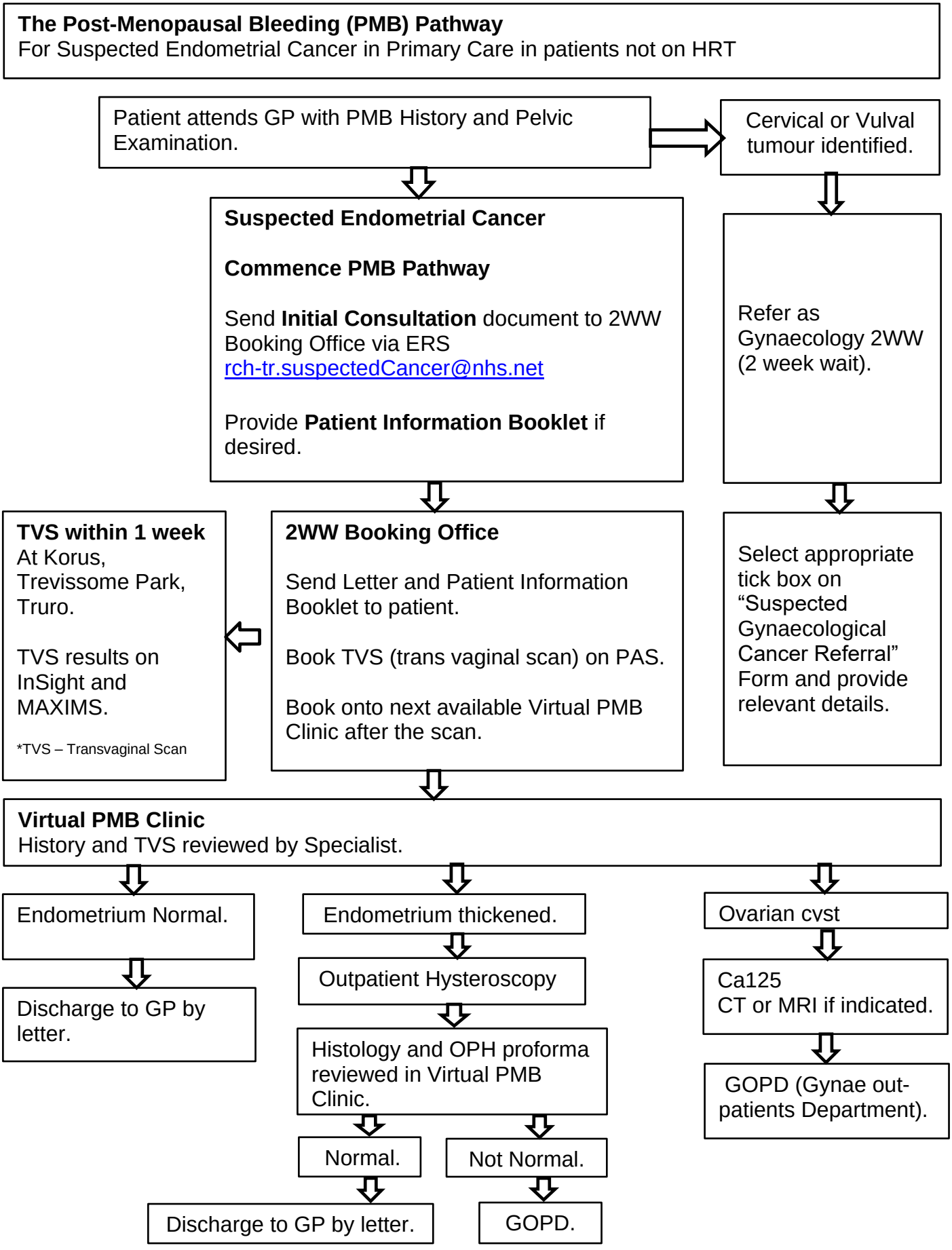
Royal Cornwall Hospitals
NHS Trust

The Post-Menopausal Bleeding Service Clinical Guideline

V2.0

November 2023

Summary


The Post-Menopausal Bleeding (PMB) Pathway
For Suspected Endometrial Cancer in Primary Care in patients not on HRT
Patient attends GP with PMB History and 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 (2 week wait).
TVS within 1 week
At Korus, Trevissome Park, Truro.
TVS results on InSight and MAXIMS.
*TVS – Transvaginal Scan
2WW Booking Office
Send Letter and Patient Information Booklet to patient.
Book TVS (trans vaginal scan) on PAS.
Book onto next available Virtual PMB Clinic after the scan.
Select appropriate tick box on "Suspected Gynaecological Cancer Referral" Form and provide relevant details.
Virtual PMB Clinic
History and TVS reviewed by Specialist.
Endometrium Normal.
Discharge to GP by letter.
Endometrium thickened.
Outpatient Hysteroscopy
Histology and OPH proforma reviewed in Virtual PMB Clinic.
Normal.
Discharge to GP by letter.
Not Normal.
GOPD.
Ovarian cvst
Ca125
CT or MRI if indicated.
GOPD (Gynae out-patients Department).

1. Aim/Purpose of this Guideline

1.1. This guideline applies to patients 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 patients (>12 months since last menstrual period) with:

- Uterus present (e.g., no previous hysterectomy).
- One or more episodes of vaginal bleeding.
- Asymptomatic endometrial thickening (≥10mm) or suspicious endometrium on TVS.
- HRT (hormone replacement therapy) users with:
  - Persistent bleeding 6 weeks after stopping HRT.
  - Unscheduled bleeding more than 6 months after starting or changing continuous combined HRT in those:
    - BMI ≥40. (BMI - Body Mass Index)
    - Age ≥65.
  - Bleeding outside the expected bleed on sequential HRT that persists for more than 2 cycles after starting or changing the dose, OR bleeding on sequential HRT that is it heavy or prolonged in those:
    - BMI ≥40.
    - Age ≥65.

1.2. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 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 (follicle-stimulating hormone) 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 9703 new cases in the UK in 2016 - 2018. The 10 year survival is 72%.

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.

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 blind biopsy 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 localised lesions such as endometrial polyps, which may be neoplastic.

