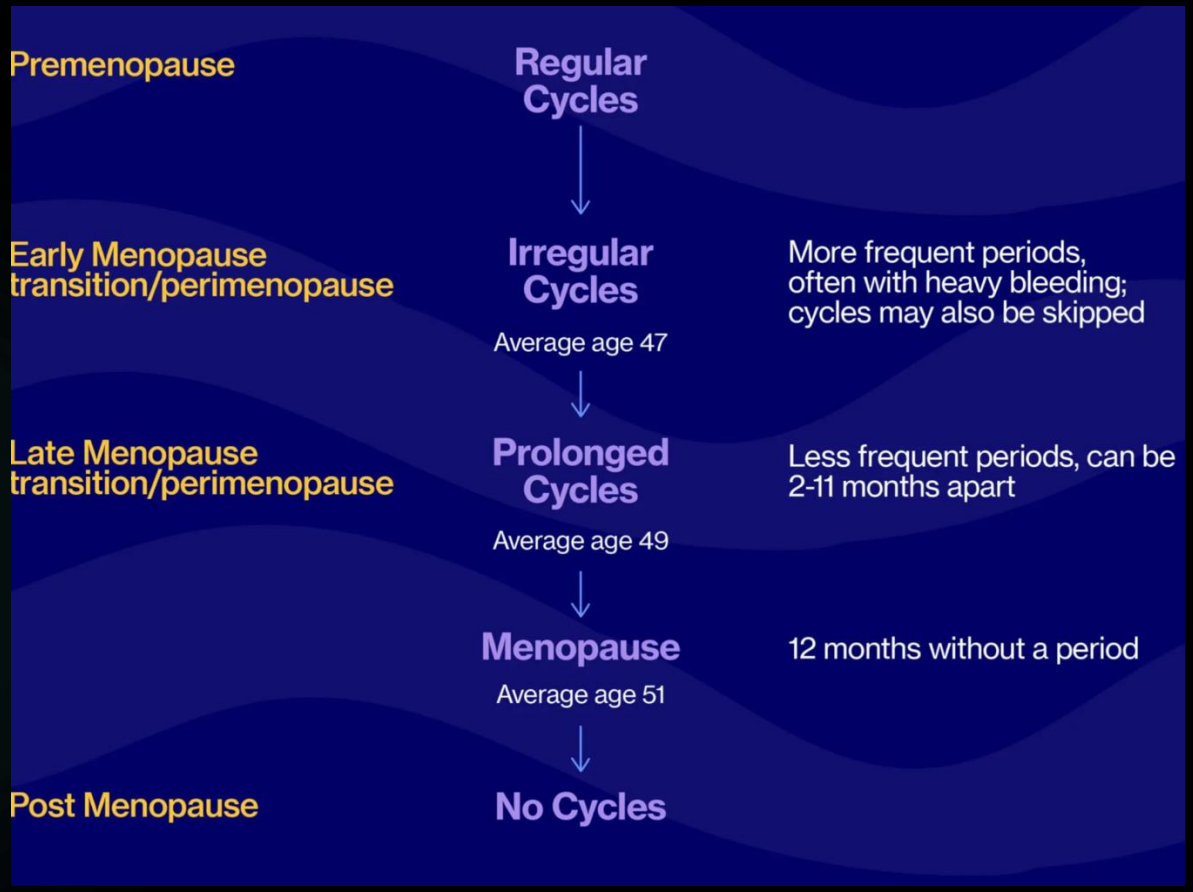
Unscheduled Bleeding on HRT

- Dr Orla Conlon, Consultant Gynaecologist.

The Menopause Transition



BMS joint guideline

Management of unscheduled bleeding on hormone replacement therapy (HRT)

This joint guideline has been prepared on behalf of the British Menopause Society, in partnership with the British Society of Gynaecological Endoscopy, British Gynaecological Cancer Society, Faculty of Sexual & Reproductive Healthcare, Getting It Right First Time (GIRFT), Royal College of General Practitioners and the Royal College of Obstetricians & Gynaecologists.

