The PMB Pathway
For Suspected Endometrial Cancer in Primary Care

Patient attends GP with PMB History & Pelvic Examination ➔ Cervical or Vulval tumour identified

Suspected Endometrial Cancer
Commence PMB Pathway

Send Initial Consultation document to 2WW Booking Office via ERS
rch-tr.suspectedCancer@nhs.net

Provide Patient Information Booklet if desired

Refer as Gynaecology 2WW

TVS within 1 week
Scan clinics at:
RCHT
WCH
Camborne/Redruth
Bodmin

TVS results on InSight

2WW Booking Office
Send Letter & Patient Information Booklet to patient
Book TVS on PAS
Book onto Virtual PMB Clinic the Friday after the TVS appointment

Select appropriate tick box on “Suspected Gynaecological Cancer Referral” Form and provide relevant details

Virtual PMB Clinic
Friday morning: History and TVS reviewed by Specialist

Endometrium Normal
Discharge to GP by letter

Endometrium thickened
Outpatient Hysteroscopy
Histology reviewed in Virtual PMB Clinic

Normal
Discharge to GP by letter

Not Normal

Ovarian cyst
Ca125 CT or MRI if indicated

GOPD
1. **Aim/Purpose of this Guideline**

1.1. This guideline applies to people presenting to with suspected endometrial cancer in Primary and Secondary Care. It encompasses their management from presentation through to the point of excluding or diagnosing endometrial cancer.

The PMB Pathway is for the management of postmenopausal people (>12 months since last menstrual period) with:

- Uterus present (eg no previous hysterectomy)
- One or more episodes of vaginal bleeding
- Unscheduled bleeding > 6 months after starting continuous combined HRT
- Heavy, prolonged or breakthrough bleeding over 2 consecutive cycles of HRT
- Asymptomatic endometrial thickening (≥11mm) or suspicious endometrium on TVS

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### Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

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DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

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2. The Guidance

2.1. Background

2.1.1. Post-Menopausal Bleeding

Menopause is defined by the World Health Organization 1996 declaration as the permanent cessation of menstruation resulting from the loss of ovarian follicular activity. Menopause is the last menstrual bleed and can be diagnosed retrospectively after 1 year of amenorrhoea in the absence of hormonal contraception and any pathologic disorder that could be responsible for the amenorrhoea.

Plasma oestradiol below 20 pg/ml (range 5–25 pg/ml) and FSH more than 50 mU/ml are consistent with cessation of ovarian function, however, there are no hormonal marker(s) that can reliably confirm menopause.

For practical, clinical use an arbitrarily established length of amenorrhea (12 months) is used to define retrospectively whether a woman has reached menopause.

In the UK, the median age of the menopause is 51 years.

Postmenopausal bleeding (PMB) refers to any vaginal bleeding that occurs 1 year after the menopause regardless of cause but excluding expected/scheduled bleeding that occurs with sequential hormone replacement therapy (HRT).

PMB is common especially during the first year after the 12 months of amenorrhea. 1 in 10 women experience PMB in the first year after the menopause.

Patients with PMB have approximately a 10–15% chance of having endometrial carcinoma. Ninety percent of women with endometrial carcinoma present with vaginal bleeding. Endometrial cancer is the most common gynaecological malignancy, and the fourth commonest malignancy in women. There were 8984 new cases in the UK in 2015. The 10 year survival is 78%.
Risk factors for endometrial cancer include:

- Obesity (up to 50% of cases are preventable/directly attributable to obesity)
- Diabetes (although overweight/obesity may explain this association)
- Age >75 years
- Tamoxifen
- Unopposed oestrogens
- Polycystic ovary syndrome
- Nulliparity
- Lynch Syndrome/HNPCC

PMB is usually attributed to an intrauterine source, but may arise from the vulva, vagina, cervix, fallopian tubes, or it may be related to ovarian pathology. The bleeding may originate from extra genital sites such as the urethra, bladder, and the bowel.

The approach to PMB requires prompt and effective evaluation to exclude cancer of the genital tract or pre-malignant lesions of the endometrium (endometrial hyperplasia).

PMB is most commonly caused however by benign conditions. Vaginal atrophy, endometrial atrophy, endometrial polyps and fibroids, are commonly identified on investigation for PMB. It is always difficult to be certain if these findings are the cause of the bleeding, or if they are incidental to the presentation of PMB, and indeed whether or not treatment is indicated or helpful.

2.1.2. Investigations for PMB

There is at present no universally accepted national UK guideline or evidence based strategy or to recommend the investigations of choice, guide the interpretation of investigation results or advise on the sequence in which the various available investigations should be undertaken for women with PMB. It is usually recommended that local protocols for the investigation of PMB should reflect local resource availability and expertise.

2.1.2.1. Transvaginal Ultrasound for Endometrial Thickness

Transvaginal ultrasound for endometrial thickness is accepted in the UK as the most appropriate first line investigation for women with PMB.
Although there has been debate over the years about exact cut off values, it is generally accepted in UK practice that an endometrial thickness of ≤ 4 mm is associated with a very low risk of endometrial pathology. Expectant management is therefore recommended for these women. This is supported by the ACOG 2018 Committee Opinion on “The Role of Transvaginal Ultrasonography in Evaluating the Endometrium of Women With Postmenopausal Bleeding”.

Following initial publications suggesting that an endometrial thickness of 3-5mm reliably excluded endometrial cancer, a large number of multi-centre confirmatory trials have been published which show that an ET of ≤ 4 mm has a greater than 99% negative predictive value for endometrial cancer.

It is estimated that 1:339 endometrial cancers will be missed using a cut off value of ≤ 4 mm. It is therefore important that women experiencing persistent symptoms are offered further investigation.

Ronghe et al looked at follow-up of women with PMB and an endometrial thickness of ≤ 4mm on initial investigation. They showed that none of the women undergoing expectant management developed cancer over the subsequent year of follow-up.

2.1.2.2. Endometrial Assessment

Women whose endometrial thickness is above the recommended cut off are offered some form of endometrial assessment. Available methods of endometrial assessment include or hysteroscopic assessment, either in the outpatient setting or in theatre under general or regional anaesthesia.

A variety of clinic-based, blind endometrial sampling systems are available and include the Pipelle device (used at RCHT) which has been shown to obtain adequate endometrial tissue samples in 43%-91% of cases.

One study reports that in women with an endometrial thickness of ≤ 4 mm a pipelle endometrial biopsy was only possible in 82%, and of these a sample adequate for histological diagnosis was obtained in 27%.
Overall, clinic-based blind endometrial sampling is associated with a procedure failure rate of around 10%, and approximately 10% of samples will result in insufficient tissue for histological diagnosis. Evidence suggests that such patients may have underlying intrauterine lesions, including malignancy, especially if the endometrial thickness is above the acceptable threshold value. Women with “non-diagnostic” endometrial biopsy specimens should therefore be offered further investigation.

Blind methods of endometrial sampling may fail to identify focal pathology of the endometrium. Although blind sampling is a satisfactory investigation for the detection of endometrial neoplasia that affects the entire endometrial surface, it may be less effective in detecting localized lesions such as endometrial polyps, which may be neoplastic.

Hysteroscopy allows direct visualization of the endometrial cavity. It can be performed in the clinic with local or no anaesthesia or in the operating theatre under anaesthetic. With 3-4mm hysteroscopes dilation of the cervix may not be necessary. Another advantage of hysteroscopy is that endoscopically guided removal of lesions may be performed immediately upon diagnosis, during the same procedure.

Hysteroscopy is superior to endometrial biopsy alone, D&C, and ultrasonography for the identification of structural lesions of the endometrium such as endometrial polyps. Whether or performed in clinic or in theatre, hysteroscopy has good patient acceptability. In a study designed to determine the preferences of women regarding a primary assessment tool for evaluation of postmenopausal bleeding, 95% preferred to undergo outpatient hysterectomy rather take a 5% chance that a lesion could be missed. Hysteroscopic visualization alone is relatively inaccurate in the diagnosis of atypical hyperplasia and carcinoma. Hysteroscopy should always be performed in conjunction with endometrial sampling or curettage.