Hysteroscopy allows direct visualisation 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 and C (dilation and curettage), 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 visualisation 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 (transvaginal ultrasound) 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. Unscheduled Bleeding on Hormone Replacement Therapy

HRT commonly causes unscheduled vaginal bleeding, especially in the first 6 months of use, and after missed doses or regime/prescription changes. It is estimated that 25-50% of users will discontinue HRT as a result of troublesome bleeding. Cancer is very unlikely to be the underlying cause of bleeding, especially in patients without risk factors. There is no increased risk of endometrial cancer from HRT unless unopposed oestrogen is used in a woman with an intact uterus. Local audit suggests that the patients who are most likely to develop endometrial cancer on HRT are those over 65 years

of age and those with a BMI ≥ 40.

There is a lack of evidence to guide the investigation of unscheduled bleeding on HRT, and no national guidance on this topic. Investigation carries a risk of iatrogenic injury, both physical and psychological, and this needs to be taken into consideration when discussing investigation and management with patients.

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. 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. Action should be taken if unscheduled bleeding occurs over 2 consecutive cycles, or the bleeding is heavy or prolonged.

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.

The following management strategies are suggested in patients under 65 with a BMI < 40:

- Stop HRT for 6 weeks:
  - If the bleeding settles, then no further investigation needed.
  - If the bleeding persists, refer on 2WW pathway.
- Change the HRT regime.

Advice and guidance on the management of menopause and HRT can be obtained from Dr Jo Parry by emailing kernowhealthcic.menopauseadviceandguidance@nhs.net

Local audit suggests that patients on HRT and who are ≥ age 65, or with a BMI ≥ 40 are at higher risk of endometrial cancer, so it is suggested that a 2WW referral for suspected endometrial cancer from the outset is preferable.

Further information can be found in appendix 7.

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, echogenic fluid in the cavity, or thickened endometrium ≥10 mm, should be referred for a discussion surrounding further investigation. 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 Outpatient Hysteroscopy (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

Patients who meet the pathway inclusion criteria will be manged on a shared, guideline based pathway provided by Cornwall and Isles of Scilly Integrated Care Board (CIOS ICB) 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.
- A brief gynaecological history.
- 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).

2.2.6. The patient can be given an information leaflet if desired at initial presentation: "The Post-Menopausal Bleeding Service: Information for Patients" can be downloaded from: http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/PatientInformation/Gynaecology/RCHT1797PostMenopausalBleeding.pdf

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. 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 and 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 Standard Operational Policy (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 patients with ET ≤ 4mm OR < 7mm on sequential HRT.
- Diagnostic OPH for patients with:
  - ET > 4mm in those not on HRT, or on CCT.
  - ET ≥ 7mm on sequential HRT.
  - Endometrium not visible.
  - Suspicious/Irregular endometrium/echogenic fluid/obvious endometrial malignancy on TVS.
  - Risk factors for endometrial cancer (e.g., Tamoxifen).
  - Recurrent PMB.
- Operative OPH for patients with:
  - ET ≥ 10mm/Likely polyp/SMF (Anticoagulation to be stopped if ET >2cm).
- Complex patients (e.g., 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 and OPH Review and 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:

- Patients with the following results will be discharged back to the care of their GP:
  - Insufficient histology (provided normal appearance of

endometrium at OPH, if the view was not adequate then further biopsy may be considered depending on individual assessment).

- Inactive endometrium.
- Proliferative/ secretory endometrium.
- Benign polyp/ SMF.

- Patients with endometrial hyperplasia with no atypia will be followed up in either the Gynaeoncology clinic or the Hyperplasia Clinic at WCH (West Cornwall Hospital), as appropriate depending on their history.
- Patients with endometrial hyperplasia with atypia or endometrial malignancy will be followed up in the Gynaeoncology clinic within 1 week by a Gynaeonocology Consultant.
- Patients with endometrial hyperplasia will be managed in accordance with the RCOG Green Top Guidance No 67 “Management of Endometrial Hyperplasia”.
- Patients with endometrial cancer will be managed in accordance with the BGCS Uterine Cancer Guidelines: Recommendations for Practice.
- Patients who have had suboptimal views of their endometrial cavity at OPH may be offered further investigations depending on the clinical situation.

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 e.g., 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”.

  http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/PatientInformation/Gynaecology/RCHT1797PostMenopausalBleeding.pdf

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

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Audit of both process and outcome will be undertaken at least annually.
Lead	Mr. Ryan Hogan, Consultant Gynaecologist.
Tool	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)	Mr. Ryan Hogan, Consultant Gynaecologist.

Information Category	Detail of process and methodology for monitoring compliance
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 Diversity And Inclusion 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

Information Category	Detailed Information
Document Title:	The Post-Menopausal Bleeding Service Clinical Guideline V2.0
This document replaces (exact title of previous version):	The Post-Menopausal Bleeding Service Clinical Guideline V1.1
Date Issued/Approved:	November 2023
Date Valid From:	November 2023
Date Valid To:	November 2026
Directorate / Department responsible (author/owner):	Mr. Ryan Hogan, Consultant Gynaecologist
Contact details:	(01872) 252525
Brief summary of contents:	This guideline applies to patients 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.
Suggested Keywords:	Post-Menopausal Bleeding
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Gynaecology Specialty Meeting
General Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming approval by specialty and care group management meetings:	Melanie Gilbert
Links to key external standards:	No external standard available
Related Documents:	http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Gynaecology/TheInitial

Information Category	Detailed Information
	ManagementOfOvarianCystsAfterTheMenopauseClinicalGuideline.pdf References are supplied in Appendix 8
Training Need Identified?	None
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Gynaecology

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
12/05/2020	V1.0	Initial version	Sophia Julian Consultant Gynaecological Oncologist
October 2022	V1.1	Updated Summary, section 2.2.15 and Appendix 3 following a PSR2 investigation (Patient Safety Review) to highlight (2.2.15) that those women who have had suboptimal views of their endometrial cavity at OPH may be offered further investigations depending on the clinical situation, and to add a prompt to the PMB pathway (appendix 3) to consider further investigation in the event of a poor view. Updated to new template.	Jane Borley Consultant Gynaecological Oncologist
October 2023	V2.0	The guidance has been updated to include a new pathway of care for those experiencing unscheduled bleeding on HRT, incorporating the new KCIC Menopause and HRT Advice and Guidance Service and the change to ultrasound provision. All ultrasound scans for suspected endometrial cancer and unscheduled bleeding on HRT will now be provided by Korus at Trevissome, not provided by RCHT.	Sophia Julian, Consultant Gynaecological Oncologist

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

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	The Post-Menopausal Bleeding Service Clinical Guideline V2.0
Directorate and service area:	Primary Care / CIOS ICB (**for reference**) WCHIV Care Group- Gynaecology Radiology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Sophia Julian, Consultant Gynaecological Oncologist
Contact details:	(01872) 252525

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	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 mandated April 2020.
4. How will you measure each outcome?	See section 3 - Monitoring compliance and effectiveness.

