York Teaching Hospital NHS Foundation Trust and

NHS Scarborough & Ryedale CCG

Management of Women with Postmenopausal Bleeding

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Review	Policy will be reviewed every two years or earlier if new evidence comes to light

Contents

Introduction and Scope

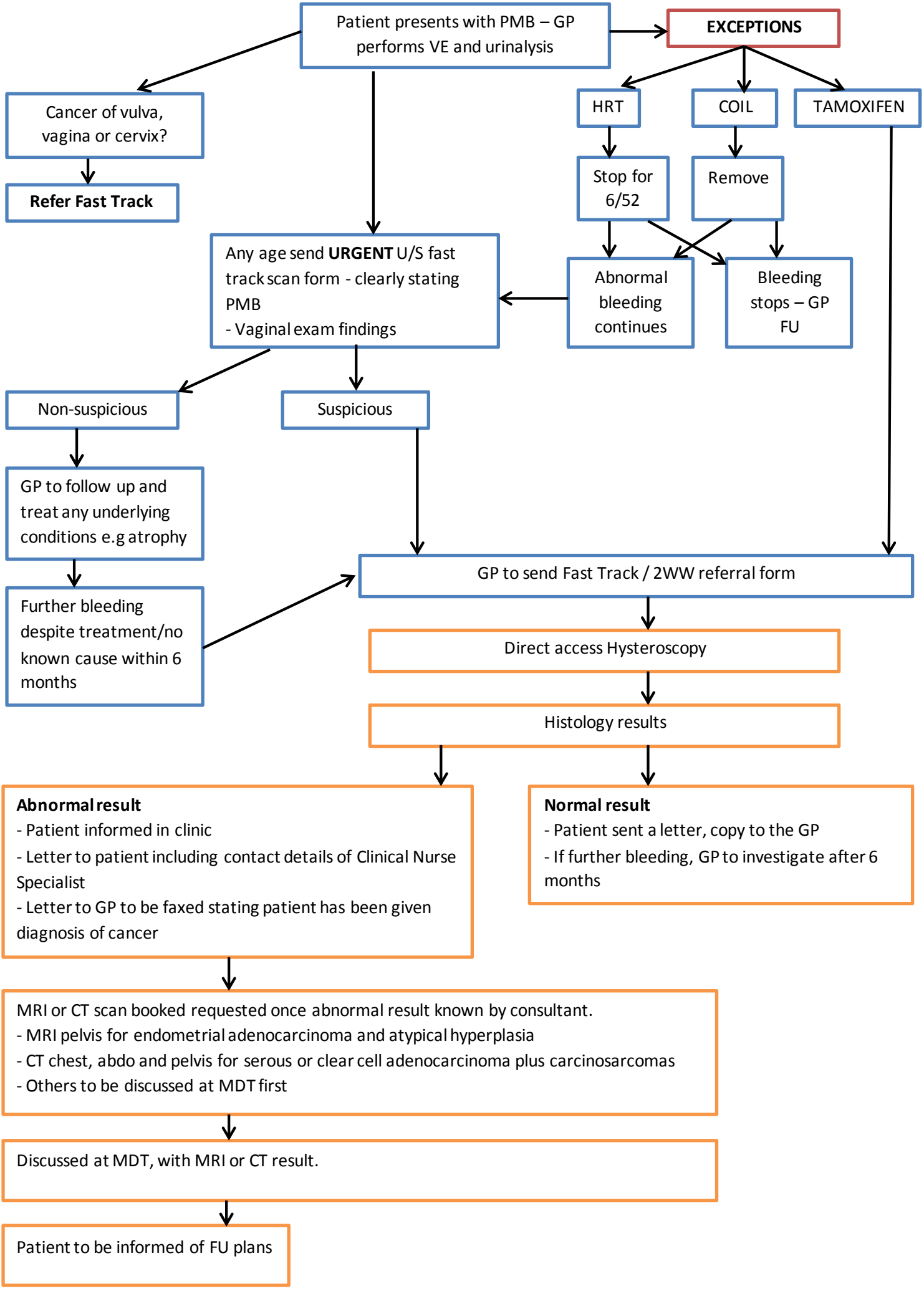
It is the policy of the gynecology department at York Teaching Hospitals NHS Trust to care for women in accordance with best available evidence along with regional/national guidance. The following guidance sets out the expected pathway for women presenting with Postmenopausal Bleeding (PMB) from primary through to tertiary care.

PMB is defined as an episode of vaginal bleeding 12 months or more after the last period.

PMB is a cardinal symptom of endometrial cancer and does require further investigation. Approximately 10% of women up to 60 years of age presenting *and* referred with post-menopausal bleeding have endometrial cancer and this rises to 13% over the age of 60. For women with HRT presenting with PMB or unscheduled bleeding this risk falls to 1%.

Other causes of bleeding from the genital tract also need to be considered such as cervical cancer, atrophy and HRT.

Endometrial cancer can also present with unexplained vaginal discharge or haematuria.