#### 2.1.3. Endometrial Polyps

The aetiology and natural history of endometrial polyps is unknown. There is a lack of clarity with regard to their clinical significance; whilst endometrial polyps are highly prevalent in all types of abnormal uterine bleeding, they are also commonly found in women without bleeding.

The reported prevalence is estimated to be between 7.8% to 34.9%, depending on the definition, diagnostic method, and the population studied. It is reported that more postmenopausal than premenopausal women are affected.
Most endometrial polyps are benign; however they may be hyperplastic.

The estimated prevalence of endometrial hyperplasia and malignancy within polyps varies, but is usually cited as around 1 - 4% in asymptomatic post-menopausal women, and 3 - 5% in symptomatic post-menopausal women.

Malignant transformation is said to occur in up to 12.9% of polyps.

Risk factors for malignancy within uterine polyps include bleeding symptoms, increasing age, post-menopausal status, obesity, diabetes, hypertension, polyp size greater than 1.5 cm and tamoxifen use.

The highest risk of malignancy is in endometrial polyps in postmenopausal women with symptoms.

The surgical treatment of uterine polyps is excision or ‘polypectomy’, which aims to treat associated symptoms of bleeding and to obtain tissue for histological examination. The need to remove polyps may be questioned in light of the observations that polyps are common, most are benign, and some may regress spontaneously.

The effect of polypectomy on periodic blood loss appears to be questionable.

An attempt has been made to determine the significance of uterine polyps on the risk of recurrent PMB by randomising women with PMB to either polypectomy or expectant management. Women with PMB and a thickened endometrium on TVUS and a subsequently benign endometrial biopsy were randomised to undergo hysteroscopy and polypectomy or expectant management. Nearly, one in five women experienced recurrent PMB over the year, but differences in the prevalence of recurrent PMB were not observed between the groups. Thus, expectant management on symptomatic grounds seems a viable option as opposed to hysteroscopic polypectomy. There was a 6% incidence of atypical hyperplasia or cancer in the hysteroscopically removed polyps. Hysteroscopic polypectomy thus appears to be indicated to aid diagnosis of serious endometrial disease but not to alleviate bleeding symptoms.

2.1.4. **Hormone Replacement Therapy**

HRT can lead to unscheduled vaginal bleeding, and 25-50% of women will discontinue HRT as a result.

There is a lack of evidence to guide the investigation of unscheduled bleeding on HRT.
Continuous combined regimens (CCHRT) usually lead to amenorrhoea. Up to 80% of women will experience unscheduled bleeding or spotting in the first 6 months of treatment. Bleeding on continuous combined HRT regimens should be investigated on the PMB pathway if it occurs after 6 months of therapy or if it occurs after amenorrhoea has been established.

For women on sequential HRT, abnormal bleeding may be heavy, frequent or manifest as a change in pattern at the end of or after the progestogen phase, or may occur at any time, when it is referred to as breakthrough bleeding. Irregular bleeding is experienced by 8–40% of sequential HRT users. It is recommended that women experiencing unscheduled bleeding on sequential HRT are investigated if their symptoms occur over 2 consecutive cycles.

In women on sequential HRT with PMB the mean endometrial thickness is about 2mm greater than in women with PMB who are not on sequential HRT. Despite this, the sensitivity of transvaginal ultrasound does not vary significantly with hormone use, and it is accurate in excluding endometrial disease.

2.1.5. Tamoxifen

Tamoxifen is a selective oestrogen receptor modulator (SERM) widely used in the treatment of breast cancer. It has a weakly oestrogenic action on the endometrium and is associated with an increased risk of endometrial polyps and endometrial hyperplasia. It at least doubles the risk of endometrial cancer amongst postmenopausal women.

Tamoxifen induced sub-epithelial stromal hypertrophy leads to high false positive rate on transvaginal ultrasound scan, even at an endometrial thickness cut-off of 10mm, and a low positive predictive value.

2.1.6. Asymptomatic Endometrial Thickening

Endometrial thickening may be reported on ultrasound examinations undertaken for reasons other than PMB. Using the same threshold in women without PMB has a high false positive rate and poor sensitivity. Alternative ET cut-offs have been suggested, however there is no consensus on recommended measurements.

Women with endometrial thickening and other positive findings on ultrasound, such as increased vascularity, inhomogeneity of endometrium, fluid in the cavity, or thickened endometrium over 10
mm, should be referred for a discussion surrounding further investigations. Decisions about further investigations should be made on a case-by-case basis taking into account individual risk factors for endometrial cancer.

2.1.7. Recurrent/Persistent PMB

Women with recurrent PMB after initial negative investigations are no more likely to have endometrial cancer than those presenting for the first time but re-investigation is generally recommended if six months has elapsed.

Women presenting with ongoing or persistent PMB should be offered OPH in addition to TVS, as anecdotal evidence would suggest that on occasion endometrial cancer can be present with an endometrial thickness of <4mm. These tend to be type 2 endometrial cancers.

2.2. The PMB Pathway

People who meet the pathway inclusion criteria will be managed on a shared, guideline based pathway provided by Kernow CCG and RCHT allowing seamless transfer between primary and secondary care sectors.

A project based on the same principles reported in 2007, using the same endometrial thickness cut off was demonstrated to be efficient and safe, with no woman discharged to the GP after initial ultrasound diagnosed with malignancy over the subsequent 12 month period.

2.2.1. At initial presentation people reporting PMB should have:

- A history of the presenting symptoms taken
- A brief gynaecological history taken
- A pelvic examination of the vulva, vagina and cervix should be considered (as lower genital tract tumours are a cause of PMB) and these cancers are managed on a different pathway. If there is an obvious vulval, vaginal or cervical tumour a gynaecology two-week wait referral for the appropriate suspected cancer should be initiated.
- Their vaginal pessary removed (where relevant) to facilitate subsequent TVS.

2.2.2. Some patients who do not undergo pelvic examination at initial presentation will subsequently be asked to attend for OPH, and a pelvic examination will be undertaken at the time of OPH. If a lower genital tract tumour is identified, a biopsy should be taken where
possible and the patient booked into the next available appropriate clinic.

2.2.3. Patients who do not undergo pelvic examination at the time of presentation, and who do not need an OPH will be asked to make an appropriate appointment at their GP Surgery to have this done after their case has been reviewed in the Virtual PMB Clinic.

2.2.4. Patients who have had a vaginal pessary removed will be asked to contact the healthcare provider who usually looks after their pessary to have it re-inserted after their case has been reviewed in the Virtual PMB Clinic if they do not need an OPH.

2.2.5. The GP should record the history and examination findings on the “PMB Pathway for Suspected Endometrial Cancer” section of the Gynaecology 2WW referral form (see Appendix 3 for PMB Clinical Documents).


2.2.7. The “PMB Pathway: Initial Consultation” document should be sent by email to the 2WW Office: rch-tr.suspectedCancer@nhs.net

2.2.8. A TVS will be scheduled within 7 days of receipt of referral. TVS appointments will be offered as close to the patient’s home as possible, within the 7 day time frame. The patient will be telephoned with an appointment on the day of the referral (see Appendix 4 for PMB Administration SOP).

2.2.9. The history, along with the TVS report and images will be reviewed weekly by a specialist practitioner in the Virtual PMB Clinic.

2.2.10. The “PMB Pathway: TVS Review & Recommendation” document will be completed in the Virtual PMB Clinic and actioned on the same day by the PMB secretarial team (see Appendix 3 for PMB Clinical Documents and Appendix 4 for PMB Administration SOP).