Information Category	Detailed Information
5. Who is intended to benefit from the policy?	People with a uterus who report post-menopausal bleeding. Other groups of patients will also benefit through re-allocation of healthcare resource.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: Yes • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Gynaecology Specialty Meeting
6c. What was the outcome of the consultation?	Approved
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	The document refers to all post-menopausal patients with a uterus who experience vaginal bleeding regardless of age.
Sex (male or female)	No	The document refers to all post-menopausal patients with a uterus regardless of how they identify.
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	The document refers to all post-menopausal patients with a uterus regardless of how they identify.

Protected Characteristic	(Yes or No)	Rationale
Race	No	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.
Disability (e.g., physical or cognitive impairment, mental health, long term conditions etc.)	No	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
Religion or belief	No	The document refers to all post-menopausal patients with a uterus regardless of religious or other belief, however, all staff should be aware of any beliefs that may impact on the decision to treat and should respond accordingly
Marriage and civil partnership	No	The document refers to all post-menopausal patients with a uterus regardless of marital or civil partnership status.
Pregnancy and maternity	No	By definition, the document does not impact on patients who are pregnant or receiving maternity healthcare.
Sexual orientation (e.g., gay, straight, bisexual, lesbian etc.)	No	The document refers to all post-menopausal patients with a uterus regardless of sexual orientation.

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

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 a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3: Clinical Documents

Suspected Gynaecological Cancer Referral Form

GP or GDP Details:	**Patient Details:**
Name:	Name:
Address:	Address:
	Please check phone numbers
	Home Phone:
	Mobile Phone:
Phone:	Work Phone:
Email:	Date of Birth:
	NHS Number:
Date of decision to refer:	Hospital Number:

Please confirm that the patient is aware that this is a suspected cancer referral: Yes ☐ No ☐
Date(s) that patient is unable to attend within the next two weeks: *If patient is not available for the next 2 weeks, and aware of nature of referral, please only refer when able and willing to accept an appointment.*
Please tick if you have seen this patient in your surgery prior to making this cancer referral ☐ Patients should ideally be physically examined prior to a gynaecology cancer referral to allow for this physical examination.
Reasonable adjustments required (learning disability / other comms needs e.g., deaf/blind/ other inequalities)

- The patient **must** be available to attend for investigations over the next 2 weeks.
- Women with gynaecological cancer are often elderly with multiple co-morbidities.
- Ascertain their wishes about investigation for possible cancer prior to referral.
- Provide the following information to ensure appropriate support in clinic.

CAPACITY	Yes	No
Does the patient have capacity to make decisions about their healthcare?	☐	☐
Dementia	☐	☐
Learning Difficulties	☐	☐
Next of Kin needed to accompany the patient to appointments	☐	☐

MOBILITY	Yes	No
Weight bearing	☐	☐
Bed bound	☐	☐
Hoist required	☐	☐
Weight (couch limit for TVUSS 225kg)		**kg**
Height (**helpful** 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.	☐

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.

Ovarian cancer

☐ Physical examination identifies ascites and/or a pelvic or abdominal mass (which is not obviously uterine fibroids).

☐ Ca125 > 35 IU/ml and Ultrasound suggesting ovarian cancer.

Result of CA125:

Date of imaging : The report must be attached to this referral.

Measure serum Ca125 in women (especially over 50) with persistent/frequent > 12 times per month:

- *Persistent abdominal distension/bloating*
- *Early satiety / loss of appetite*
- *Pelvic or abdominal pain*
- *Increased urinary urgency and/or frequency.*
- *Symptoms suggestive of IBS*

Cervical cancer

☐ Appearance of the cervix on examination is consistent with cervical cancer.

Ca125 and USS are NOT indicated in suspected cervical cancer.

Vulval cancer

☐ Unexplained vulval lump, ulceration or bleeding.

Vaginal cancer

☐ Unexplained palpable mass or ulceration in or at the entrance to the vagina.

Which is not obviously a vaginal or uterine prolapse?

Clinical History:

Clinical Examination:

Clinic Pathways

- Ovarian cancer referrals are booked into the Gynaeoncology Clinic or booked straight to test.
- Vulval and vaginal cancers are booked into the Vulval Clinic
- Cervical cancer referrals are booked into the Cervical Assessment Clinic.
- Endometrial cancer referrals are managed on the PMB Pathway in the Virtual PMB Clinic
- Isles of Scilly patients may undergo a telephone assessment prior to attendance for diagnostics.

The PMB Pathway
For Suspected Endometrial Cancer

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

Non-HRT users

- Post-menopausal (> 12 months since LMP) ☐
- Re-referral within 6 months of previous investigation for PMB i.e., "Persistent PMB" ☐
- Asymptomatic Endometrial thickening (≥10mm) / Suspicious endometrium on TVS ☐

HRT users

- Unscheduled bleeding on HRT AND ≥ 65 years ☐
- Unscheduled bleeding on HRT AND BMI ≥ 40 ☐
- Bleeding that continues for ≥6 weeks after stopping HRT ☐

Unscheduled bleeding is defined as:

- *Bleeding > 6 months after starting continuous combined HRT.*
- *Heavy, frequent, a change in pattern at the end of the progestogen phase or breakthrough bleeding over 2 consecutive cycles of sequential HRT.*

Advice on bleeding on HRT falling outside the above criteria can be obtained from:

- KHCIC HRT Advice Service kernowhealthcic.menopauseadviceandguidance@nhs.net
- Health Pathways https://cornwallios.communityhealthpathways.org/16007.htm

Nature of bleeding	Pink	☐
	Brown / old blood	☐
	Fresh red blood	☐
Amount of bleeding	Slight/spotting	☐
	Same as a normal period	☐
	More than a normal period	☐
Duration	Days	
	Single episode	☐
	Recurrent	☐
	Now settled	☐
	Ongoing bleeding	☐
Examination findings: To check for vulval or cervical tumours		
	No vulval tumour seen	☐
Please remove vaginal pessaries (where applicable)	No vaginal tumour seen	☐
to facilitate transvaginal ultrasound	No cervical tumour seen	☐
	Not examined	☐

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
3. Provide the patient with "PMB Service: Information for Patients" if desired: Layout 1 (cornwall.nhs.uk)

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

Additional Information:

This pathway is for patients with clinical indications of a new malignancy in accordance with:
National Collaborating Centre for Cancer 2015 guidelines: https://www.nice.org.uk/guidance/ng12

Endometrial Cancer
NICE (2015) Guidance suggests to consider requesting an USS for women >55 with
- Unexplained symptoms of vaginal discharge:
    - Who are presenting with these symptoms for the first time or
    - have thrombocytosis or
    - report haematuria, or
    - visible haematuria and
    - low haemoglobin levels or
    - thrombocytosis or
    - high blood glucose levels

Cervical Cancer
Women with unexplained post-coital bleeding (a normal cervix) should be referred to a gynaecology clinic for assessment by a gynaecologist. If cervical cancer is suspected, they will be referred for colposcopy within 2 weeks.
This strategy is in line with the recommendations of:
- NHSCP Colposcopy and Programme Management (2010)
- Management of Cervical Cancer 2008 (SIGN Guideline No. 99 Jan 2008)
- NHS Information Standards Board Data Standards KC65 Colposcopy Clinics Return (2003)
- Menopause Diagnosis and Management (NICE 2015)

"Safety Netting" (NICE 2015)
For those not referred on a cancer pathway it is up to individual clinicians in general practice to arrange for review at a suitable time interval and encourage patients to report any changes in symptoms.

Macmillan rapid referral guidelines:
http://www.macmillan.org.uk/Documents/AboutUs/Health_professionals/PCCL/Rapidreferralguidelines.pdf

Advice on patients falling outside the remit of these guidelines can be obtained from:

Miss S Julian or Miss J Borley, Consultant Gynaecological Oncologists
Mr R Hogan or Miss A Glover, Consultant Gynaecologists
Secretaries: 07919 130669 or 07425 612038

Virtual PMB Clinic Form

(Date)	PMB Pathway: TVS Review and Recommendation

Risk Factors for Endometrial Cancer		**Drug History**	
Age		No anticoagulant	☐
BMI		Low Dose Aspirin	☐
BMI >35	☐	High Dose Aspirin	☐
NIDDM	☐	Clopidogrel	☐
Age >75	☐	Ticagrelor	☐
Nulliparity	☐	Warfarin	☐
Tamoxifen	☐	Rivaroxaban	☐
HRT	☐	Apixaban	☐
Lynch Syndrome	☐	Edoxaban	☐

Date of USS				
Endometrium Visible	Yes	☐	**Not visible: Book Diagnostic OPH**	
	No	☐	Letter 3 to patient	☐
			Previous Hysterectomy	
			Letter 10 to GP	☐

Endometrial Thickness	mm	**ET ≤ 4mm OR < 7mm on sequential HRT**		
		Discharge to GP		☐
		Letter 2A to patient		☐
		Letter 2B to patient (includes VVA advice/leaflet)		☐
		Include 11 KHCIC Information		☐
If obvious malignancy on TVS then diagnostic OPH		**ET > 4mm OR ≥ 7mm on sequential HRT**		
Is acceptable even if ET ≥10mm		Book for Diagnostic OPH		☐
		Letter 3 to patient		☐
ET ≥ 10mm or Likely polyp or Fibroid	☐	**Book Operative OPH**		☐
		Letter 3 to patient		☐
Anticoagulation ONLY needs to be stopped		Letter 4a ……..	Days	☐
for operative hysteroscopy when ET >2cm		Letter 4b (warfarin)	Days	☐
		Letter 4c (rivaroxaban/apixaban)	Days	☐
		Letter 4d (do not stop your ……)		☐
Suspicious/Irregular endometrium/fluid	☐	**Book Diagnostic OPH**		☐
Risk factors (e.g., Tamoxifen)	☐	Letter 3 to patient		☐
Referral for recurrent PMB	☐			

No adnexal cysts/masses ≥ 3cm	☐	**Ovarian Cyst Management**	
Simple cysts < 3cm need no further action		Letter 5 to patient	☐
		Book blood tests on ICE	☐
Ovarian Cyst ≥ 3cm	☐	Ca125 (all cysts)	☐
Size		CEA (complex cysts only)	☐
Simple	☐	U and E (needed prior to CT scan)	☐
Complex	☐	CT Scan (large complex cysts/ascites)	☐
Ascites	☐	MRI scan (for clarification re nature of cyst)	☐
		Book GOPD with GO Consultant (state timeframe)	☐

GOPD review prior to further investigation	☐	Letter 9 to patient	☐

Signed (name and role)

(Date)	PMB Pathway: Histology Review and Recommendation

Outpatient Hysteroscopy		
Date		
Good view	☐	
Poor view	☐	⟹ **Consider further investigation**
Normal uterine cavity/endometrium	☐	

Cervical Histology			
Benign Polyp	☐	Letter 6B	☐
Benign Cervical Biopsy	☐	Letter 6D	☐

Pipelle Histology			
Insufficient + Normal endometrium at OPH	☐	Discharge to GP: Letter 6A	☐
Inactive	☐	On HRT: Include 11 KHCC HRTA and G	☐
Proliferative / Secretory / Menstrual	☐		
Progestogen effect	☐		
Simple endometrial hyperplasia	☐	Return to GOPD: Letter 8	☐
Complex endometrial hyperplasia	☐	Book WCH Hyperplasia Clinic (4 weeks)	☐
Endometrial hyperplasia with atypia	☐	Book GOPD with GO Consultant (1 week)	☐
Endometrial malignancy	☐	Book GOPD with GO Consultant (1 week)	☐
		Book CT CAP for ≥ G2 Malignancy/Type 2	☐
Endometrial Polyp/Fibroid Resected	☐		
Benign	☐	Discharge to GP: Letter 6C	☐
Simple endometrial hyperplasia	☐	Return to GOPD: Letter 8	☐
Complex endometrial hyperplasia	☐	Book GOPD with SYB (4 weeks)	☐
Endometrial hyperplasia with atypia	☐	Book GOPD with GO Consultant (1 week)	☐
Endometrial malignancy	☐	Book CT CAP for ≥ G2 Malignancy/Type 2	☐

GOPD review prior to further investigation	☐	Book GOPD with GO Consultant (1 week)	☐
		Letter 9 to patient	☐