Published: April 2024
Next review date: April 2027

Download full joint guideline

BMS British Menopause Society — The specialist authority for menopause & post reproductive health

BSGE — BRITISH SOCIETY for GYNAECOLOGICAL ENDOSCOPY

BRITISH GYNAECOLOGICAL CANCER SOCIETY

FSRH The Faculty of Sexual & Reproductive Healthcare

GIRFT — GETTING IT RIGHT FIRST TIME

RCGP Royal College of General Practitioners

Royal College of Obstetricians & Gynaecologists

Heavy menstrual bleeding: assessment and management

NICE guideline [NG88] Published: 14 March 2018 Last updated: 24 May 2021

Guidance

Download guidance (PDF)

Quality standard - Heavy menstrual bleeding

Next >

This guideline covers assessing and managing heavy menstrual bleeding (menorrhagia). It aims to help healthcare professionals investigate the cause of heavy periods that are affecting a woman's quality of life and to offer the right treatments, taking into account the woman's priorities and preferences.

For information on related topics see our women's and reproductive health summary page.

⚠ In **May 2021**, we reinstated recommendations on the use of ulipristal acetate (Esmya) for uterine

National Women & Infants Health Programme

QUICK SUMMARY DOCUMENT

Assessment and Management of Postmenopausal Bleeding

This Quick Summary Document (QSD) is a resource for all clinicians working in healthcare in Ireland who are involved in the care of women with postmenopausal bleeding (PMB).

Following a comprehensive literature review a number of evidence-based recommendations for management of postmenopausal bleeding were agreed upon.

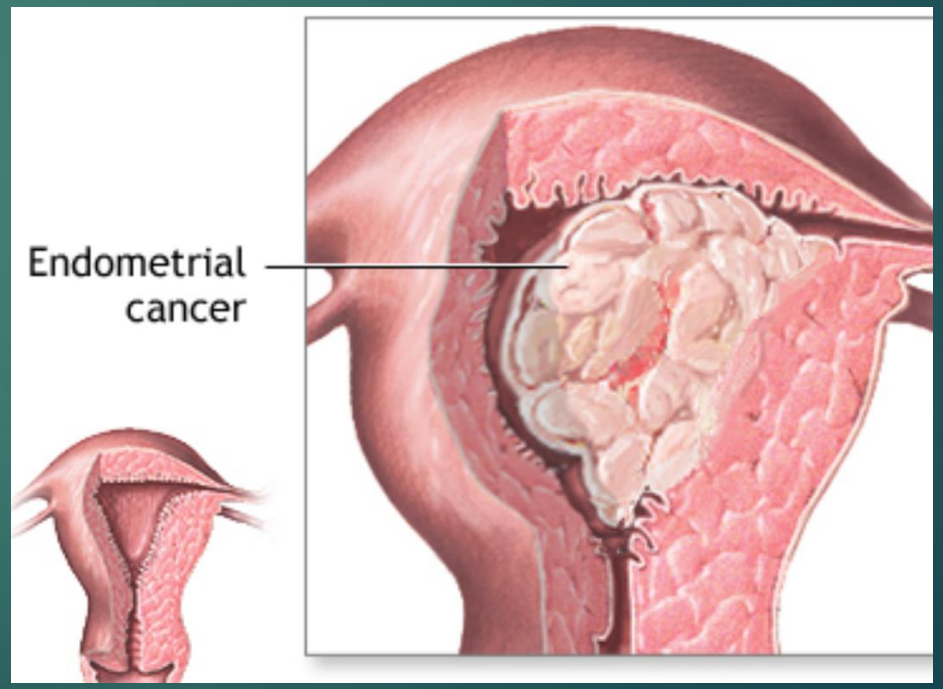
Key Recommendations

1. We recommend that menopause should be defined as the final menstrual period followed by 12 months of amenorrhoea.

Causes….. It can be normal….

- HRT itself…
- Endometrial Polyps/ fibroids/ Hyperplasia
- Adenomyosis/ Endometriosis
- Cervical Pathology
- Vulvovaginal Disorders including STIs
- Bleeding disorders/ Blood thinners
- Endocrine Disorders

Rule out Endometrial Carcinoma



Complete the jigsaw…

What do we do?

History

- LMP
- Bleeding pattern before HRT
- Pelvic pain/ deep dyspareunia
- Discharge
- Vulvovaginal/ Urinary Symptoms

Bleeding Pattern

- No of Episodes
- Type
- Duration
- Regularity
- Precipitating factors

What else do we need to know?

- Duration
- Dose of current preparation
- Compliance
- IUS ? Out of date
- Prior preparation and interval of use
- Application
- Awareness of order
- Other sources of oestrogen
- Contraceptive use
- Pregnancy Risk
- Cervical screening history
- Sexual history
- Drug interactions
- Malabsorption Syndrome

Risk Factors for Endometrial Cancer

Minor

MINOR risk factors for endometrial cancer

- BMI 30-39
- Unopposed estrogen > 3 months but < 6 months
- Tricycling HRT (quarterly progestogen) for > 6 but < 12 months
- > 6 months but < 12 months of using norethisterone or medroxyprogesteorne acetate for < 10 days / month or, micronised progesterone for < 12 days / month, as part of a sequential regimen
- Where the progestogen dose is not in proportion to the estrogen dose for > 12 months (including expired 52 mg LNG-IUD)
- Anovulatory cycles, such as in Polycystic ovarian syndrome
- Diabetes

Major

MAJOR risk factors for endometrial cancer

- BMI ≥ 40
- Genetic predisposition (Lynch / Cowden syndrome)
- Estrogen-only HRT for > 6 months in women with a uterus
- Tricycling HRT (quarterly progestogen) for > 12 months
- Prolonged sHRT regimen: use for more than 5 years when started in women aged ≥ 45
- 12 months or more of using norethisterone or medroxyprogesterone acetate for < 10 days / month or, micronised progesterone for < 12 days / month, as part of a sequential regimen

The HRT Maze

HRT doses

The guideline makes recommendations for increasing progesterone doses as estrogen doses increase, as shown in these charts:

1. Estrogen doses

	Ultra-low dose	Low-dose	Standard dose	Moderate dose	High dose
Oestrogel	½ pump	1 pump	2 pumps	3 pumps	4 pumps
Sandrena	0.25mg	0.5mg	1.0mg	1.5-2.0mg	3mg*
Lenzetto spray	1 spray	2 sprays	3 sprays	4-5 sprays*	6 sprays*
Patch	12.5µg	25µg	50µg	75µg	100µg
Oral estradiol	0.5mg	1.0mg	2.0mg	3.0mg^	4.0mg^

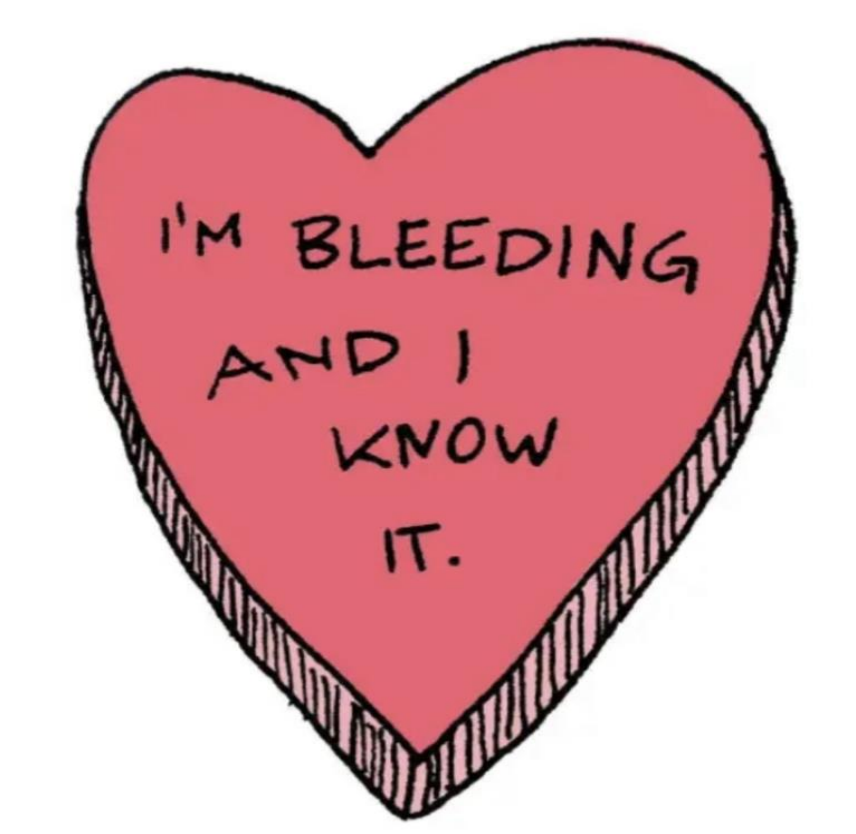
* Off-license use ^ Off-license use – rarely required to achieve symptom control mg = milligrams µg = micrograms