2.2.11. Actions from the Virtual PMB Clinic may include:

- Discharge to the care of the GP with advice to re-present if the bleeding is persistent or recurs after 6 months for women with ET ≤ 4mm OR < 7mm on sequential HRT
- Diagnostic OPH for women with:
  - ET > 4mm OR ≥ 7mm on sequential HRT
  - Endometrium not visible
  - Suspicious/Irregular endometrium/fluid/obvious endometrial malignancy on TVS
  - Risk factors for endometrial cancer (eg Tamoxifen)
  - Recurrent PMB

- Operative OPH for women with
  - ET ≥ 10mm/Likely polyp/SMF (Anticoagulation to be stopped if ET >2cm)

- Complex patients (eg those with significant co-morbidities, dementia etc) may be asked to attend for an appointment with a consultant to enable patient-centred decision making surrounding appropriate investigation

- Incidental findings of adnexal cysts/masses will be managed as per RCHT Guideline “The Initial Management of Ovarian Cysts After the Menopause”

2.2.12. Results will be communicated to patients using standard letter templates (see Appendix 5 for PMB Standard Letter Templates).

2.2.13. Patients attending for OPH will be managed as per the PMB OPH Operational Policy (see Appendix 6).

2.2.14. All results for patients on the PMB Pathway will be reviewed weekly in the Virtual PMB Clinic and the “PMB Pathway: Histology Review & Recommendation” document will be completed for action by the PMB Secretarial team (see Appendix 3: PMB Clinical Documents).

2.2.15. Histology results will be actioned using the standard letter templates (Appendix 5) as follows:

- Women with the following results will be discharged back to the care of their GP:
  - Insufficient histology (provided normal appearance of endometrium at OPH)
  - Inactive endometrium
  - Proliferative / Secretory endometrium
  - Benign polyp / SMF
- Women with endometrial hyperplasia with no atypia (simple or complex) will be followed up in the Gynaeoncology clinic within 4 weeks by an Associate Specialist or Gynaeoncology Consultant as appropriate depending on their history.

- Women with endometrial hyperplasia with atypia or endometrial malignancy will be followed up in the Gynaeoncology clinic within 1 week by a Gynaeoncology Consultant.

- Women with endometrial hyperplasia will be managed in accordance with the RCOG Green Top Guidance No 67 “Management of Endometrial Hyperplasia”.

- Women with endometrial cancer will be managed in accordance with the BGCS Uterine Cancer Guidelines: Recommendations for Practice.

### 2.3. Non-Primary Care Referrals

2.3.1. Some patients who meet the criteria for investigation on the PMB Pathway present in secondary care eg to emergency gynaecology, whilst as in-patients under the care of another specialty or during visits to other gynaecology clinics. Their management may need to be individualised depending on their circumstances.

2.3.2. A history should be taken, as for patients presenting in primary care, and where possible the patient should undergo a pelvic examination to exclude a vulval, vaginal or cervical malignancy as the cause of the bleeding. If a lower genital tract malignancy is seen on examination, the patient should be discussed with the on call gynaecology consultant if the presentation is acute, or referred to the relevant 2WW clinic if this is more appropriate.

2.3.3. Some clinicians may prefer to manage their own patients (especially outpatients) according to the general principles set out in this document without referral to the PMB Service.

2.3.4. Internal referrals can be made to the PMB Service using the proforma on MAXIMS “PMB (Gynaecology) Outpatient Service”

2.3.5. If an internal referral is made:

- Where appropriate, an urgent TVS should be requested by the referring practitioner. The “Ordering HCP” and “Resp Clinician” boxes on the request should be changed manually to “PMB Service”
At the time of referral, where possible the patient should be given RCHT patient information leaflet number 1797 “Post-menopausal Bleeding: Information for patients referred to the PMB Clinic” 

2.3.6. The referral will then be processed by the PMB Service in the usual way.

2.3.7. Complex patients, for example where there are concerns about capacity, suitability for investigation or suitability for cancer treatment, may benefit from consultant review in the gynaeoncology clinic prior to making decisions about investigation/treatment.

2.3.8. In the acute setting, if after clinical assessment, an internal referral to the PMB Service or gynaeoncology clinic is not appropriate the patient should be discussed with the gynaecology consultant on call, an appropriate plan made, documented, communicated to the patient and actioned by the managing team.
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>A program of ongoing prospective audit of both process and outcome will be built into the clinical process and undertaken from the time of inception of the pathway.</th>
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</table>
| Lead                     | Miss S Julian  
PMB Lead  
Consultant Gynecological Oncologist |
| Tool                     | Real time process and outcome data will be recorded for every patient receiving healthcare on the PMB pathway.  
An annual report will be produced and presented to the Directorate meeting. |
| Frequency                | As above |
| Reporting arrangements    | As above |
| Acting on recommendations and Lead(s) | Miss S Julian  
PMB Lead  
Consultant Gynecological Oncologist |
| Change in practice and lessons to be shared | Required changes to practice will be identified and actioned within 3 months, immediately if required. A lead member of the team will be identified to take each change forward where appropriate.  
Lessons will be shared with all the relevant staff/stakeholders |

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>The Post-Menopausal Bleeding Service Clinical Guideline V1.0</th>
</tr>
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<tbody>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>New Document</td>
</tr>
<tr>
<td>Date Issued/Approved:</td>
<td>13/05/2020</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>January 2021</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>January 2024</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Sophia Julian Consultant Gynaecological Oncologist</td>
</tr>
<tr>
<td>Contact details:</td>
<td>(01872) 2523215</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This guideline applies to people presenting to with suspected endometrial cancer in Primary and Secondary Care. It encompasses their management from presentation through to the point of excluding or diagnosing endometrial cancer.</td>
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<tr>
<td>Suggested Keywords:</td>
<td>Post-Menopausal Bleeding</td>
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<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Approval route for consultation and ratification:</td>
<td>Obs and Gynae Specialty Meeting</td>
</tr>
<tr>
<td>General Manager confirming approval processes</td>
<td>Mary Baulch</td>
</tr>
<tr>
<td>Name of Governance Lead confirming approval by specialty and care group management meetings</td>
<td>Caroline Amukusana</td>
</tr>
<tr>
<td>Links to key external standards</td>
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</tr>
<tr>
<td>References are supplied in Appendix 8</td>
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<tr>
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Publication Location (refer to Policy on Policies – Approvals and Ratification):

Internet & Intranet ✔️ Intranet Only

Document Library Folder/Sub Folder: Gynaecology

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tbody>
<tr>
<td>12/05/2020</td>
<td>V1.0</td>
<td>Initial version</td>
<td>Sophia Julian Consultant Gynaecological Oncologist</td>
</tr>
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</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry. This document is only valid on the day of printing

Controlled Document

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## Appendix 2. Initial Equality Impact Assessment

### Section 1: Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>The Post-Menopausal Bleeding Service Clinical Guideline V1.0</th>
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<tr>
<td><strong>Directorate and service area:</strong></td>
<td><strong>Is this a new or existing Policy?</strong></td>
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<tr>
<td>Primary Care / KCCG (for reference)</td>
<td>New</td>
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<tr>
<td>WCSH – Gynaecology Radiology</td>
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<tr>
<td><strong>Name of individual/group completing EIA</strong></td>
<td><strong>Contact details:</strong></td>
</tr>
<tr>
<td>Sophia Julian Consultant Gynaecological Oncologist</td>
<td>Secretary Nadia Francis Ext 2729</td>
</tr>
</tbody>
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### 1. Policy Aim

**Who is the strategy / policy / proposal / service function aimed at?**

To provide a pathway for clinicians involved in the management of people with a uterus who report post-menopausal bleeding.

### 2. Policy Objectives

**To standardise the management of this group of patients and provide healthcare for them as close to home and as efficiently as possible whilst retaining specialist oversight of the process.**

### 3. Policy Intended Outcomes

To meet the mandated NHS “28 days faster diagnosis” target by May 2020. The target will come into force in April 2020.

### 4. How will you measure the outcome?

See section 3 - Monitoring compliance and effectiveness

### 5. Who is intended to benefit from the policy?

People with a uterus who report post-menopausal bleeding. Other groups of patient will also benefit through re-allocation of healthcare resource.

### 6a). Who did you consult with?

<table>
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<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
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<td></td>
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</tr>
</tbody>
</table>

**Please record specific names of groups:**

1. The Gynaecology/PMB team
2. The Gynaecology Management/Leadership Team
3. The Gynaecology Patient Support Group
4. KCCG Senior Clinical Leadership Team
5. KCCG Commissioners
6. GPs attending the RCHT “Two Week Wait Referral Event”

GPs attending an educational session on “Post Menopausal Bleeding” hosted by The Duchy Hospital.

### b). Please list any groups who have been consulted about this procedure.

- The Gynaecology/PMB team
- The Gynaecology Management/Leadership Team
- The Gynaecology Patient Support Group
- KCCG Senior Clinical Leadership Team
- KCCG Commissioners
- GPs attending the RCHT “Two Week Wait Referral Event”
- GPs attending an educational session on “Post Menopausal Bleeding” hosted by The Duchy Hospital.
7. The Impact
Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

Are there concerns that the policy **could** have a positive/negative impact on:

<table>
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<th>Protected Characteristic</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<td>Age</td>
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<td></td>
<td>The document refers to all post-menopausal people with a uterus who experience vaginal bleeding regardless of age.</td>
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<tr>
<td>Sex (male, female non-binary, asexual etc.)</td>
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<td></td>
<td></td>
<td>The document refers to all post-menopausal people with a uterus regardless of how they identify.</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>X</td>
<td></td>
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<td>The document refers to all post-menopausal people with a uterus regardless of how they identify.</td>
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<tr>
<td>Race/ethnic communities /groups</td>
<td>X</td>
<td></td>
<td></td>
<td>Any information provided will be in an accessible format for the patient’s needs – i.e. available in different languages if required/access to an interpreter if required</td>
</tr>
<tr>
<td>Disability (learning disability, physical disability, sensory impairment, mental health problems and some long term health conditions)</td>
<td>X</td>
<td></td>
<td></td>
<td>Those patients with any identified additional needs will be referred for additional support as appropriate - i.e to the liaison team or for specialist equipment. Information will be provided in a format to meet the patient’s needs e.g. easy read, audio etc</td>
</tr>
<tr>
<td>Religion/other beliefs</td>
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<td>The document refers to all post-menopausal people with a uterus regardless of religious or other belief.</td>
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<td>Marriage and civil partnership</td>
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<td>The document refers to all post-menopausal people with a uterus regardless of marital or civil partnership status.</td>
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<tr>
<td>Pregnancy and maternity</td>
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<td>By definition, the document does not impact on people who are pregnant or receiving maternity healthcare.</td>
</tr>
<tr>
<td>Sexual orientation (bisexual, gay, heterosexual, lesbian)</td>
<td>X</td>
<td></td>
<td></td>
<td>The document refers to all post-menopausal people with a uterus regardless of sexual orientation.</td>
</tr>
</tbody>
</table>

If all characteristics are ticked ‘no’, and this is not a major working or service change, you can end the assessment here as long as you have a robust rationale in place.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Sophia Julian
Consultant Gynaecological Oncologist
If you have ticked ‘yes’ to any characteristic above OR this is a major working or service change, you will need to complete section 2 of the EIA form available here: 
Section 2. Full Equality Analysis

For guidance please refer to the Equality Impact Assessments Policy (available from the document library) or contact the Human Rights, Equality and Inclusion Lead debby.lewis@nhs.net
### Appendix 3: Clinical Documents

**GP or GDP Details:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Date of decision to refer:</td>
<td>Home Phone:</td>
</tr>
<tr>
<td></td>
<td>Mobile Phone:</td>
</tr>
<tr>
<td></td>
<td>Email:</td>
</tr>
<tr>
<td></td>
<td>Date of Birth:</td>
</tr>
<tr>
<td></td>
<td>NHS Number:</td>
</tr>
</tbody>
</table>

**Patient Details:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Date of decision to refer:</td>
<td>Home Phone:</td>
</tr>
<tr>
<td></td>
<td>Mobile Phone:</td>
</tr>
<tr>
<td></td>
<td>Email:</td>
</tr>
<tr>
<td></td>
<td>Date of Birth:</td>
</tr>
<tr>
<td></td>
<td>NHS Number:</td>
</tr>
</tbody>
</table>

*Please check phone numbers*

**CAPACITY & COMMUNICATION**

- Does the patient have capacity to make decisions about their healthcare?
- Dementia
- Learning Difficulties
- Next of Kin needed to accompany the patient to appointments
- Is the patient able to read and understand written information?
- Is the patient able to take and understand telephone calls?
- If no, how would you like us to communicate with the patient?

**MOBILITY**

- Weight bearing
- Bed bound
- Hoist required
- Weight (couch limit for TVUSS 165kg / 26 stone) kg
- Height (needed to calculate BMI as risk factor for endometrial cancer) m

**INTERPRETER REQUIRED (INCLUDING BSL)**

State which language:

**ATTACH THE GP ELECTRONIC SUMMARY**

We need details of past medical history, up to date drug history and allergies in order to be able to perform risk assessment and book investigations appropriately.

*Requests with incomplete information will be rejected*

---

*The above details are required before we can begin booking appointments*

GPs may decide not to refer patients meeting these criteria via this pathway. If referring via another pathway, please state the reason for this decision in the urgent/routine referral.
The PMB Pathway

For Suspected Endometrial Cancer

DO NOT USE THIS PATHWAY FOR PATIENTS WHO HAVE HAD A HYSTERECOMY

Entry criteria (tick all that apply)
- Post-menopausal (> 12 months since LMP)
- One or more episodes of bleeding
- Unscheduled bleeding 6 months after starting continuous combined HRT
- Unscheduled/Abnormal bleeding over 2 consecutive sequential HRT cycles
- Re-referral within 6 months of previous investigation for PMB ie "Persistent PMB"
- Asymptomatic Endometrial thickening (≥10mm) / suspicious endometrium on TVS

<table>
<thead>
<tr>
<th>Parity</th>
<th>Number of Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature of bleeding</td>
<td>Pink</td>
</tr>
<tr>
<td>Amount of bleeding</td>
<td>Slight/spotting</td>
</tr>
<tr>
<td>Duration</td>
<td>Days</td>
</tr>
</tbody>
</table>

Examination findings: To check for vulval or cervical tumours
- Please remove vaginal pessaries (where applicable) to facilitate transvaginal ultrasound

<table>
<thead>
<tr>
<th>Examination findings</th>
<th>No vulval tumour seen</th>
<th>No vaginal tumour seen</th>
<th>No cervical tumour seen</th>
</tr>
</thead>
</table>

Two actions are now required:
1. Send this form via ERS to the RCHT Two-week Wait Booking Office
2. Inform the patient that she will be telephoned with an appointment for a transvaginal scan within one week

What happens next:
- The patient will be telephoned on the day of receipt of referral with an appointment for a TVS
- Advise her to keep her phone nearby, switched on and answer it
- The history and ultrasound scan will be reviewed in the “Virtual PMB Clinic”
- Both GP and patient will be contacted with the “Virtual PMB Clinic” outcome
- If the TVS is normal, the patient will be discharged with advice by letter, copied to GP
- If the TVS is not normal, further tests will be organised directly with the patient by the “Virtual PMB Clinic”
- If there is a vulval, vaginal or cervical tumour, then the appropriate referral should be initiated
The previous two pages form part of the RCHT Urgent Two Week Wait Gynaecology document, which can be found here - https://doclibrary-rcht.cornwall.nhs.uk/RoyalCornwallHospitalsTrust/Internet/DocumentsLibrary/AZServices/CancerServices/ReferralForms.aspx
## PMB Pathway: TVS Review & Recommendation

### Risk Factors for Endometrial Cancer

<table>
<thead>
<tr>
<th>Factor</th>
<th>Drug History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>No anticoagulant</td>
</tr>
<tr>
<td>BMI</td>
<td>Low Dose Aspirin</td>
</tr>
<tr>
<td>BMI &gt;35</td>
<td>High Dose Aspirin</td>
</tr>
<tr>
<td>NIDDM</td>
<td>Clopidogrel</td>
</tr>
<tr>
<td>Age &gt;75</td>
<td>Ticagrelor</td>
</tr>
<tr>
<td>Nulliparity</td>
<td>Prasugrel</td>
</tr>
<tr>
<td>Tamoxifen</td>
<td>Warfarin</td>
</tr>
<tr>
<td>HRT</td>
<td>Rivaroxaban</td>
</tr>
<tr>
<td>Lynch/HNPCC</td>
<td>Apixaban</td>
</tr>
</tbody>
</table>

### Date of USS

<table>
<thead>
<tr>
<th>Endometrium Visible</th>
<th>Yes</th>
<th>No</th>
<th>Not visible: Book Diagnostic OPH (Mon/Thur am)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Endometrial Thickness

<table>
<thead>
<tr>
<th>mm</th>
<th>ET ≤ 4mm OR &lt; 7mm on sequential HRT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discharge to GP</td>
</tr>
<tr>
<td></td>
<td>Letter 2A to patient</td>
</tr>
<tr>
<td></td>
<td>Letter 2B to patient (includes VVA advice/leaflet)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>mm</th>
<th>ET &gt; 4mm OR ≥ 7mm on sequential HRT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Book for Diagnostic OPH (Mon or Thurs am)</td>
</tr>
<tr>
<td></td>
<td>Letter 3 to patient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>mm</th>
<th>ET ≥ 10mm or Likely polyp or Fibroid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Book Operative OPH (Thurs pm)</td>
</tr>
<tr>
<td></td>
<td>Letter 3 to patient</td>
</tr>
</tbody>
</table>

### Anticoagulation

- **ET > 2cm**
  - Anticoagulation **ONLY needs to be stopped**
  - **for operative hysteroscopy**
  - Letter 4a (not to stop your) Days
  - Letter 4b (warfarin) Days
  - Letter 4c (rivaroxaban/apixaban) Days
  - Letter 4d (do not stop your) Days

### Suspicious/Irregular endometrium/ fluid

- Book Diagnostic OPH (Mon/Thur am)
- Letter 3 to patient

### Referral for recurrent PMB

- Book Diagnostic OPH (Mon/Thur am)
- Letter 3 to patient

### Ovarian Cysts/masses ≥ 3cm

- Simple cysts < 3cm do not require any further action
- Ovarian Cyst
  - Letter 5 to patient
  - **Remember to book all blood tests on ICE**
  - Ca125 (all cysts)
  - CEA (only for complex cysts/ascites)
  - U&E (needed prior to CT scan)
  - CT Scan (large complex cysts/ascites)
  - MRI Scan (if clarification of nature needed)

### Simple unilateral cyst ≥ 3cm and ≤ 5cm

- Book GOPD with SYB (4 weeks)
- All others
  - Book GOPD with GO Consultant (3 weeks)

### GOPD review prior to further investigation

- Book GOPD with GO Consultant (1 week)
- Letter 9 to patient

### Dictate letter numbers and instructions to secretary on Winscribe

Signed (Name and Role)
# PMB Pathway: Histology Review & Recommendation

## Outpatient Hysteroscopy

<table>
<thead>
<tr>
<th>Date</th>
<th>Good view</th>
<th>Poor view</th>
<th>Normal uterine cavity/endometrium</th>
</tr>
</thead>
</table>

## Cervical Histology

<table>
<thead>
<tr>
<th>Benign Polyp</th>
<th>Letter 6B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benign Cervical Biopsy</td>
<td>Letter 6D</td>
</tr>
</tbody>
</table>

## Pipelle Histology

<table>
<thead>
<tr>
<th>Insufficient + Normal endometrium at OPH</th>
<th>Discharge to GP: Letter 6A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inactive</td>
<td></td>
</tr>
<tr>
<td>Proliferative / Secretory / Menstrual</td>
<td></td>
</tr>
<tr>
<td>Progestogen effect</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Simple endometrial hyperplasia</th>
<th>Return to GOPD: Letter 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex endometrial hyperplasia</td>
<td>Book GOPD with SYB (4 weeks)</td>
</tr>
<tr>
<td>Endometrial hyperplasia with atypia</td>
<td>Book GOPD with GO Consultant (1 week)</td>
</tr>
<tr>
<td>Endometrial malignancy</td>
<td>Book CT CAP for ≥ G2 Malignancy/Type 2</td>
</tr>
</tbody>
</table>

## Endometrial Polyp/Fibroid Resected

<table>
<thead>
<tr>
<th>Benign</th>
<th>Discharge to GP: Letter 6C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple endometrial hyperplasia</td>
<td>Return to GOPD: Letter 8</td>
</tr>
<tr>
<td>Complex endometrial hyperplasia</td>
<td>Book GOPD with SYB (4 weeks)</td>
</tr>
<tr>
<td>Endometrial hyperplasia with atypia</td>
<td>Book GOPD with GO Consultant (1 week)</td>
</tr>
<tr>
<td>Endometrial malignancy</td>
<td>Book CT CAP for ≥ G2 Malignancy/Type 2</td>
</tr>
</tbody>
</table>

## GOPD review prior to further investigation

| Book GOPD with GO Consultant (1 week) | Letter 9 to patient |

## Dictate letter numbers and instructions to secretary on Winscribe

### Notes

Signed (Name and Role)
Appendix 4: PMB Service Administration Standard Operational Policy

Women presenting with PMB are managed on a pathway involving shared care between the GP and PMB Services at RCHT.

The GP will record the history and examination findings in the relevant section of the Gynaecology Two-Week Wait referral form, entitled “The PMB Pathway for Suspected Endometrial Cancer Initial Consultation”

Copies of this document will be sent to the Two-Week Wait Booking Office via the ERS.

The referrals do not require vetting by a clinician.

On receipt of a standard PMB referral in the 2WW Booking Office:

- Check that the referral contains all the necessary information, including full details of the presenting complaint, past medical history and drug history. Referrals containing incomplete information are to be put on hold until complete information has been received from the referring practice (PMB standard letter 10 to be completed)
- Patients who do not have capacity to make decisions about their health care (eg owing to dementia or learning difficulties) should be flagged up to the PMB Secretarial team, who will liaise with the relevant clinician for advice
- Similarly, if a patient’s weight exceeds the safe limit for the scan couch, the PMB Secretarial team will need to liaise with the relevant clinician for advice prior to booking an ultrasound scan
- The patient is sent in the post:
  - PMB standard letter 1
  - The “PMB Service: Information for Patients” booklet (RCHT 1797)
- An appointment for a transvaginal ultrasound should be booked on PAS and the patient informed of the date, time and location by telephone. Remind the patient to expect a transvaginal scan (she should already be aware).
- PMB TVS Clinics are run at several locations. Where possible book the scan close to the patient’s home, provided this is within one week of receiving the referral.
  - West Cornwall Hospital – Monday - 4 patients a.m. - JULSO/WCU
  - Camborne & Redruth – Tuesday - 4 patients a.m. - JULSO/BAU
  - Royal Cornwall Hospital – Tuesday – 8 patients a.m. - JULSO/TRU
  - Bodmin Hospital – Wednesday – 8 patients a.m. - JULSO/BHU
- The patient will be booked onto the Friday Virtual PMB Clinic in the same week as the scan appointment
- Write the date, time and location of the TVS appointment on the referral, scan and email it to: rch-tr.ClinicalImaging@nhs.net. The email inbox is checked daily
- The scanned referral, including the patient summary is to be uploaded into MAXIMS as a “Referral Letter” under Specialty: “PMB Service”
On receipt of the referral in the Ultrasound Department
- The patient details are entered into CRIS by the imaging admin team
- The referring clinician is to be entered as “PMB Service”

Patients referred having already had an Ultrasound Scan
- On occasion patients may have already have had an ultrasound scan prior to being referred on the PMB Pathway
- Provided the date on the ultrasound report is within 3 months of the date of referral, it does not need to be repeated
- The patient is sent in the post:
  - PMB standard letter 1A
  - The “PMB Service: Information for Patients” booklet (RCHT 1797)
- The patient will be booked onto the Friday Virtual PMB Clinic that week

Internal Referrals
- Are made on MAXIMS via the PMB (Gynaecology) Outpatient Service
- The MAXIMS inbox is checked daily by the duty secretary for that day and sent to the duty consultant for vetting and instructions
- Patients who have not had an USS booked at the time of referral will have a scan booked by the duty consultant (if appropriate). They are placed on a pending list and added to Virtual PMB clinic when the scan has been scheduled.

Non-attendances
The booking office will review the TVS clinic outcomes from PAS (updated by the imaging team) to identify non-attenders.
- Patients who do not attend their first TVS appointment will be telephoned by the booking office to reschedule their appointment.
- Patients who do not attend their second TVS appointment will be discharged back to the care of their GP. The standard RCHT letter is to be sent to the patient by the booking office. A new referral will be necessary should they wish to attend for a scan subsequently.

Cancellations
- Patients who wish to cancel their first TVS appointment will be advised to phone the 2WW Booking Office to reschedule.
- Patients who wish to cancel and reschedule their second TVS appointment will be discharged back to the care of their GP. The standard RCHT letter is to be sent to the patient by the booking office. A new referral will be necessary should they wish to attend for a scan subsequently.

The Virtual PMB Clinic
- The clinic code is JULSO/PMB.
- Runs weekly, on a Friday morning.
- On Thursday mornings the clinic is prepped in the same way as any other clinic.
- The “PMB Pathway: TVS Review & Recommendation” page to be filed in the case notes with the referral; the patient ID label affixed and clinic date-stamped for new patients.
- There are 30 slots at 5 minute intervals; the clinic can be overbooked if needed to accommodate all the patients for that week. Simply add extra time slots to the end of the clinic.
• The clinician undertaking the clinic will complete the clinical documents, and dictate the actions onto Winscribe for the secretarial staff to action.

After the Virtual PMB Clinic
Secretarial staff will:
• Scan the “PMB Pathway: TVS Review & Recommendation” document into MAXIMS as Specialty: “PMB Service”
• Complete the standard patient letters
  o The letters do not need to be reviewed by the clinician unless requested by the individual clinician
  o Send the letter to the patient and GP
  o Upload it onto MAXIMS as “Patient Correspondence” under PMB Service
• Book outpatient hysteroscopy appointments
  o Diagnostic hysteroscopy all day Tuesday and Thursday morning
  o Operative hysteroscopy on Thursday afternoon
  o All patients to be telephoned with their appointment details and sent an appointment letter
• Book a follow-up appointment in the Virtual PMB Clinic for 2 weeks after the outpatient hysteroscopy appointment.
• Outcome the clinic on PAS using the codes supplied on the “PMB Pathway: TVS Review & Recommendation”

During the OPH Clinic
A clinical diagnosis of endometrial cancer can often be made at the time of OPH. If the hysteroscopist identifies a woman with endometrial cancer they may wish to contact the PMB Secretarial team to arrange follow-up in the gynaecology clinic the following week.
• Tell the clinic staff the date and time of the appointment, they will record it on the clinic outcome sheet
• Print off the appointment letter and give it to the patient before she goes home if possible

OPH Histology Results
All histology results from OPH will be reviewed during the Virtual PMB Clinic. The clinician will complete the “PMB Pathway: Histology Review & Recommendation” and the secretarial staff will complete the necessary actions:
• Scan the “PMB Pathway: Histology Review & Recommendation” document into MAXIMS as Specialty: “PMB Service”
• Complete the standard patient letter
  o The letters do not need to be reviewed by the clinician, unless requested by the clinician
  o Send the standard letter to the patient and GP
  o Upload it onto MAXIMS as “Patient Correspondence”
• Book outpatient clinic appointments and send appointment letters
Histology does not need to be reviewed in MDT at this stage. MDT will be organised by clinicians, admin staff should not usually need to be involved, unless requested by clinical staff.

Pre-operative diagnoses of Grade 1 endometrial cancer will be discussed at MDT with the hysterectomy results (where applicable).

Pre-operative diagnoses of Grade 2 endometrial cancer and all type 2 endometrial cancers will have the histology reviewed at the same time as their staging CT scan, after they have been seen in clinic.

**Ordering Patient Information Leaflets**

Patient Information Leaflets are ordered by emailing rch-tr.patientinformation@nhs.net

Subject Line: “Order”

State in the body of the email that you require RCHT Leaflet number 1797 (Post-Menopausal Bleeding) and how many copies you require

Include the budget code for gynaecology outpatients

**Useful Contacts:**

**2WW Booking Office**

Contact: Emma Wheeler
Telephone: 01872 253371
Email: rch-tr.suspectedCancer@nhs.net

**RCHT Ultrasound Department**

Contact: Kirsty Richards, Imaging Access Lead
Telephone: 01872 252285
Email: rch-tr.ClinicalImaging@nhs.net

**PMB Secretaries**

Contacts: Nadia Francis or Tammy Paine
Telephone: (08172)2522729 or (01872)2523862
Email: nadia.francis4@nhs.net or tammy.paine@nhs.net
Appendix 5: Standard Letter Templates

Letters to be cc to GP where indicated

Letter 1
Introductory letter

Dear,

Your doctor has told us that you have been having some post-menopausal bleeding. This means bleeding from the vagina that happens 12 months or more after your periods have stopped.

This is a common symptom, especially in women in the first year or so after the menopause and is usually nothing to worry about.

In about 1 in 10 of women the cause of the bleeding turns out to be cancer, most often cancer of the lining of the womb (known as the endometrium), or sometimes the cervix (neck of the womb) or rarely the vulva (the genitals). This means that 9 out of 10 women will not have cancer.

Most of the time cancer of the lining of the womb can be treated successfully, especially if it is picked up early.

For this reason, you have been referred you to the post-menopausal bleeding service. An ultrasound scan will be organised for you. By now, you should have received an appointment for the ultrasound. If you have not received a scan appointment within 1 week of seeing your doctor it is important to get in touch with the Booking Office on the telephone number above.

*If you have a vaginal pessary to treat prolapse (for example a ring pessary) this will need to be removed before you have the scan. If it is not possible for the pessary to be removed, when you attend for the scan please make sure you have a full bladder.*

Your scan will be looked at in the hospital. We will contact you by letter with the scan results 1-2 weeks after you have had the scan and explain the next step. If the scan is normal usually no further tests are needed.

Depending on the scan results we may contact you by telephone or by letter to invite you to come to clinic for an outpatient hysteroscopy and biopsy (looking inside the womb with a camera and taking a sample of tissue from the lining of the womb).

It is very important to read the enclosed booklet which contains more information about what to expect over the next few weeks. **Keep the booklet safe, as you may need to look at it again.** If you have any questions, please contact the PMB Service on the above phone number.

Yours sincerely,

Miss S Julian
Consultant Gynaecological Oncologist / PMB Service Lead

Enc: Patient Information Leaflet Post-Menopausal Bleeding (RCHT 1797)
Letter 1A
Introductory Letter
For patients who have already had an USS prior to referral

Dear,

You have been referred to us because you have recently had an ultrasound scan which has shown some slight abnormalities in the lining of your womb.

You may or may not be post-menopausal, but we oversee all of these referrals in the post-menopausal bleeding service.

Your scan will be looked at in the hospital. We will contact you by letter to explain the next step, within 1-2 weeks of receiving the referral from your doctor.

Depending on what the scan shows, we may contact you by telephone or by letter to invite you to come to clinic for an outpatient hysteroscopy and biopsy (looking inside the womb with a camera and taking a sample of tissue from the lining of the womb). We may need to have a consultation with you first to decide what to do.

It is very important to read the enclosed booklet which contains more information about what to expect over the next few weeks. Keep the booklet safe, as you may need to look at it again. If you have any questions, please contact the PMB Service on the above phone number.

Yours sincerely,

Miss S Julian
Consultant Gynaecological Oncologist / PMB Service Lead

Enc: Patient Information Leaflet Post-Menopausal Bleeding (RCHT 1797)
Letter 2A

**ET ≤ 4mm**
or
**<7mm on sequential HRT**

**No further action**
**No need for vaginal ERT (eg already on systemic HRT)**

Dear,

I am very pleased to be able to let you know that I have reviewed your ultrasound scan results. The lining of your womb was normal and no problems were identified with your ovaries.

We do not need to see you for any further tests at the hospital.

*If you have not yet had an internal examination done by your GP it is very important to book into have this done as soon as possible. This is to make sure that there is nothing wrong with your vulva (genitals), vagina (front passage) or cervix (neck of the womb), as these organs are not seen on the ultrasound scan.*

*When you phone the GP surgery please explain that the post-menopausal bleeding clinic has asked for you to have an internal examination performed in the surgery. The receptionist will then be able to book you an appointment with the right person.*

If you had a vaginal pessary removed before having the scan, please make arrangements to have it re-inserted by whoever normally looks after your pessary.

If you experience persistent bleeding, or another episode of bleeding more than 6 months from now it is important to go back to see your GP for another check-up.

Further information can be found in the “Post-Menopausal Bleeding” booklet that we sent you last time.

Yours sincerely,

Miss S Julian
Consultant Gynaecological Oncologist / PMB Service Lead

Cc. GP
Letter 2B

ET ≤ 4mm
or
<7mm on sequential HRT

No further action
May benefit from Vaginal ERT

Dear,

I am very pleased to be able to let you know that I have reviewed your ultrasound scan results. The lining of your womb was normal and no problems were identified with your ovaries.

We do not need to see you for any further tests at the hospital.

If you have not yet had an internal examination done by your GP it is very important to book into have this done as soon as possible. This is to make sure that there is nothing wrong with your vulva (genitals), vagina (front passage) or cervix (neck of the womb), as these organs are not seen on the ultrasound scan.

When you phone the GP surgery please explain that the post-menopausal bleeding clinic has asked for you to have an internal examination performed in the surgery. The receptionist will then be able to book you an appointment with the right person.

One of the commonest causes of post-menopausal bleeding is “atrophy” of the vagina, cervix or endometrium. This means thinning of the tissues that happens naturally in all women with age. Please find enclosed a booklet containing further information about this. If you think that you might benefit from treatment, please make an appointment with your GP.

If you had a vaginal pessary removed before having the scan, please make arrangements to have it re-inserted by whoever normally looks after your pessary.

If you experience persistent bleeding, or another episode of bleeding more than 6 months from now it is important to go back to see your GP for another check-up.

Further information can be found in the “Post-Menopausal Bleeding” booklet that we sent you last time.

Yours sincerely,

Miss S Julian
Consultant Gynaecological Oncologist / PMB Service Lead

Cc. GP
Enc. Patient Information Leaflet “Vulvovaginal Atrophy and Low Dose Vaginal Oestrogen Therapy”
Letter 3

ET > 4mm
ET 7mm or more on sequential HRT
For Outpatient Hysteroscopy and Biopsy

Enclose RCOG Patient Information Leaflet “Outpatient Hysteroscopy”

Download and Print from here:

Dear,

I have reviewed the results of your recent ultrasound scan. The scan shows that the lining of your womb is slightly thickened. This is usually nothing to worry about, but we would suggest further tests in order to be sure.

I would recommend that you attend the clinic to have an outpatient hysteroscopy and a biopsy taken from the lining of the womb. If it turns out that there are any polyps or small fibroids present inside the womb, sometimes these can usually be removed at the same time, sometimes we may ask you to come back for a further appointment on another day.

Information about having a hysteroscopy can be found in the “Post-Menopausal Bleeding” booklet that we sent you last time.

[Insert Letter 4 – Stopping Anticoagulation if required]

An appointment to have the hysteroscopy is enclosed. If the appointment is inconvenient please contact us on the above number, so that it can be re-arranged.

If you had a vaginal pessary removed before having your ultrasound scan, and you would like to have it re-inserted after your hysteroscopy, please bring your pessary with you.

It can be helpful to bring a family member or friend with you to your appointment, please feel free to do so if you think this would be helpful for you.

Yours sincerely,

Miss S Julian
Consultant Gynaecological Oncologist / PMB Service Lead

Cc. GP
Enc.
RCOG Information For You: Outpatient Hysteroscopy
Letter 4
Stopping Anticoagulation

Letter 4A: Antiplatelet Drugs
Aspirin
Clopidogrel
Ticagrelor
Prasugrel

You will need to stop your [insert drug name here] 5 days before the day of your hysteroscopy. You can restart it the day after your hysteroscopy provided that you are not experiencing heavy vaginal bleeding.

Letter 4B: Warfarin
You will need to stop your Warfarin [X days] before the day of your hysteroscopy
You can restart it at your usual dose the day after your hysteroscopy provided that you are not experiencing heavy vaginal bleeding.
You will need to get in touch with the person who monitors your INR (Warfarin levels) to let them know that we have asked you to stop your treatment temporarily.

Letter 4C: Rivaroxaban/Apixaban
You will need to stop your [insert drug name here] [X days] before your procedure.
You can restart it the day after your hysteroscopy provided that you are not experiencing heavy vaginal bleeding.

Letter 4D: Do not stop anti-coagulation
There will be no need to stop your [insert drug name here] before your appointment

Miss S Julian
Consultant Gynaecological Oncologist / PMB Service Lead
Cc. GP
Letter 5
Incidental finding of ovarian cyst

Dear,

I have now reviewed the results of your recent ultrasound scan. This shows that there is a cyst on your left/right/both of your ovaries. It measures

This is more than likely nothing to be concerned about. We do need some further information to help us to decide on the best way forward for you.

Please make an appointment with the nurse at your GP surgery to have a blood test done as soon as possible.

[I have taken the liberty of requesting a CT/MRI scan for you. You will receive an appointment for the scan from the x-ray department within the next 2 weeks.]

We will see you in the clinic to explain the results of your tests to you. Please find enclosed a clinic appointment. If the appointment is inconvenient please contact us on the above number, so that it can be re-arranged.

It can be helpful to bring a family member or friend with you to your appointment, please feel free to do so if you think this would be helpful for you.

Yours sincerely.

Miss S Julian
Consultant Gynaecological Oncologist / PMB Service Lead

Cc. GP
Letter 6

Normal histology on pipelle biopsy
- Insufficient provided endometrium was normal at time of OPH
- Inactive
- Secretory / Proliferative / Menstrual
- Progestogen effect

I am very pleased to be able to let you know that I have received the results of your recent:

[Letter 6A] Endometrial biopsy (the sample of tissue taken from the womb lining).
The biopsy that was taken from the lining of the womb did not show any abnormality.

[Letter 6B] Cervical polyp
The polyp that was removed from your cervix was benign.

[Letter 6C] Endometrial polyp
The polyp that was removed from inside the womb was benign.

[Letter 6D] Cervical Biopsy
The biopsy that was taken from your cervix did not show any abnormality.

We do not need to see you for any further tests at the hospital this stage.

If you experience persistent bleeding, or another episode of bleeding more than 6 months from now it is very important to go back to see your GP so that another check-up can be arranged for you to ensure that all is still well.