Patient presents with PMB – GP performs VE and urinalysis
EXCEPTIONS
HRT
COIL
TAMOXIFEN
Stop for 6/52
Remove
Cancer of vulva, vagina or cervix?
Refer Fast Track
Any age send URGENT U/S fast track scan form - clearly stating PMB
- Vaginal exam findings
Abnormal bleeding continues
Bleeding stops – GP FU
Non-suspicious
Suspicious
GP to follow up and treat any underlying conditions e.g atrophy
Further bleeding despite treatment/no known cause within 6 months
GP to send Fast Track / 2WW referral form
Direct access Hysteroscopy
Histology results
Abnormal result
- Patient informed in clinic
- Letter to patient including contact details of Clinical Nurse Specialist
- Letter to GP to be faxed stating patient has been given diagnosis of cancer
Normal result
- Patient sent a letter, copy to the GP
- If further bleeding, GP to investigate after 6 months
MRI or CT scan booked requested once abnormal result known by consultant.
- MRI pelvis for endometrial adenocarcinoma and atypical hyperplasia
- CT chest, abdo and pelvis for serous or clear cell adenocarcinoma plus carcinosarcomas
- Others to be discussed at MDT first
Discussed at MDT, with MRI or CT result.
Patient to be informed of FU plans

Guidance for GPs

Women should have a full history, gynaecological examination and urinalysis. If cancer of the genital tract other than endometrial is suspected then **Fast track / 2WW** referral should be made at this stage. If endometrial cancer is suspected then an urgent pelvic ultrasound scan within 2 weeks is first line.

Any age with unexplained discharge that are presenting for the first time or have thrombocytosis or haematuria should be considered for urgent referral for pelvic ultrasound scan.

Any age with visible haematuria and low haemoglobin levels or thrombocytosis or high blood glucose levels should be considered for urgent referral for pelvic ultrasound scan.

For women taking HRT then consideration should be given to stopping this. If bleeding continues after 6 weeks then they should be referred for a scan at this stage. If the woman is unwilling to stop HRT then they should be informed that if they have any abnormal endometrial pathology then HRT could worsen this and referral for an urgent/2WW scan should be on the basis of the following:

- Persistent unscheduled bleeding on tibolone or continuous combined HRT after the first 6 months of treatment or after amenorrhoea established
- Breakthrough bleeding or heavy/prolonged bleeding at the end of the progestogen phase for sequential regimens

For women currently taking **Tamoxifen** then fast track referral straight to hysteroscopy should be made as endometrial assessment on a scan in these women is difficult to interpret. This **does not** apply to those taking Anastrozole.

For women with **recurrent PMB** occurring some months after a normal scan and following treatment of potential causes such as infection, referral for fast track/2WW Gynaecology referral for hysteroscopy should be made. For women who have had a normal hysteroscopy, then go on to have further bleeding, re-investigation should be considered after 6 months with a scan initially. If the time period between episodes of PMB is greater than 6 months a further scan request can be made rather than direct referral to secondary care.

For women with an **IUCD** in situ these should be removed before requesting a scan as the endometrium cannot be assessed with an IUCD in-situ. If the woman is unwilling to have her IUCD removed or it is felt necessary clinically to leave it in-situ and endometrial pathology is suspected then referral to direct access hysteroscopy can be made as a fast track/2WW referral. It should be noted that these women are supposed to be post-menopausal. If the diagnosis of the menopause is in doubt due to a mirena IUS being in situ, the IUS could be removed to see if menstruation returns.

All women should be made aware that further investigations could lead to a diagnosis of cancer.

Guidance for GPs once scan result is available

For those with a non-suspicious scan result (endometrial thickness less than or equal to 5mm) then the woman needs to be informed of the result and plans made for treatment if necessary. This could include topical oestrogens for atrophy or adjustments to HRT.

Fibroids are very common and in the presence of a normal endometrium do not require any action

Atrophic Vaginitis is one of the commonest non-malignant causes of PMB and is appropriate to manage in primary care with topical oestrogens (e.g. a 3 month course of Vagifem)

Lichen Sclerosus may also be found at examination in post-menopausal women. It can be managed in primary care with topical steroids and routine annual examinations to exclude any suspicious changes.

There is a 2-4% lifetime risk of vulval malignancy with this condition.

For those with a **suspicious scan, fast track / 2WW** referral should be made and the women will be informed by telephone or sent an appointment for outpatient hysteroscopy. The woman needs to be informed of the scan results and the intention to refer for urgent hysteroscopy. An information leaflet regarding outpatient hysteroscopy is sent with each appointment letter, but it would be useful if a copy of this could be given to the patient by primary care. Click here for leaflet.

If the woman is not sure she wants an outpatient hysteroscopy she still needs to attend this appointment to discuss the alternatives – most women tolerate the procedure well and the instruments are no bigger than pipelle samplers which have been used in outpatients for many years.