2. Progesterone/progestogen doses

Estrogen dose	Micronised Progesterone		Medroxyprogesterone		Norethistrone		LNG-IUD (52mg)
	continuous	sequential	continuous	sequential	continuous	sequential	
Ultra/Low	100mg	200mg	2.5mg	10mg	5mg†	5mg†	One – for up to 5 years of use
Standard	100mg	200mg	2.5-5.0mg	10mg	5mg†	5mg†	
Moderate	100mg	200mg	5.0mg	10mg	5mg	5mg	
High	200mg	300mg	10mg‡	20mg‡	5mg	5mg	

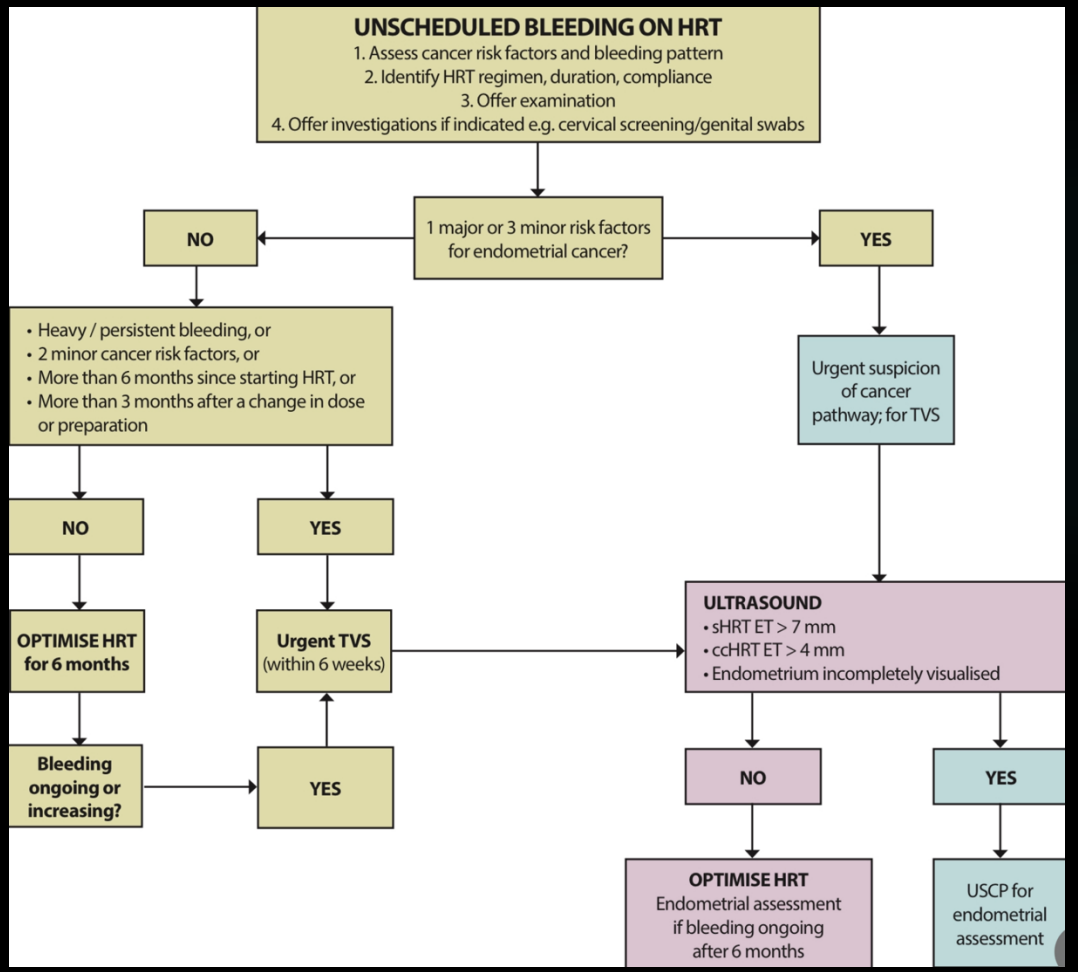
† 1mg provides endometrial protection for ultra-low to standard dose estrogen but the lowest stand-alone dose currently available in the UK is 5mg (off-license use of three noriday POP i.e. 1.05mg, could be considered if 5mg is not tolerated).

