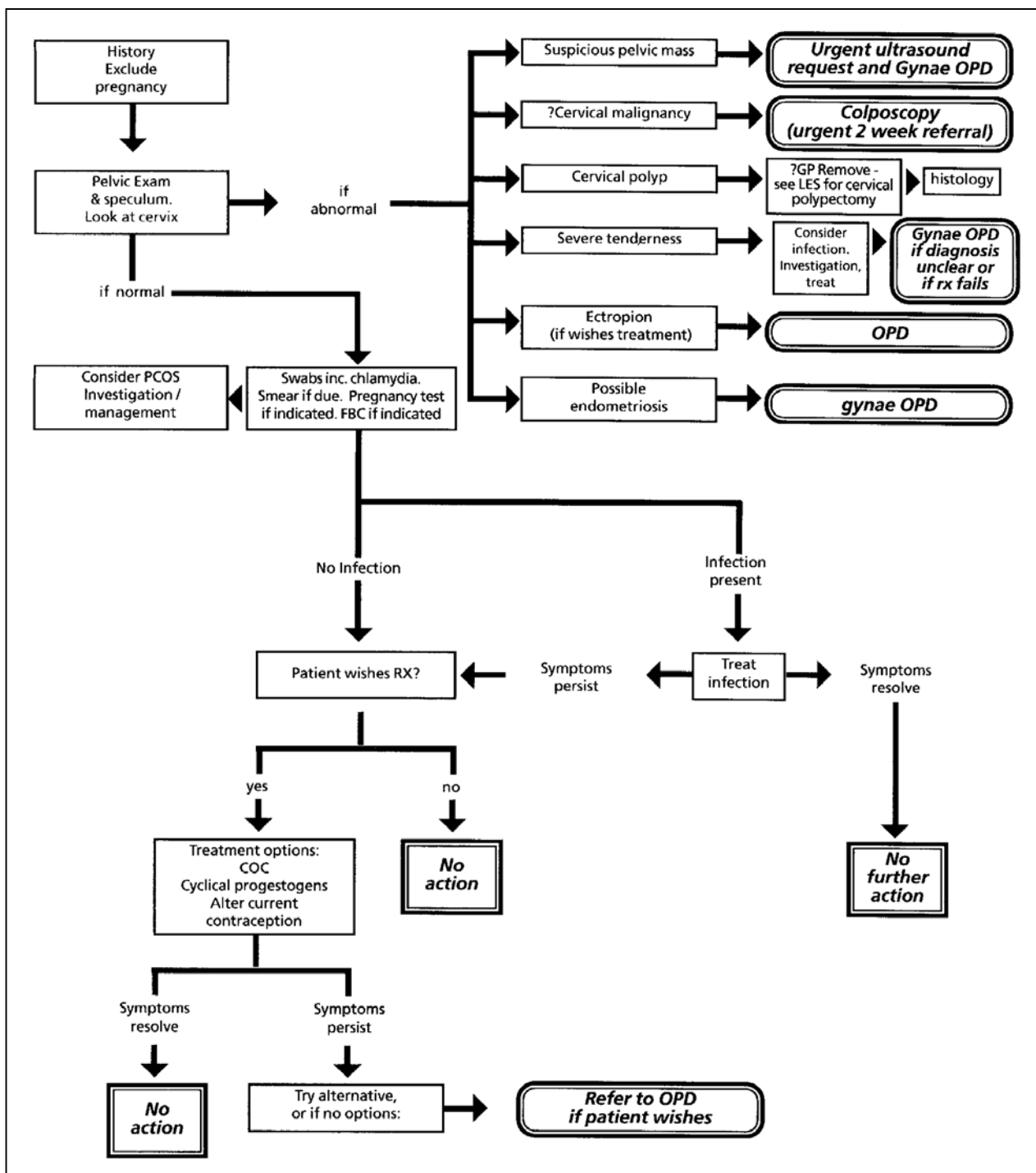
- Weight >90kg
- FH Colon Ca
- FH Endometrial Ca
- Infertility / nulliparity
- Diabetes
- Previous history PCOS

The most TYPICAL presentation of endometrial Ca is an elderly patient with persistent, streaky blood loss (unlike a period type of flow)

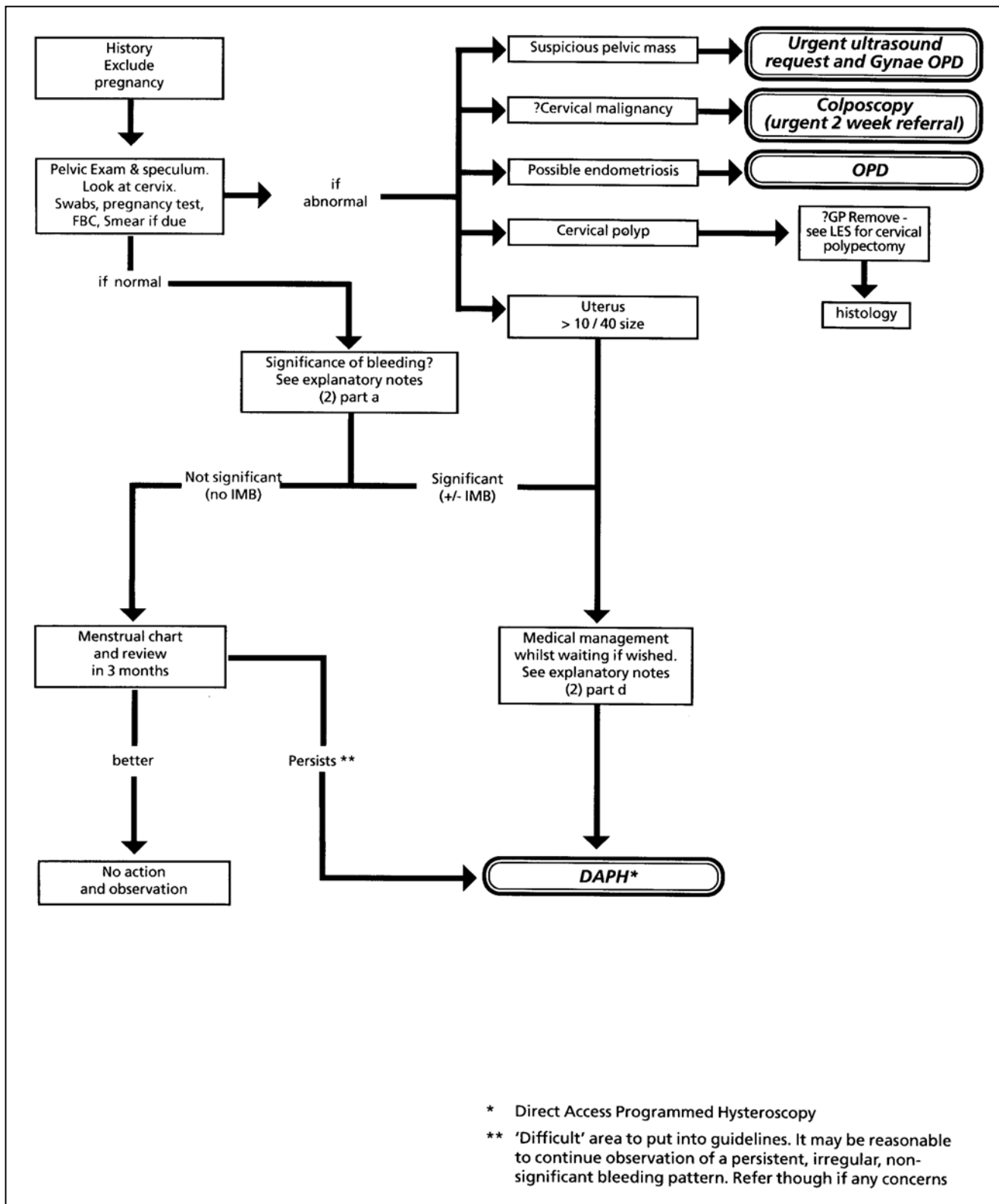
Options for MEDICAL TREATMENT for irregular bleeding

- COC (if no contra indications, non smoker)
- Cyclical progestogens (day 5 – 25 of cycle eg Norethisterone 5mg tds, dydrogesterone 10mg bd or medroxy progesterone acetate 5 – 10mg.)
- Consider HRT if clinically low oestrogen state. More difficult/controversial
- ?Mirena – especially if menorrhagia also.