The scan result should include a statement as to whether the result is suspicious or not and if referral is recommended.

Guidance for Hysteroscopy Clinic

Women should be given an appointment within 14 days from the fast track / 2WW referral date.

All women should have a history and BMI performed

If an outpatient hysteroscopy is not possible then urgent day unit procedure should be booked within 14 days.

If hysteroscopy possible and cause for bleeding seen such as a polyp, a biopsy should be taken even if the polyp is too large for removal. The woman can be downgraded from fast track only with normal histology.

If outpatient hysteroscopy not possible in a woman with multiple medical problems then consultant opinion needs to be sought before booking inpatient procedure. Risk assessment of cancer vs risk of anaesthetic is required.

It should be discussed with the patients how they would like to be informed of their results. If abnormal this would usually be a choice between a telephone call or an urgent clinic appointment. Those with normal results would usually receive a letter. Their decision should be documented in the notes.

Patients should be informed as soon as possible via their chosen route. If abnormal, then letters to the patient confirming diagnosis and possible further treatments should be sent urgently once they have received their diagnosis. This should include contact details of the clinical nurse specialist.

A copy of the patient letter should be sent to the GP with a separate letter informing them the patient has received a diagnosis of cancer. These should be faxed/electronically sent to the surgery, backed up by a telephone call to the surgery so that they are expecting the letters and the GPs can take timely appropriate action.

There is no need to wait for the MDT if histology is endometrial adenocarcinoma, atypical hyperplasia, serous or clear cell adenocarcinoma plus carcinosarcomas. An MRI or CT scan should be booked (as per guidance in the pathway above) and U&E's checked if not done recently.

The woman needs to be discussed at the next MDT meeting even if MRI or CT not yet available as a care plan or care can be made.

Once a treatment plan is made by the MDT, the woman needs to be informed by letter which may include an appointment with a Consultant. This could be a pre-operative appointment.

Implementation

GPs informed via Scarborough & Ryedale CCG. The pathway was initially presented and approved at the Business Committee in October 2017 with a full briefing to all practices following. Pathway implementation date was the 29th January 2018. The information was made available on the SRCCG RSS pages found here: http://www.scarboroughryedaleccg.nhs.uk/rss-srccg

Any updated versions will be shared with GPs via the SRCCG GP newsletter and then subsequently updated on the RSS internet site.

Monitoring and Audit

Audit of the pathway will be done via the SRCCG Gynaecology Task & Finish group.

Consultation

The original policy was written by Miss Claire Oxby in liaison with the Vale of York CCG clinic lead for Women's Health, Dr Emma Broughton and Dr Joan Meakins. It was reviewed and approved by the VoYCCG Gynaecology MDT and official gynaecology clinical governance approval on 13.05.16.

In conjunction with York Teaching Hospitals NHS Trust, SRCCG have adopted the pathway and this has been discussed with the Cancer Leads at Scarborough Hospital, Miss S Ramaswamy and Miss Louise Hayes.

Appendix 1 – Fast Track Referral Proforma

York Teaching Hospital NHS
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Suspected Gynaecological Cancer– Referral Form

For patients who need to be seen within **2 weeks**

Date of Referral			
Patient Name		Referring GP	
Patient Address		GP Address	
Patient Postcode		GP Postcode	
Date of Birth		Fax No.	
NHS No.		Surgery Tel No.	
Tel No.		Hospital No.	
Mobile No.		Please check that the patient's phone numbers are correct	

- Confirm that your patient understands that they have been referred onto a "suspected cancer pathway" ☐
- Confirm that your patient has received the information leaflet ☐
- Confirm that your patient is available to attend an appointment within 2 weeks of this referral** ☐

** If, after discussion, your patient chooses to **not** attend within 2 weeks, when will they be available?

ANY OF BELOW PMB SYMPTOMS – refer for Fast Track Hysteroscopy

PMB is bleeding more than 12 months after cessation of regular periods.

- Any age **PMB** and **suspicious ultrasound scan** ☐
- Any age **PMB** continuing 6 weeks after stopping HRT or the removal of coil and **suspicious ultrasound scan** ☐
- Any age **PMB** and taking **Tamoxifen** (no scan needed) ☐
- Any age **PMB** after a **normal ultrasound scan** which is **recurrent and unexplained** ☐

ANY OF BELOW PRESENTING SYMPTOMS – refer for Fast Track Gynae Clinic

- Suspicious **pelvic mass** found on ultrasound scan ☐
  Insert serum Ca125 here if recently requested or confirm this has been requested
- **Suspicious lesion of cervix** on speculum examination ☐
- **Suspicious lesion of vagina** on speculum examination ☐
- **Suspicious lesion of vulva** ☐
- **High suspicion of ovarian cancer (insert CA125 and request ultrasound scan)** ☐
- **I confirm I have performed an abdominal and pelvic assessment** **YES / NO**
- **Is a full scan report attached** **YES / NO**

(Ensure images are transferred to hospital radiology department)

Any additional information: