Management of irregular menstrual bleeding in pre-menopausal women

Aetiology
- Cervical cancer
- Endometrial cancer.
- Cervical ectropion.
- Fibroids.
- Endometrial or cervical polyps.
- Associated with dysfunctional uterine bleeding (not enough progesterone to maintain endometrium)
- Hormonal contraception – particularly progesterone-only methods and particularly in the first 6m.
- STIs including chlamydia.

How to assess in General Practice?
- Take a gynaecological and sexual history – check if using hormonal contraceptives.
- Rule out pregnancy in women of child-bearing age.
- Do not delay examination if a woman is bleeding
- Perform a gynaecological examination specifically to visualise the cervix for ectropia and cancers.
  Assess for fibroids, cervical excitation or adnexal tenderness (PID)
  If the cervix appears abnormal – refer.
- Only do a cervical smear if it is due (this is a screening test – not an investigation for symptomatic women – if a woman has a regular and up-to-date cervical screening history, the risk of cervical disease is low).
- Consider STI swabs.

Refer USS:
- Pelvic mass on examination (?fibroid/ovarian)
- Women aged >45y with inter-menstrual bleeding – however, see below.

Beware (2005 NICE guidelines suggested that even if the cervix appears normal, smear is clear and swabs negative, if abnormal bleeding persists for more than 6–8w refer to colposcopy [this is because of poor predictive value of visualization of the cervix by eye]

If post coital bleeding should do smear even if under 25

Management
- Hysteroscopic removal of polyps and small fibroids may resolve bleeding [submucosal fibroids are associated with threefold increase risk of perimenopausal bleeding].
- The management options for larger fibroids include trans-cervical resection, uterine artery embolisation or GnRH analogues to shrink.
- Cryotherapy of cervical ectropion.
- Cancers – via cancer pathway
- Dysfunctional uterine bleeding:
  - 1st Line: Mirena coil [progesterone-containing IUDs] and contraceptive implants

- 2nd Line: Combined pill [can tricycle for 3 months before having withdrawal bleed. Particularly helpful if become anaemic with the irregular bleeding

  For bleeding associated with hormonal contraception, the FSRH guidelines (July 2015), recommend that, assuming no contraindications, the COCP can be added to progesterone only methods for up to 3m to try and regulate bleeding. Mefenamic acid or tranexamic acid can be used with DMPA to reduce bleeding duration in the short term.

  Antifibrinolytic agents (tranexamic acid) - helpful to reduce flow and provide symptomatic control during the period itself.

All women >45 should be referred with IMB [even if USS is normal] for endometrial biopsy

Practical tip – best time to assess endometrium is after a period (and up to mid cycle)
Endometrial thickness >14 is cut-off for normal thickness if premenopausal women.

GYNAECOLOGICAL CANCERS

Endometrial cancer:

Refer 2WW	if 55 and over with post-menopausal bleeding
Consider cancer referral	if under 55 and post-menopausal bleeding
Consider direct access USS	>=55 with: • unexplained symptoms of vaginal discharge who: ○ are presenting with these symptoms for the first time or ○ have thrombocytosis or ○ report haematuria, or • visible haematuria and ○ low haemoglobin levels or ○ thrombocytosis or ○ high blood glucose level

Cervical cancer: Refer 2WW: visual appearance consistent with cervical cancer
Vaginal cancer: Refer 2WW: **an unexplained palpable mass in or at the entrance to the vagina**
Vulval cancer: Refer 2WW: vulval lump, ulceration or bleeding

Ovarian cancer:
80% of cases in the UK present with advanced disease.

Refer 2WW	physical examination identifies ascites and/or a pelvic or abdominal mass (which is not obviously uterine fibroids)
Consider possibility of ovarian cancer:	woman (especially if 50 or over) reports having any of the following symptoms on a persistent or frequent basis – particularly more than 12 times

	per month:
	• persistent abdominal distension (women often refer to this as 'bloating')
	• feeling full (early satiety) and/or loss of appetite
	• pelvic or abdominal pain
	• increased urinary urgency and/or frequency.
	OR
	• Any of the following:
	  ○ unexplained weight loss
	  ○ Fatigue
	  ○ Changes in bowel habit
	OR
	• New onset of IBS symptoms in last 12 months in women aged >=50 [IBS rarely presents at this age]
	
	PERFORM CA125: If >35 do urgent USS abdomen and pelvis.
	If CA125<35 or [if CA125 is raised but USS is normal: safety net – return if more frequent/persistent]

Breast cancer

Refer 2WW	• >30 with new lump +/-pain
	• >=50: with any of the following in one nipple only
	  ○ discharge
	  ○ retraction
	  ○ other changes of concern e.g. Paget's

Consider cancer referral	• Skin changes suggestive breast cancer • >=30 with unexplained axillary lump