2a Irregular bleeding < 40 years old



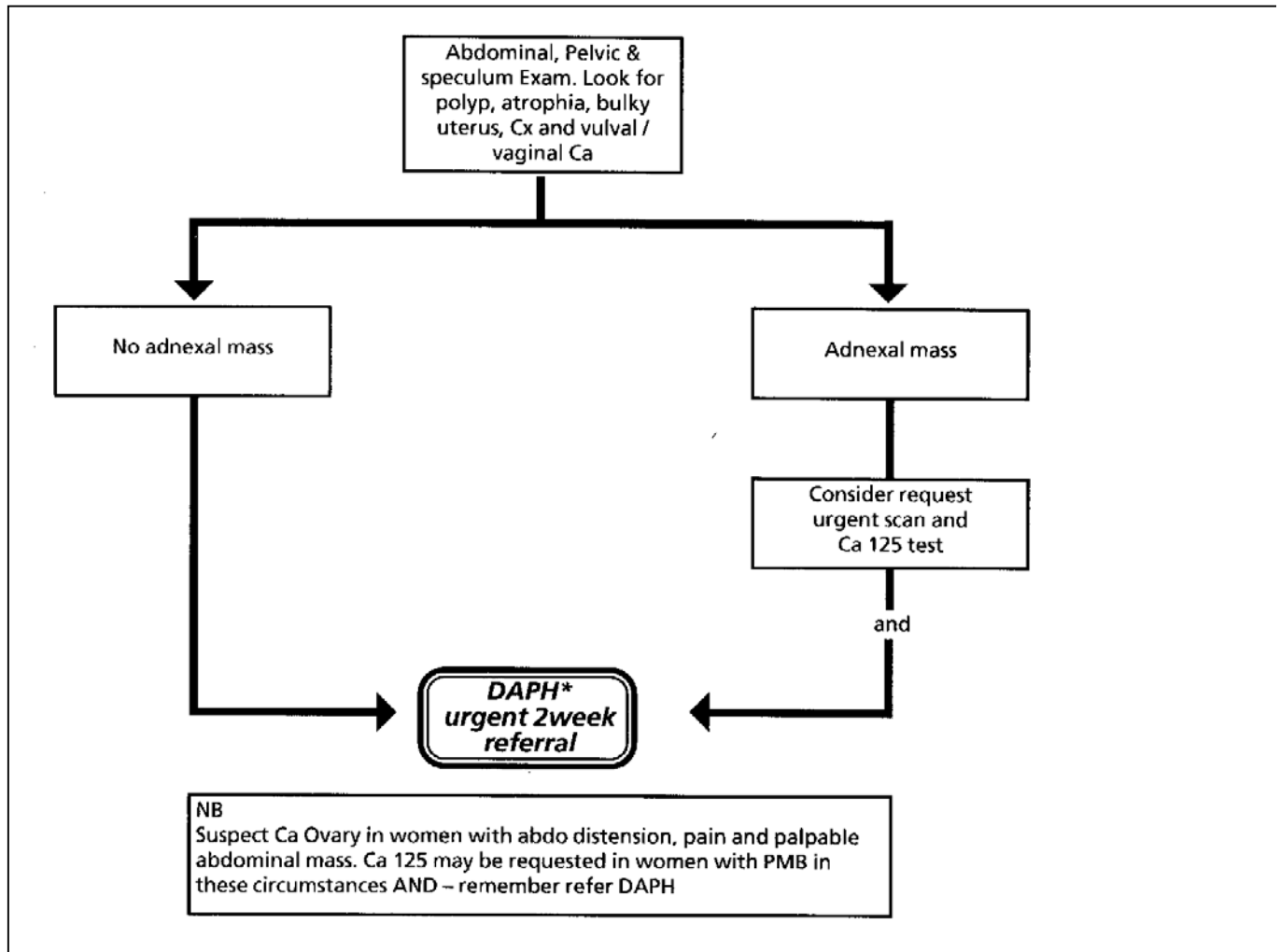
2b Irregular bleeding > 40 years old



3 Post menopausal bleeding

Bleeding which occurs > 1 year from cessation of menses

All routes lead to DAPH. Urgently



* Direct Access Programmed Hysteroscopy note: may be 'grey areas' though Telephone gynaecologist for advice if needs be.

1 Referral urgency

Urgent (< 2 weeks):	post menopausal bleeding high suspicion of uterine cancer, eg suspicious examination, multiple risk factors for endometrial Ca with significant bleeding.
Soon:	Perimenopausal bleeding – significant (see earlier descriptors)
Routine:	Perimenopausal, persistent, not significant bleeding

2 Contraindications to hysteroscopy

Pregnancy,
Recent PID,
Cervical pathology (*refer to Colposcopy OPD*)
Inability to abduct legs
Note: age is not a CI to hysteroscopy

3 Ultrasound

Ultrasound will soon be introduced to the DAPH service. Patients found to have a thicker endometrium will go on to have a hysteroscopy.

This will all be carried out at a single clinic visit.

Note: refer as usual for DAPH, NOT to Ultrasound Department