Letter numbers and instructions to secretary on Winscribe	☐
Histology not reported yet - review next week	☐

Notes

Signed (Name and Role)

Appendix 4: PMB Service Administration Standard Operational Policy

Patients 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.
- The scanned referral, including the patient summary is to be uploaded into MAXIMS as a “Referral Letter” under Specialty: “PMB Service”.
- Patients who do not have capacity to make decisions about their health care (e.g., owing to dementia or learning difficulties) should be flagged up to the PMB Secretarial team, who will liaise with the relevant clinician for advice.
- If a patient’s weight exceeds the safe limit for the scan couch, the PMB Secretarial team will need to liaise with the PMB Service lead 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 an ultrasound scan at Korus 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.
- The 2WW form will be sent to Korus in eRS.
- An appointment for the next Virtual PMB Clinic after the scan appointment will be booked.
- Ultrasound results will be uploaded to InSIght and MAXIMS by Korus in real time, under the care of “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 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

Korus will inform the booking office of non-attendances on the day, by email.

- 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 codes are:
    - JULSO/PMB.
    - HOGRY/PMB.
    - GLOAL/PMB.
- Is held once a week.
- The “PMB Pathway: TVS Review and Recommendation” page to have the patient ID label affixed and clinic date-stamped.
- 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.
- Individual clinicians may cap their clinic numbers to allow completion of the clinic in 4 hours.
- The clinician undertaking the clinic will complete the clinical documents and upload the actions onto Winscribe for the secretarial staff to action.

After the Virtual PMB Clinic

Secretarial staff will:

- Scan the “PMB Pathway: TVS Review and Recommendation” document into MAXIMS as Specialty: “PMB Service”.
- Complete the standard patient letters.
    - The letters do not need to be reviewed by the clinician unless requested by the individual clinician.
    - Send the letter to the patient and GP.
    - Upload it onto MAXIMS as “Patient Correspondence” under PMB Service.
- Book outpatient hysteroscopy appointments.
    - PMB OPH clinics are all day Tuesday and Thursday.
    - All patients to be telephoned with their appointment details and sent an appointment letter.
    - Send the RCOG Leaflet “Outpatient Hysteroscopy” with the appointment https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/gynaecology/pi-outpatient-hysteroscopy.pdf

- 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 suppled on the “PMB Pathway: TVS Review and Recommendation”.

During the OPH Clinic

A clinical diagnosis of endometrial cancer can often be made at the time of OPH. If the hysteroscopist identifies endometrial cancer, they may wish to contact the PMB Secretarial team to arrange follow-up in the gynaeoncology clinic in 2 weeks.

- 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 and Recommendation” and the secretarial staff will complete the necessary actions:

- Scan the “PMB Pathway: Histology Review and Recommendation” document into MAXIMS as Specialty: “PMB Service”.

- Complete the standard patient letter.

    - The letters do not need to be reviewed by the clinician, unless requested by the clinician.

    - Send the standard letter to the patient and GP.

    - 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

1. Patient Information Leaflets are ordered by emailing: rch-tr.patientinformation@nhs.net
2. Subject Line: “Order”.
3. State in the body of the email that you require RCHT Leaflet number 1797 (Post-Menopausal Bleeding) and how many copies you require.
4. Include the budget code for gynaecology outpatients.

Useful Contacts:

2WW Booking Office

Contact: Emma Goldsworthy

Telephone: 01872 253371

Email: rch-tr.suspectedCancer@nhs.net

Korus

Michaela Ettinger, Business Manager

Telephone: 01872555755

Mobile: 07764556547

Email michaela.ettinger@nhs.net

Scott Rogers, Lead Sonographer

Telephone: 01872 555755

Email: scott.rogers1@nhs.net

Jo Price, Admin Manager

Telephone 01872 555755

Email jo.price1@nhs.net

Korus Health Generic Email: ppl.korushealth@nhs.net

PMB Secretaries

Telephone

07425 612038

079190130669

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. Please attend your scan appointment with a full bladder. 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 by whoever normally looks after your pessary. If the pessary is not removed, you may not be able to have the scan.

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,

Mr R Hogan
Consultant Gynaecologist / 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 you to us because you have recently had an ultrasound scan which has shown some 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,

Mr R Hogan
Consultant Gynaecologist / 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 (e.g., 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,

Consultant

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,

Consultant

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:
https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/gynaecology/pi-outpatient-hysteroscopy.pdf

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,

Consultant

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.

Consultant

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.

Consultant

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,

Consultant

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,

Consultant

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 have a consultation with 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 is usually helpful to have a family member or friend with you to help you with making decisions about your healthcare.

Yours sincerely,

Consultant

Cc. GP

Letter 10
Feedback to Primary Care

Not to be copied to the patient

Dear Doctor,

This patient has been referred on the two week wait pathway with suspected endometrial cancer. The patient has had a hysterectomy, so cannot have endometrial cancer. We have been asked by the commissioning team at KHCIC to draw this matter to your attention, in order to ensure appropriate patient management and allocation of resource in future.

In future, patients presenting with post-menopausal bleeding who have previously had a hysterectomy should be offered a speculum examination. If the vulva and vagina are normal, then the most likely cause of the bleeding is vulvovaginal atrophy, and the patient can be offered vaginal oestrogen treatment. Vulvovaginal atrophy is the cause of post-menopausal bleeding in around 90% of patients.

If there is a lesion suggestive of either vulval or vaginal cancer on examination, then a two-week wait referral for suspected vulval or vaginal cancer should be initiated.

Yours sincerely,

Enclosure 11

For patients with unscheduled bleeding on HRT

KHCIC HRT Advice and Guidance Service

The RCHT Gynae advice and guidance service is not commissioned to answer menopause ad HRT queries. KHCIC fund an HRT advice service, run by Dr Jo Reay, a GP with a particular interest in menopause management. This service can be used by any Primary Care health professional.

To access the service, please email your query to: kernowhealthcic.menopauseadviceandguidance@nhs.net

Include the patient's name and NHS number in the body of the email.
Add the practice secretaries' email address so that the thread can be filed in the patient's notes.
Queries sent without the above information will be sent back unanswered.

Free information on the management of menopause in primary care can be found here: https://youtu.be/yCM7Yrar53U

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 allocated to 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 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.**

Diagnostic OPH Clinics

- Women with obvious malignancy, ET <10mm and no obvious polyp on ultrasound, and women on Tamoxifen will be booked into a diagnostic OPH clinic.
- Anti-coagulation can continue.

Operative OPH Clinics

- For women with ET ≥ 10mm (that is not obviously a malignancy) or an obvious polyp on USS.
- Women will only be asked to stop anti-coagulation for ET ≥ 20mm.

Hysteroscopy Outcome

Failed	No concern identified	Benign looking polyp ET <10mm	Probable malignancy (in endometrium or malignant looking polyp)
• Patient discomfort. • Inadequate view. • Lesion not suitable for OP treatment.			

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. Explain 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”

Secretary / Clinic Booking Clerk Action

Allocate a date for gynaeoncology team theatre list ONLY. No need to book VPMB follow-up.		Book patient for gynaeoncology clinic 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 and C.

Results

Results letter from operating surgeon.	Results letter from PMB Service in 3 weeks.	Results letter from PMB Service in 3 weeks.

Appendix 7 Unscheduled Bleeding on HRT Advice for Primary Care

Unscheduled vaginal bleeding with HRT **is common** and unlikely to be caused by cancer.

1 in 10 women *not* using HRT experience postmenopausal bleeding (PMB) in the first year after the menopause.

The incidence of cancer in women who experience unscheduled bleeding on HRT is <1:200.

With combined HRT [whether continuous combined or sequential combined], up to 80% of women will experience unscheduled bleeding or spotting in the first 6 months of treatment.

Unscheduled bleeding decreases after 6–12 months of use, and after 9 months, only 3–10% of women will still experience it.

With the transdermal route, unscheduled bleeding occurs in 10–20% of women after 12 months of use.

With a sequential regimen, irregular bleeding is experienced by 8–40% of users. Less than 10% of women experience recurrent episodes of breakthrough bleeding.

There is no increased risk of endometrial cancer from HRT unless unopposed oestrogen is used in a woman with an intact uterus.

Investigation of unscheduled bleeding on HRT is primarily to exclude endometrial malignancy or endometrial hyperplasia, which is pre-malignant. It is also important to diagnose **other benign conditions such as polyps or fibroids that could be responsible for the unexpected bleeding.**

Overall, the incidence of benign pathology may be significant, yet the likelihood of malignancy is low in the majority of women on HRT.

Investigation carries a risk of iatrogenic injury, both physical and psychological, and this needs to be taken into consideration when discussing investigation and management with women.

Hysteroscopy with endometrial sampling remains the gold standard for uterine cavity evaluation in the UK. However, hysteroscopy is invasive, expensive and can lead to postoperative morbidity such as infection (including tubo-ovarian abscesses requiring surgical drainage) or post procedure pain and bleeding. Intraoperative complications include uterine perforation with attendant risk of injury to abdomino-pelvic organs.

Among women with postmenopausal bleeding, a thin endometrium (≤ 4mm) safely excludes endometrial pathology and may not require any further investigation unless recurrent/persistent bleeding or any risk factors for endometrial cancer are present.

Following a scan showing an endometrial thickness ≤ 4mm, the risk of endometrial cancer decreases to 1:339, regardless of hormone use.

Endometrial thickness does not differ in women on sequential or continuous combined HRT (3.6 mm versus 3.2 mm) if measured at about the fifth day after taking the last progestogen pill.

If on sequential combined HRT, ideally check endometrial thickness using transvaginal ultrasound within a week of the last progestogen pill.

Chaotic or non-cyclical bleeding or PMB should ALWAYS be investigated *before* starting HRT so that endometrial pathology can be excluded.

HRT regimens

Women who are still having periods or are < 12 months from their final period are usually offered sequential combined HRT (SCT).

Women who are > 12months from their final period will be prescribed continuous combined HRT (CCT).

Continuous combined HRT (CCT) gives better endometrial protection than sequential combined HRT (SCT).

- Therefore, women should be swopped to CCT at least within 5 years of SCT use and ideally after 12-24 months depending on how regular their periods were before starting HRT.

- If the periods were infrequent, then they are likely to be able to swop to CCT after 12 months. If they were regular or frequent, then consider swopping to CCT after 24 months of HRT.

- If they are swopped too soon, their own ovarian function breaks through and they will experience chaotic bleeding. If this happens, simply swop back to SCT for another 12 months and then try again.

- If they take 4 days or more to start bleeding after stopping their progesterone phase on SCT, then they are probably ready to swop to CCT.

Assessment of unscheduled bleeding on HRT

History

- Duration of bleeding.

- Type of HRT.

- Date of starting HRT.

- Date of any change in HRT preparation, including any missed doses.

- Date of last natural menstrual period.

- Family history of endometrial cancer or Lynch Syndrome.

- Risk factors for endometrial cancer e.g., age >70, obesity, type 2 diabetes, PCOS and FHX endometrial cancer. (Smoking is not a risk factor for endometrial cancer – it is actually protective thorough an “antioestrogen” effect).

Examination

- Abdominal palpation to identify large pelvic masses.
- External examination of the vulva to look for bleeding lesions.
- Speculum examination to look for cervical pathology.
- Bimanual examination – for assessment of pelvic masses.
- If it is necessary to postpone examination to another day, do not delay referral or investigation.

Red Flags

Abnormal examination findings suggestive of vulval, vaginal, cervical or ovarian malignancy.

Family history of endometrial cancer or Lynch Syndrome.

Management

Bleeding which clearly follows one or two missed progesterone doses can usually be ignored, but unopposed oestrogen for long periods is a risk for endometrial cancer.

Bleeding within 6 months of starting HRT is common and does not usually require action.

Bleeding within 6 months of a change in HRT is common and does not usually require action.

When *does* unscheduled bleeding require action?

Bleeding persisting more than 6 months after starting continuous combined HRT or changing the dose is “unscheduled” and requires action:

- Either stopping/changing HRT.
- Or investigation with TVS in Primary Care.

Bleeding outside the expected bleed on sequential HRT that persists for more than 2 cycles after starting or changing the dose OR bleeding on sequential HRT that is heavy or prolonged requires action:

- Either stopping/ changing HRT.
- Or investigation with TVS in Primary Care.

Unscheduled bleeding on HRT with Mirena IUS

- Those with an “in date”, (i.e., within 5 years of insertion as per FSRH advice for endometrial protection with HRT) are very unlikely to develop endometrial cancer.

- The Mirena IUS is an effective treatment for endometrial hyperplasia and is used to treat endometrial cancer in some situations.

- **Do not remove an “in date” Mirena solely for the purpose of measuring endometrial thickness with ultrasound.** An endometrial thickness can usually be obtained at transvaginal ultrasound with a Mirena in situ especially if a good AP view can be achieved.

What action is required?

Refer women with unscheduled bleeding (more than 6 months after starting/changing dose of CCT or persisting >2 cycles of SCT) on the 2ww Suspected Gynaecological Cancer pathway women with:

  - BMI ≥40.

  - Age ≥65y.

Outside the above criteria, discuss the option of stopping HRT for 6 weeks.

- If the bleeding continues for more than 6 weeks following cessation of HRT, then refer on 2WW The PMB Pathway for suspected endometrial cancer.

- If the bleeding settles after 6 weeks, then HRT can be re-started without the need for further investigation. A change of HRT regime may be required.

The following might be a useful guide regarding changing HRT for unscheduled bleeding:

- ## Unscheduled bleeding on SCT

  - After addressing possible causes like poor compliance, drug interactions and malabsorption problems, the following strategies can be used:

  - If the withdrawal bleeding is heavy or prolonged, increasing the dose or changing the type of progestogen or reducing the dose of oestrogen may help.

  - If bleeding occurs early in the progestogen phase, increase the dose or change the type of progestogen.

  - Spotting before the withdrawal bleed may be due to inadequate endometrial stromal formation, and a higher oestrogen dose could be tried.

  - If there is irregular bleeding, change the regime or increase the progestogen dose. In the case of painful bleeding, change the type of progestogen.

- **Unscheduled bleeding on CCT**

  Persistent bleeding after 6 months or bleeding commencing after a period of amenorrhoea should be investigated.

  Bleeding patterns are better with lower oestrogen dose and as women get older.

  After excluding endometrial pathology, the following strategies can be used:

  - increasing the dose or changing the type of progestogen
  - or fitting a 52 mg levonorgestrel-releasing intrauterine system (e.g., Mirena).
  - If all other options do not work, then changing to sequential HRT is another option.

If you need advice about bleeding problems on HRT, your secretary can email a referral to Dr Parry on kernowhealthcic.menopauseadviceandguidance@nhs.net

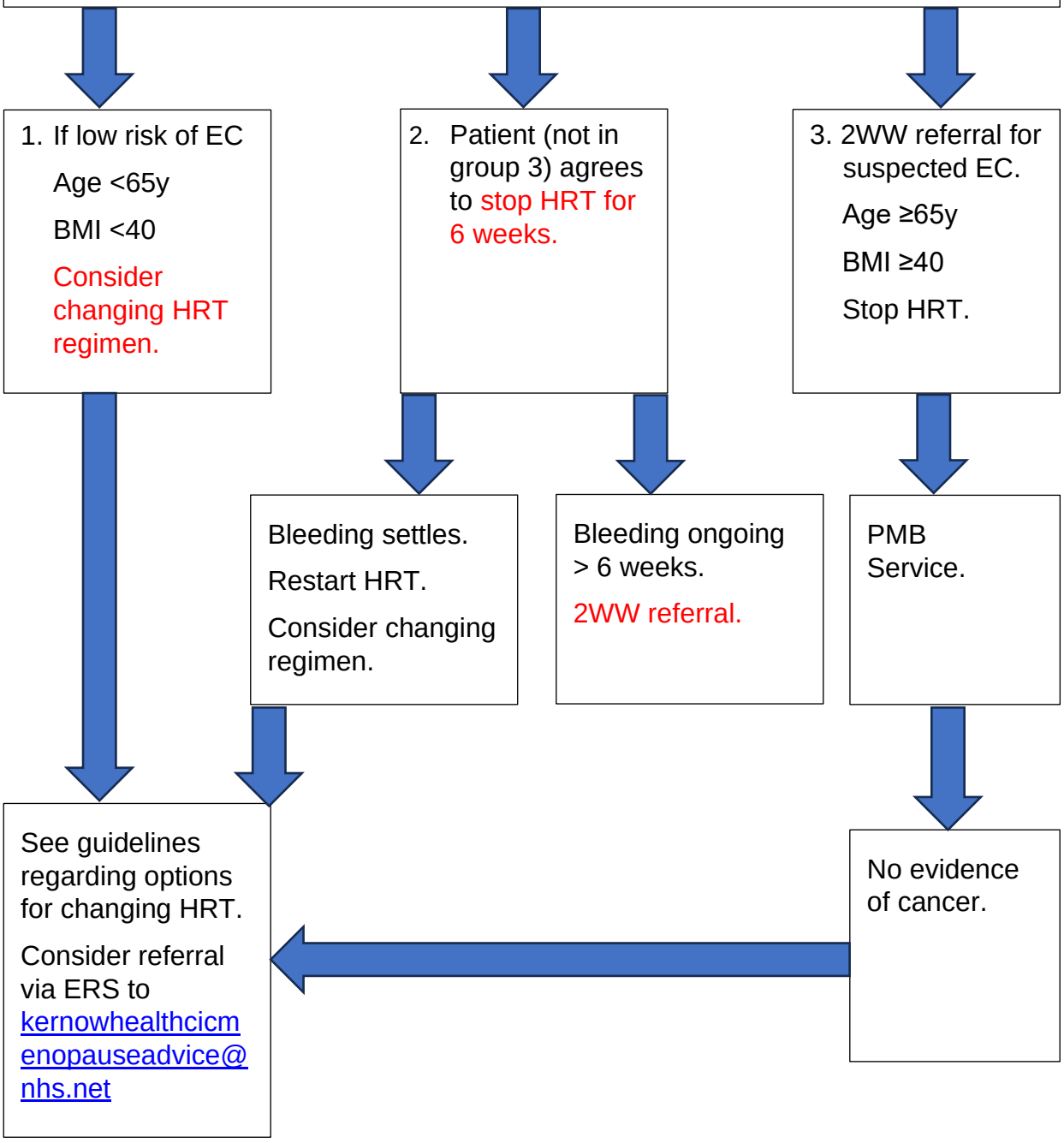
Unscheduled Bleeding on HRT

Bleeding > 6 months after starting CCT.

Unscheduled bleeding over 2 or more consecutive sequential HRT cycles, or heavy/ prolonged bleeding.