‡ There is limited evidence in relation to optimal MPA dose with high dose estrogen; the advised dose is based on studies reporting 10mg providing protection with



- Abdominal; assess for fibroids, ovarian mass, pain
- Vulvo-vaginal; assess for atrophy, dermatoses, mass, ulceration, prolapse
- Cervical appearance; assess for mass, polyp, ectropion with contact bleeding, IUD threads
- Genital tract swabs; vulvovaginal including chlamydia / gonorrhoea- if indicated by sexual history
- Cervical screening if overdue
- Pregnancy test (if appropriate)
- BMI
- Thyroid function/ Prolactin

Bleeding on HRT Dilemma



Informed consent

If the patient declines investigations, explore barriers, recommend weaning off HRT and offer non-hormonal alternatives

Histology is Key…need to rule out Endometrial Carcinoma

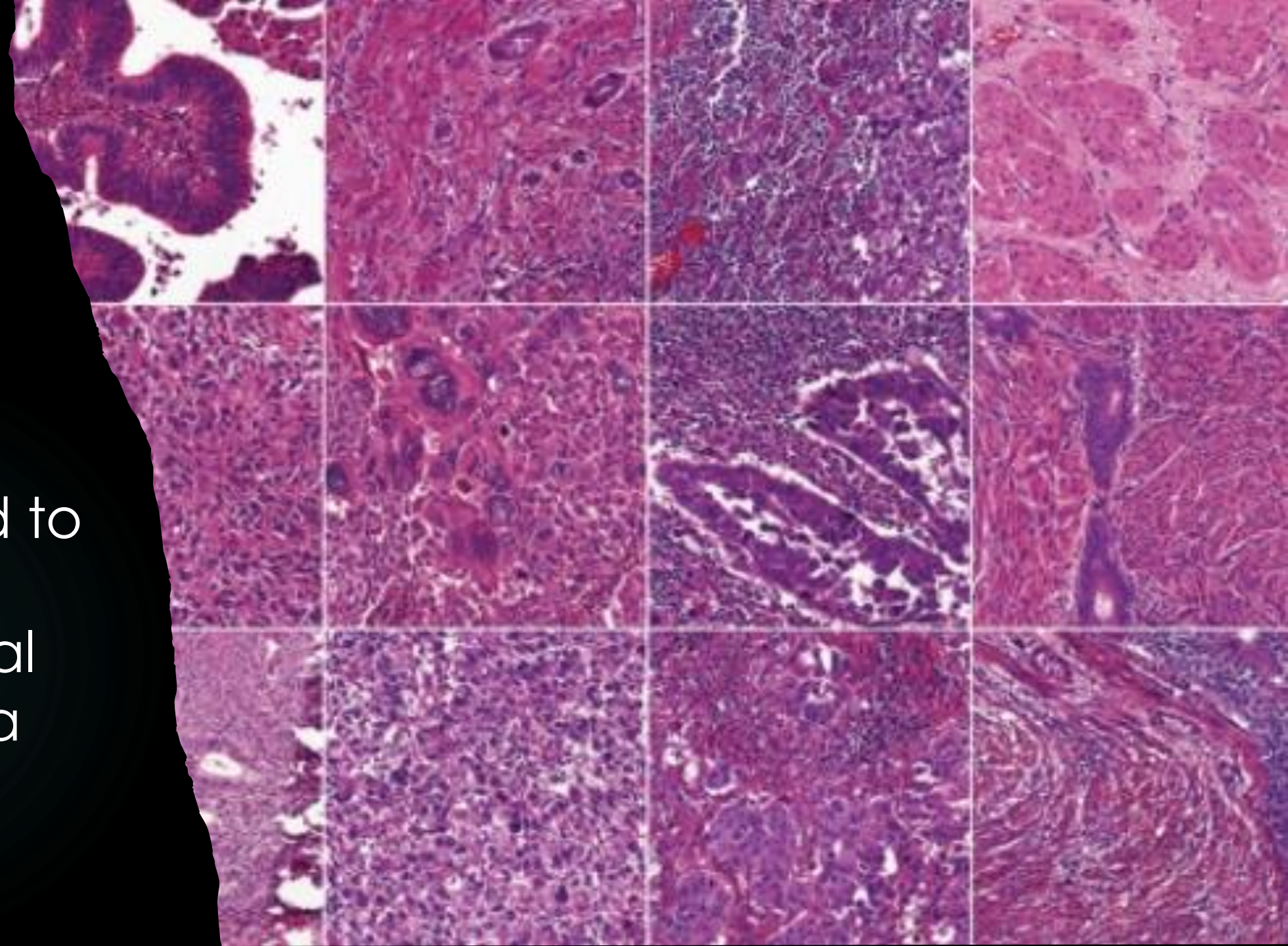


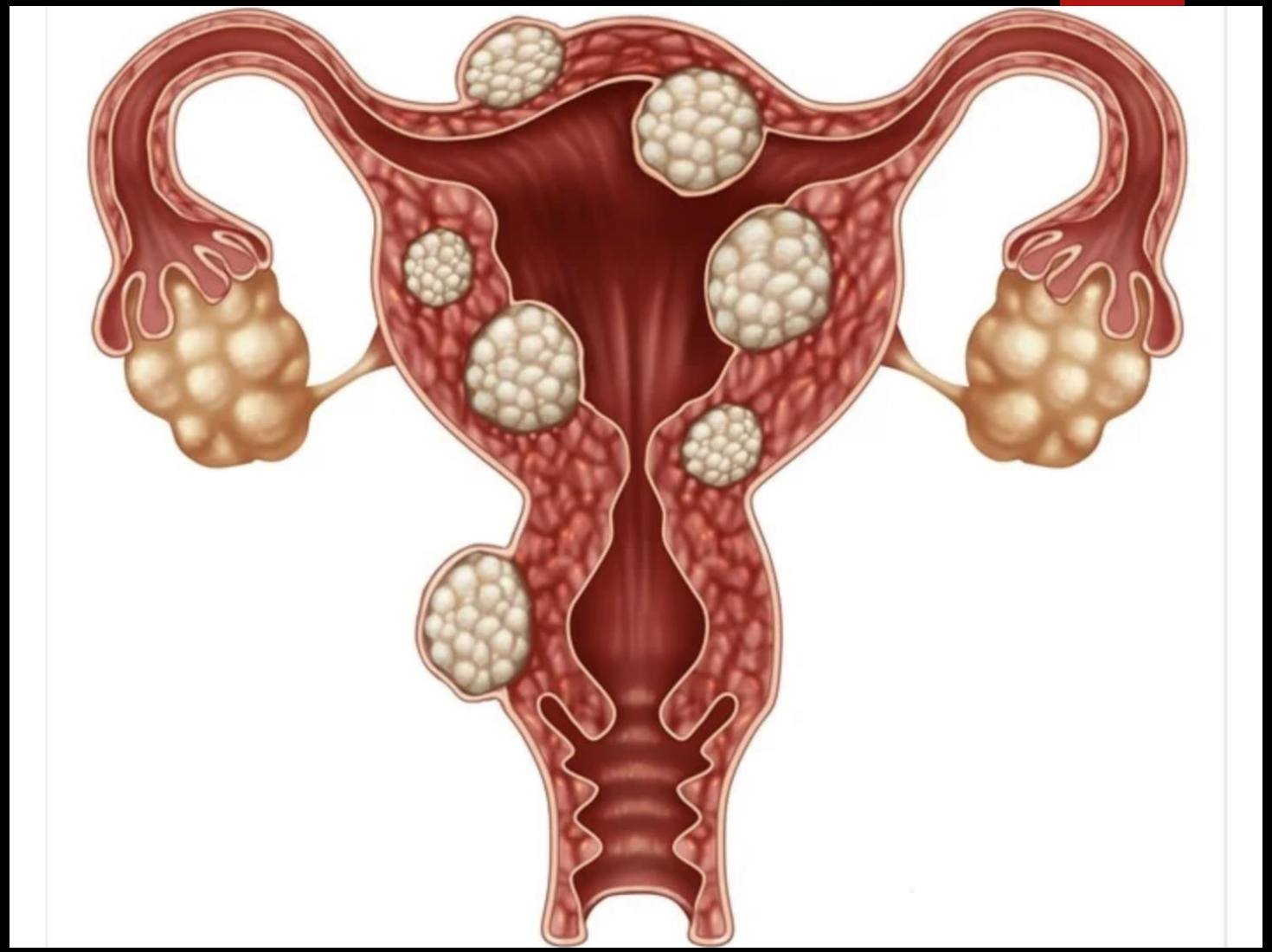
Table 4: Histological outcomes in women taking standard dose estrogen who have unscheduled bleeding and a thickened endometrium on ultrasound scan

