



PRIMARY CARE
WOMEN'S HEALTH FORUM

How to manage women presenting with abnormal uterine bleeding in primary care without face to face contact

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This advice has been produced by clinical expert consensus and adapted from recommendations published by RCOG/BSGE/BGCS/BMS. It is not intended to replace the need to apply personalised clinical judgement.

How to manage women presenting with abnormal uterine bleeding in primary care without face to face contact

Heavy Menstrual Bleeding (HMB)

Women with HMB should initially be managed by remote communication. They should be reassured that the risk of malignancy is negligible.¹

Careful history to determine:

- Nature of bleeding
- Severity of symptoms
- Impact of symptoms
- Severity of possible anaemia
- Likely cause.

Refer to secondary care if:

- HMB torrential or prolonged.
- Trial of treatment has failed.
- Severe anaemia suspected.
If not arranging acute admission treat with 1.5g tranexamic acid and prescribe iron.

If no symptoms of severe anaemia offer treatment according to NICE HMB CG88:²

- Treatment options:
 - Non-hormonal (repeat cyclically and start treatment on first day of subsequent bleeds):
 - › Tranexamic acid 1.5g tds for 5 days
 - › NSAID of choice provided no contra-indications
 - › Combination of above.
 - Hormonal
 - › Medroxyprogesterone Acetate 10mgs tds cyclically for 3 weeks with one-week break
 - › Combined Hormonal contraception if no contra-indications for use, ref UKMEC.³

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Intermenstrual Bleeding (IMB)

Women with IMB should initially be managed by remote communication. They should be reassured that the risk of malignancy is negligible.¹

Careful history to determine:

- Severity of symptoms
- Likely cause
- Sexual history to assess risk for STI – consider asking patient to perform low vaginal swab (send to patient or organise through local sexual health provider)
- Pregnancy risk.

Arrange examination if:

- High risk of STI and/or symptoms suggestive of pelvic infection
- Cervical cancer suspected if associated post-coital bleeding and/or offensive vaginal discharge.

Otherwise:

- Reassure
- If unscheduled bleeding on hormonal contraception options include:
 - If using combined hormonal contraception (CHC) then try changing progestogen or increasing oestrogen dose
 - If using progestogen only contraception either change to or add CHC if no contra-indications for use, ref UKMEC or increase progestogen dose by additional desogestrel pill.³
- Consider trial of hormonal contraception if appropriate in current non-users, preferably CHC if no contra-indications for use, ref UKMEC.³

2 week referral to secondary care if:

- Cervical cancer is suspected on pelvic examination
- Endometrial cancer is suspected because of persistent IMB (occurring for at least 3 consecutive months) in women aged over 40 who are not using hormonal contraceptives
- Explain that if they or any of their household members have suspected or confirmed COVID-19 they will not be seen until they are no longer infectious.

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Post-menopausal bleeding (PMB) Post-coital bleeding (PCB) (occurring in women not using HRT)

Bleeding that is not obviously a period occurring over 12 months since their last menstrual bleed is a red flag symptom because 5-10% of women will have endometrial cancer.⁵

Women with PMB should initially be managed by remote communication to:

- Confirm the symptom
- Assess on an individual basis whether the risks of horizontal transmission from a hospital appointment for COVID-19 vulnerable patients outweigh the risk of delay in diagnosis or exclusion of a cancer
- Be informed a 2 week wait referral will be made to secondary care
- Explain that if they or any of their household members have suspected or confirmed COVID-19 they will not be seen until they are no longer infectious.

Women with PCB should initially be managed by remote communication to:

- Reassure them that cervical cancer is extremely unlikely if they have an in-date negative cervical screening test.

Careful history to determine:

- Severity of symptoms
- Likely cause
- Sexual history to assess risk for STI – consider asking patient to perform low vaginal swab (send to patient or organise through local sexual health provider)
- Pregnancy risk.

Arrange examination if:

- High risk of STI and/or symptoms suggestive of pelvic infection.
- The latest negative cervical screening test is not within the dates recommended for the cervical screening programme.

2 week referral to secondary care if:

- Cervical cancer is suspected on pelvic examination
- Explain that if they or any of their household members have suspected or confirmed COVID-19 they will not be seen until they are no longer infectious.

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Unscheduled bleeding on HRT

Women with unscheduled bleeding on HRT should initially be managed by remote communication. They can be reassured that the risk of endometrial cancer in women using combined HRT is lower than in women not on HRT, especially if they had not been experiencing bleeding before starting their combined HRT.

Careful history to determine:

- Type of HRT
- Severity and extent of bleeding
- Length of use of HRT
- Compliance with HRT.

Management:

For the majority of cases modifying progestogen intake will control the bleeding especially in women who experience unscheduled bleeding in the first few months after commencing HRT.

- For continuous combined HRT regimens the dose of progestogen could be increased:
- If using micronised progesterone 100 mg daily increase to 200 mg daily on continuous basis.
- If using continuous combined HRT or oestrogen plus Mirena consider adding micronised progesterone/medroxyprogesterone acetate or norethisterone to their HRT regimen.

- If ongoing unscheduled bleeding experienced change the HRT to a cyclical regimen. Or add desogestrel 75mcg if the bleeding is 'period-like' suggesting ongoing ovulation.
- For cyclical HRT regimens the dose of progestogen could be increased:
- Micronised progesterone 300 mg for 12 days a month instead of 200 mg
- Increase duration of progestogen intake to 21 days out of a 28-day HRT cycle.

Refer to secondary care:

- If unscheduled bleeding continues beyond 6 months despite modifying progestogen regimen
- Where there is a concern about the clinical presentation.

1. Pennant ME et al. Premenopausal abnormal uterine bleeding and risk of endometrial cancer. BJOG 2017; 124: 404-411

2. National Institute for Health and Care Excellence (NICE) 2018. Heavy Menstrual Bleeding: Assessment and Management. NICE NG88

3. FSRH UK Medical Eligibility Criteria for contraceptive use (UKMEC). 2016 <http://www.fsrh.org/documents/ukmec-2016/>

4. FSRH Problematic bleeding with hormonal contraception. July 2015 <https://www.fsrh.org/standards-and-guidance/documents/ceuguidanceproblematicbleedinghormonalcontraception/>

5. Gredmark T et al. Histopathological findings in women with postmenopausal bleeding. BJOG 1995;102:133-136