Yours sincerely,

Miss S Julian
Consultant Gynaecological Oncologist / PMB Service Lead

Cc. GP
Letter 8
Histology with abnormality that needs to be discussed with the patient in clinic
- Simple hyperplasia
- Complex hyperplasia
- Hyperplasia with atypia
- Endometrial malignancy

Dear,

I am writing to let you know that we have now received your results. There are some abnormalities in the lining of the womb that we need to discuss with you in the clinic. Further information about possible abnormalities can be found in the “PMB Service” booklet that we sent you previously.

Please find enclosed a clinic appointment. If the appointment is inconvenient please contact us on the above number, so that it can be re-arranged.

It can be helpful to bring a family member or friend with you to your appointment, please feel free to do so if you think this would be helpful for you.

We look forward to seeing you in the clinic soon.

Yours sincerely,

Miss S Julian
Consultant Gynaecological Oncologist / PMB Service Lead

Cc. GP
Letter 9  
For Consultant Review  

Dear ,

I am pleased to be able to write and let you know that I have reviewed your history and all of your results so far. I’d like to stress that there is nothing to worry about at this stage.

In order to decide on the best way forward for you, it would be very helpful for us to meet you in one of our clinics for a face to face discussion. Please find enclosed a clinic appointment. If the appointment is inconvenient please contact us on the above number, so that it can be re-arranged.

It is usually helpful to bring your next-of-kin, a family member or close friend with you to the clinic to help you with making decisions about your healthcare.

Yours sincerely,

Miss S Julian  
Consultant Gynaecological Oncologist / PMB Service Lead  

Cc. GP
Letter 10
Rejected Referral
Letter to GP surgery

Dear Dr,

Thank-you for referring the above patient on the PMB Pathway. Before the referral can be accepted and processed we require the following information:

| Details of the patient’s mental capacity | □ |
| Details about how to communicate with the patient | □ |
| Details of the patient’s mobility | □ |
| Height | □ |
| Weight | □ |
| GP Electronic summary | □ |
| A complete history | □ |
| Other | □ |

Once the necessary information has been received, your referral will be processed. The “date of decision to refer” will be the date of receipt of complete information.

Yours sincerely,

Miss S Julian
Consultant Gynaecological Oncologist / PMB Service Lead
Appendix 6: Outpatient Hysteroscopy Operational Policy

The Integrated PMB pathway promotes efficient resource use and enhances patient safety via:

- Scheduling either diagnostic or operative hysteroscopy as indicated
- Weekly checking and actioning histology results independently of any one individual
- A pre-defined pathway for those with abnormal findings

Histology requests

- All histology requests resulting from Diagnostic and Operative OPH clinics MUST be flagged for the “PMB Service” MAXIMS electronic inbox so that they can be acted on weekly
- The “Ordering HCP” and “Resp Clinician” will auto fill with the name of the person logged into MAXIMS. Both boxes MUST to be changed manually to “PMB Service”
- At the end of the OPH clinic, the nurse in charge is to check that all histology requests have been completed as above and indicate that the check has taken place on the clinic outcome sheet

Diagnostic OPH Clinics

- Women with ET <10mm and no obvious polyp, and women on Tamoxifen will be booked into a diagnostic OPH clinic
- Run on all day on Tuesday and Thursday morning
- 5-6 Slots per clinic
- Should allow sufficient time for operative OPH if required

Operative OPH Clinics

- For women with ET ≥ 10mm or an obvious polyp on USS
- Women will only be asked to stop anti-coagulation for ET ≥ 20mm
- Run Thursday afternoon
- 4-5 slots per clinic
### Hysteroscopy Outcome

<table>
<thead>
<tr>
<th>Failed</th>
<th>No concern identified</th>
<th>Benign looking polyp ET &lt;10mm</th>
<th>Probable malignancy (in endometrium or malignant looking polyp)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient discomfort</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inadequate view</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lesion not suitable for OP treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failed</td>
<td></td>
<td>No concern identified</td>
<td></td>
</tr>
<tr>
<td>• Patient discomfort</td>
<td></td>
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<tr>
<td>• Inadequate view</td>
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</tr>
<tr>
<td>• Lesion not suitable for OP treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Hysteroscopy Clinic Action

- **Indicate patient TCI clinic tracking sheet**
- **Book procedure on gynaeonc team list ONLY and complete waiting list referral on MAXIMS**
- **No need to allocate a date**

- **Reassure patient**
  - Pipelle biopsy to be taken.
  - Directed biopsies not taken routinely unless clinically indicated or it is anticipated that the patient will not tolerate global endometrial biopsy
  - Send as 2WW under PMB Service

- **Reassure patient**
  - Discuss Myosure vs Expectant management
  - If expectant management take pipelle and biopsy of polyp and send as 2WW under PMB Service

- **No need for polypectomy if obvious malignancy.**
  - Take biopsy and send as 48 hour turnaround under PMB Service.
  - “Warning shot” to patient
  - Phone secretary for follow-up appointment and give to patient if desired
  - Write appointment date/time on clinic outcome sheet

### Nurse in Charge of OPH

- Check that all Histology and blood tests have been requested correctly at the end of clinic
  - “Ordering HCP” AND “Resp Clinician” is “PMB Service”
  - Sign on clinic sheet that request forms have been checked

### Secretary / Clinic Booking Clerk Action

- **Allocate a date for gynaeoncology team theatre list ONLY**
- **No need to book follow-up**

- **Book patient for gynaeoncology clinic following week if requested by hysteroscopist**

### Theatre Actions

- **Send 2WW/48 hour histology under name of operating surgeon**
- **Book into GO clinic via secretaries if malignancy identified at time of H&C**

### Results

- **Results letter from operating surgeon**
- **Results letter from PMB Service in 3 weeks**
- **Results letter from PMB Service in 3 weeks**
<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Hysteroscopy</th>
<th>TCI?</th>
<th>Specimens</th>
<th>Forms Correct?</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Patient Label</td>
<td>Diagnostic e-referral completed</td>
<td>□</td>
<td>MAXIMS e-referral completed</td>
<td>None □</td>
<td>All requests made under “PMB Service” □</td>
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<tr>
<td>Patient Label</td>
<td>Diagnostic e-referral completed</td>
<td>□</td>
<td>MAXIMS e-referral completed</td>
<td>None □</td>
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<td>Patient Label</td>
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## Appendix 7: Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>2WW</td>
<td>Two-week wait</td>
</tr>
<tr>
<td>ACOG</td>
<td>American College of Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>CCHRT</td>
<td>Continuous combined hormone replacement therapy</td>
</tr>
<tr>
<td>ET</td>
<td>Endometrial Thickness</td>
</tr>
<tr>
<td>H&amp;C</td>
<td>Hysteroscopy and Curettage</td>
</tr>
<tr>
<td>HNPCC</td>
<td>Hereditary Non-Polyposis Colorectal Cancer</td>
</tr>
<tr>
<td>HRT</td>
<td>Hormone Replacement Therapy</td>
</tr>
<tr>
<td>KCCG</td>
<td>Kernow Clinical Commissioning Group</td>
</tr>
<tr>
<td>OPH</td>
<td>Outpatient Hysteroscopy</td>
</tr>
<tr>
<td>PMB</td>
<td>Post-menopausal Bleeding</td>
</tr>
<tr>
<td>RCHT</td>
<td>Royal Cornwall Hospital Trust</td>
</tr>
<tr>
<td>RCOG</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>SERM</td>
<td>Selective Oestrogen Receptor Modulator</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
</tr>
<tr>
<td>TVS</td>
<td>Transvaginal Ultrasound Scan</td>
</tr>
</tbody>
</table>
Appendix 8: References


Kremer C, Duffy S, Moroney M. Patient satisfaction with outpatient hysteroscopy versus day case hysteroscopy: randomised controlled trial. BMJ. 2000 Jan 29;320(7230):279–82


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