	ccHRT	sHRT	PMB
Atrophy / Inactive	38-66%*	58%^	52%
Polyp	6.8-31%	22%	9%
Hyperplasia	1-2%	2.5-16%	11%
Endometrial Cancer	1.3-2%	5%	9%

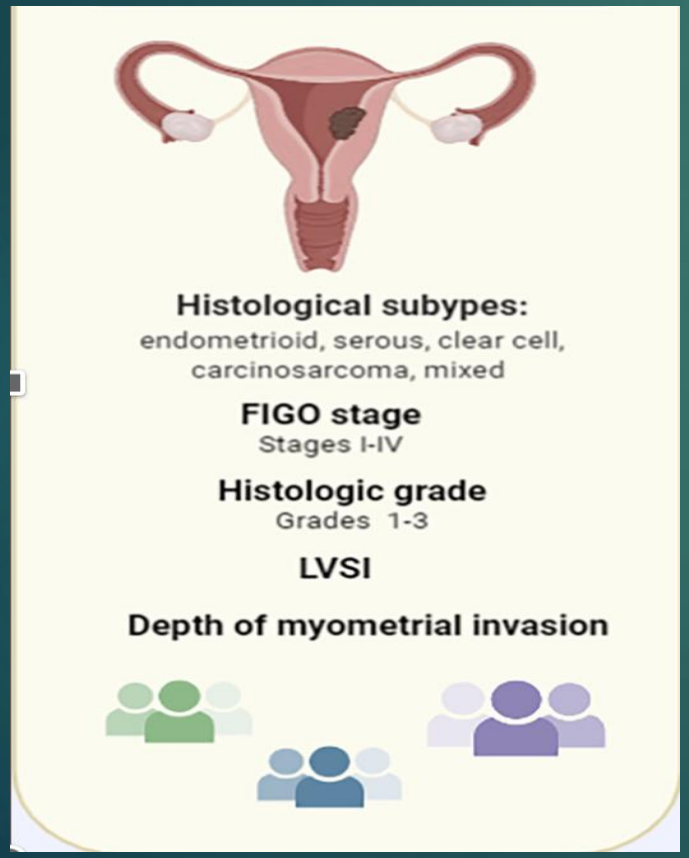
* The majority of endometrial biopsies in women taking ccHRT are reported as inactive endometrium.
^ The majority of endometrial biopsies in women taking sHRT are reported as weakly proliferative.