Consider pelvic examination to look for vulval/ vaginal/ cervical cancer as cause of bleeding.

Management options. Please read attached guidelines then:



Appendix 8 Abbreviations

2WW	Two-week wait.
ACOG	American College of Obstetricians and Gynaecologists.
AP	Anteroposterior.
BGCS	British Gynaecological Cancer Society.
CCT	Continuous Combined Therapy.
CCHRT	Continuous Combined Hormone Replacement Therapy.
CT	Computed Tomography.
EC	Endometrial Cancer.
ET	Endometrial Thickness.
FSRH	Faculty of Sexual and Reproductive Healthcare.
H and C	Hysteroscopy and Curettage.
HRT	Hormone Replacement Therapy.
IUS	Intrauterine System.
KCCG	Kernow Clinical Commissioning Group.
KHCIC	Kernow Health Community Interest Company.
LMC	Local Medical Committee.
MRI	Magnetic Resonance Imaging.
OPH	Outpatient Hysteroscopy.
PCOS	Polycystic Ovarian Syndrome.
PMB	Post-menopausal Bleeding.
RCHT	Royal Cornwall Hospital Trust.
RCOG	Royal College of Obstetricians and Gynaecologists.
SCT	Sequential Combined Therapy.
SERM	Selective Oestrogen Receptor Modulator.
SOP	Standard Operating Procedure.

SMF	Sub-mucous Fibroid.
TVS	Transvaginal Ultrasound Scan.

Appendix 9: References

ACOG Committee Opinion No. 734: The Role of Transvaginal Ultrasonography in Evaluating the Endometrium of Women With Postmenopausal Bleeding Obstetrics and Gynecology: May 2018 - Volume 131 - Issue 5 - p e124-e129

Bakour SH, Timmermans A, Mol BW, Khan KS. Management of women with postmenopausal bleeding: evidence-based review. The Obstetrician and Gynaecologist. 2012;14:243–9.

BGCS Uterine Cancer Guidelines: Recommendations for Practice Authors: Sudha Sundar, Janos Balega, Emma Crosbie, Alasdair Drake, Richard Edmondson, Christina Fotopoulou, Ioannis Gallos, Raji Ganesan, Janesh Gupta, Nick Johnson, Sarah Kitson, Michelle Mackintosh, Pierre Martin-Hirsch, Tracie Miles, Saeed Rafii, Nick Reed, Phil Rolland, Kavita Singh, Vanitha Sivalingam, Axel Walther.

Cruz Lee S, Kaunitz AM, Sanchez-Ramos L, Rhatigan RM. The Oncogenic Potential of Endometrial Polyps: A Systematic Review and Meta-Analysis. Obstetrics and Gynaecology: November 2010 - Volume 116 - Issue 5 - p 1197-1205

Dave FG, Adedipe T, Disu S, Laiyemo R. Unscheduled bleeding with hormone replacement therapy. The Obstetrician and Gynaecologist. 2019;21:95–101.

Fisher,B., Costantino,J.P., Wickerham,D.L., et al. (1998) Tamoxifen for the prevention of breast cancer: report of the National Surgical Adjuvant Breast and Bowel Project P-1 study. Journal of the National Cancer Institute. 90(18), 1371-1388.

Gull B, Carlsson S, Karlsson B, Ylöstalo P, Milsom I, Granberg S. Transvaginal ultrasonography of the endometrium in women with postmenopausal bleeding: is it always necessary to perform an endometrial biopsy? Am J Obstet Gynecol 2000;182:509–15.

Hänggi W Bersinger N, Altermatt HJ, Birkhauser MH. Comparison of transvaginal ultrasonography and endometrial biopsy in surveillance in postmenopausal HRT users. Maturitas 1997;27:133–43.

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

Lieng M, Istre O, Qvigstad E. Treatment of endometrial polyps: a systematic review. Acta Obstetricia et Gynecologica. 2010; 89: 992–1002

Munro MG; Southern California Permanente Medical Group's Abnormal Uterine Bleeding Working Group. Investigation of women with postmenopausal uterine bleeding: clinical practice recommendations. Perm J. 2014;18(1):55–70.

National Institute for Health and Care Excellence. Menopause: diagnosis and management. London: NICE;2015 [https://www.nice.org.uk/guidance/ng23].

Ronghe R, Gaudoin M. Women with recurrent postmenopausal bleeding should be re-investigated but are not more likely to have endometrial cancer. Menopause Int. 2010 Mar;16(1):9-11.

S Salim, H Won, E Nesbitt-Hawes, N Campbell, and J Abbott Diagnosis and Management of Endometrial Polyps: A Critical Review of the Literature. Journal of Minimally Invasive Gynecology, Vol 18, No 5, September/October 2011

Smith-Bindman R, Kerlikowske K, Feldstein VA, Subak L, Scheidler J,Segal M, et al. Endovaginal ultrasound to exclude endometrial cancer and other endometrial abnormalities. JAMA 1998;280:1510–7.

Tabor A, Watt HC, Wald NJ. Endometrial thickness as a test for endometrial cancer in women with postmenopausal vaginal bleeding. Obstet Gynecol 2002;99:663–70.

Timmermans A, Opmeer BC, Khan KS, Bachmann LM, Epstein E, Clark TJ et al. Endometrial thickness measurement for detecting endometrial cancer in women with postmenopausal bleeding: a systematic review and meta-analysis. Obstet Gynecol 2010;116:160–7.

Timmermans A, Opmeer BC, Veersema S, Mol BW. Patients' preferences in the evaluation of postmenopausal bleeding. BJOG. 2007 Sep;114(9):1146–9. DOI

T. Justin Clark and Helen Stevenson. Endometrial Polyps and Abnormal UterineBleeding (AUB-P): What is the relationship, how are they diagnosed and how are they treated? Best Practice and Research Clinical Obstetrics and Gynaecology 40 (2017) 89e104

Williams SC, Lopez C, Yoong A and McHugo JM. Developing a robust and efficient pathway for the referral and investigation of women with post-menopausal bleeding using a cut-off of ≤4 mm for normal thickness. The British Journal of Radiology 80(2007) 719-723

https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/uterine-cancer

https://www.rcog.org.uk/globalassets/documents/guidelines/green-top-guidelines/gtg_67_endometrial_hyperplasia.pdf

https://www.rcog.org.uk/globalassets/documents/guidelines/scientific-impact-papers/sip_32.pdf