A Clinical Guideline for Assessment of Postmenopausal Bleeding

For Use in:	Gynaecology Services
By:	Gynaecologists, radiologists, sonographers, nurses
For:	Assessment of postmenopausal bleeding
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If Yes - does the strategy/policy deviate from the recommendations of NICE? If so why?	Na

Assessment of postmenopausal bleeding

Approximately 10% of patients presenting with postmenopausal bleeding (PMB) will have a gynaecological malignancy. Since 80-90% of patients with endometrial cancer experience abnormal bleeding, the vast majority patients with malignancy presenting as PMB will be endometrial in origin. There will, however, be occasional cases of cervical, vaginal, vulval and ovarian cancer which are referred with PMB.
These cases should be referred urgently to the gynaecological oncology team.

History and examination

A comprehensive history should be taken in particular:

- Risk factors for endometrial pathology
- HRT
- Duration of symptoms
- Persistent PMB (Defined as bleeding for more than 1 month)
- BMI

Examination should include assessment of the entire lower genital tract as many patients with PMB will have a non-endometrial cause for bleeding e.g. atrophic vaginitis.

Ultrasound scan assessment

A trans-vaginal ultrasound scan (TVS) should be performed and adequately documented. If a TVS is not possible a transabdominal scan (TAS) can be performed in order to assess adenexal masses however, measurement of endometrial thickness (ET) is less accurate and therefore should not be used for endometrial assessment. Patients in whom a TVS is not possible should have a pipelle biopsy performed and subsequent OPH, as ET is not accurately assessed and may be greater than 11mm.

TVS should be performed before attempting an endometrial biopsy as this may affect the appearance of the endometrium. If an endometrial biopsy has already been taken an ultrasound should be delayed by 2 weeks.
The pelvic ultrasound report should note:

- Endometrial thickness (ET)- (measuring the anteroposterior (AP)2-layer thickness in the sagittal plane near the fundus)
- Suspected polyps
- Uterine size
- Ovarian morphology
- Presence of fibroids
- Presence of ascites

For endometrial biopsy, using a cut off of 4mm ET produces a sensitivity of 95% and specificity of 55% for detection of endometrial cancer.

The incidence of endometrial cancer in women with ET <4mm is 0.6%. Therefore patients presenting with PMB for the first time with an ET of <4mm do not require a biopsy.

In view of the false negative rate an endometrial biopsy should be obtained in all patients presenting with persistent PMB regardless of the ET.

If the endometrium is obscured by fibroids, a pipelle biopsy should always be attempted and referral for hysteroscopy is indicated unless a definitive diagnosis is made from the biopsy. Non-visualisation of the endometrium in the absence of fibroids may be due to endometrial pathology causing the endometrium to be isoechoic with the myometrium. This is an indication for hysteroscopy, unless a definitive diagnosis is made from the biopsy.

Asymptomatic women, who are found to have a thickened endometrium as a coincidental finding on ultrasound scan, do not require an endometrial biopsy unless the ET is greater than 11mm. The presence of intrauterine fluid per se, in asymptomatic women is not an indication for a biopsy.

Endometrial polyps

If an endometrial polyp is suspected on TVS then a pipelle biopsy should be performed in the first instance. Referral for hysteroscopy is indicated if malignancy is not detected.

Detection of an adnexal mass

Follow the Guideline on Management of Ovarian Masses (Trust Docs Id 769).

Endometrial biopsy

Endometrial biopsy should be performed if:

- ET ≥4mm
- ET not visualised e.g. fibroids
- Persistent PMB regardless of ET (Patients do not require further assessment if a negative pipelle has been obtained in the last 6 months)
- Suspicion of polyp or mass on TVS regardless of ET
- ET≥3mm with fluid in the endometrial cavity. The endometrial thickness either side of the intra-cavity fluid should be measured in the sagittal plane. Do not include the fluid in the measurement.

A Pipelle sampler should be used: this provides a sensitivity of 99% and 88% for detection of endometrial cancer and atypical endometrial hyperplasia in postmenopausal women respectively.

Patients in whom a pipelle sample is not possible should have the reason documented.

Indications for hysteroscopy:

Unable to pass Pipelle sampler or inadequate biopsy
Suspected polyp
ET≥11mm*
Inadequate visualisation of endometrium
Recurrent PMB (defined as 2 attendances to PMB clinic with 2 benign pipelle biopsies more than 6 months apart in the last 2 years)

Hysteroscopy should not be arranged until the results of the pipelle biopsy are known, since the result may obviate the need the investigation.

*Due to the huge fluctuation of ET in women who are pre/ peri-menopausal (i.e. last period less than 12 months ago) provided their endometrial biopsy is normal, ET>11mm alone is not an indication for hysteroscopy.
Out-patient hysteroscopy (OPH) is preferred to GA.
A failed pipelle biopsy is not a contraindication to OPH, unless the patient has had a previous endometrial ablation. Consideration should be given for referral back to the team that performed the endometrial ablation for further management.

Incidental findings of ET≥11mm in asymptomatic women on tamoxifen that have had a negative OPH in the last 12 months do not require any further investigations.

ALL sections of the PMB history proforma should be completed in ALL cases (see appendix).

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PMB Clinic Investigation Pathway

References

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