Uterine Fibroids

- Represents up to 70% of all gynaecological consultations in the Perimenopause

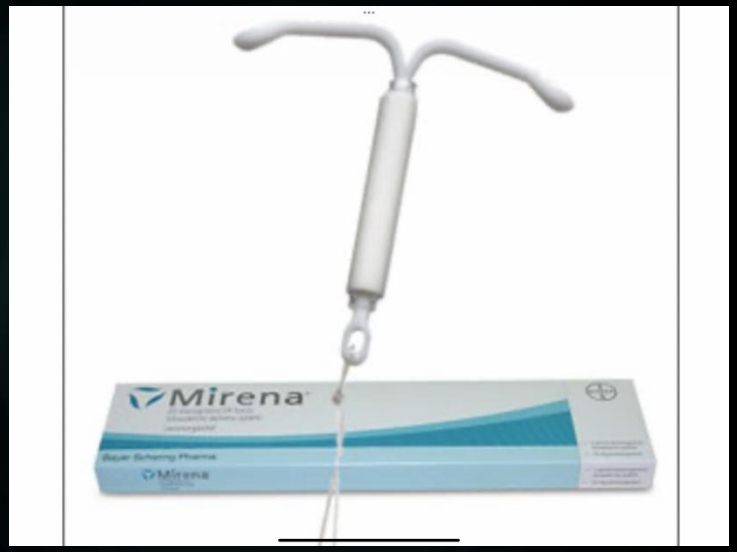


USCP



- Ambulatory Gynaecology Gynaecological Referral
- Vaginal & Abdominal Exam
- Transvaginal Ultrasound *
- Diagnostic Hysteroscopy & Endometrial Biopsy
- Surgical Hysteroscopy

The Mirena Miracle…



- **Endometrial Ablation**

- 80% satisfaction rate
- 50% significantly lighter menstruation
- 25% no menses

Other Dilemmas: Hysterectomy

- Patient had a hysterectomy?
- Get indication for hysterectomy
- Still need to take full history
- Abdominal & Vaginal examination
- Check smear history: may need vaginal vault smear
- Check if ovaries were retained: still may need an uss ? Ovarian cysts/ recurrence of Endometriosis
- Endometriosis & Adenomyosis: Continuous Combined HRT
- Women with BRCA Genes can have HRT

Other Dilemmas: Cancer

- May be due to Tamoxifen Therapy
- May be post Radiotherapy
- Cervical High grade CIN/ Carcinoma
- Vulval/ Vaginal tumours
- Lymphoma
- Rectal / Anal / Bladder cancer: if negative findings make sure rule out PR/PU bleeding

Case 1: 50 years old

- Presented for routine cervical smear to GP
- Large cervical polyp and contact bleeding
- Nulliparous
- BMI: 25-30
- Endocrinologist commenced HRT including Premique, now on Evorel Conti
- Also on Melatonin for sleep Amitriptylline, Gabapentin for peripheral neuropathy
- H/O Bowen's disease
- Never had a V/E under care of Endocrinologist
- Mole already removed from leg
- V/E confirmed mole on labia and lichen sclerosis
- Hysteroscopy confirmed endometrial polyp and cervical polyp both benign
- Mirena was inserted
- Vulval biopsies confirmed melanoma in situ & LS
- Patient never informed of benefits of Utrogestan for insomnia
- Patient wants to come off other meds

Case 2 : 70 years old

- 2 month history of PV bleeding
- Nulliparous
- High BMI
- Premature menopause aged 35
- Was on HRT for 2 years
- Ex smoker years ago
- Hyperlipidaemia
- Bipolar AD

- O/E GP saw 3-4cm cervical polyp
- Urgent referral
- Uss confirmed endometrial thickness 0.8cm
- Hysteroscopy & removal of endometrial polyp
- Endometrial Adenomcarcinoma
- Stage 1A1: Hysterectomy
- No adjuvant treatment required

Summary

- Evaluate Risk Factors for Endometrial Ca & other Ca's
- Follow evidence based guidelines on prescribing
- Follow evidence based guidelines on investigation
- Always do an abdominal and vaginal examination
- Refer if any doubt….

- ***Happy Patient…..***
- ***Happy GP…..***
- ***Happy Gynaecologist….***
- ***Thank you***