

Unscheduled Bleeding on HRT

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Target Audience:

People who need to know about this document in detail	All staff involved in the care and treatment of women experiencing unscheduled bleeding on HRT
People who need to have a broad understanding of this document	(For example: Board Members, Management Board. Senior Leaders. Board Committees.)
People who need to know that this document exists	All staff involved in the care and treatment of women experiencing unscheduled bleeding on HRT

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date:
Welsh Language Standard	Outcome:
Date of approval by Equality Team:	Choose an item.
Aligns to the following Wellbeing of Future Generation Act Objective	(00/00/0000)
	Choose an item.



Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

COMPONENTS:

A policy must contain the following components and must also be written to include the values and behaviours of the organisation wherever relevant:

It is accepted that for Clinical Policies and or other Written Control Documents (Procedures, Guidance etc.) the policy components below may not all be relevant.

For guidance on Clinical Policy Development please contact:

CTM_ClinicalPolicies@wales.nhs.uk

For guidance on Non Clinical Policy Development please contact:

CTM_Corporate_Governance@wales.nhs.uk

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BACKGROUND

Guideline Definition

Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Purpose

To assist medical and nursing staff in the care and treatment of women experiencing unscheduled bleeding on HRT

Many complaints come from poor communication and contradictory advice.

The guideline aims to minimise this by standardising the information, advice and treatment that we provide to our patients

Scope

For all staff, medical, nursing and clerical, to provide uniformity in the care and treatment of women experiencing unscheduled bleeding on HRT

Roles and Responsibilities

In seeking further advice on any uncertainties contained in this document, or if you feel that there is new or more updated advice it is your responsibility to contact the guideline author or Approval Group manager so that any amendments can be made.

The guideline Approval Group is responsible for disseminating this guideline to all appropriate staff.

The guideline author or a named alternative is responsible for updating the guideline with any amendments that they become aware of or are highlighted to them.

All health professionals are responsible to ensure that the guideline is utilised effectively, and to ensure that they are competent and compassionate in the implementation of it.

Training Requirements

There is no mandatory training associated with this guideline.

Monitoring of Compliance

- By audit and review of complaints relating to miscarriage diagnosis and management.
- The Governance Department will collate any complaints and distribute to the relevant individuals for comments, and share any learning points.
- The Service Lead will oversee any governance issues, make relevant recommendations to the directorate, and advise the Clinical Director or the directorate of any matters that require implementation.
- The Health Board reserves the right, without notice, to amend any monitoring requirements in order to meet any statutory obligations or the needs of the organisation

Complaints

All complaints should try to be resolved with the patient during any contact to avoid escalation. There concerns should be listened to and documented. If it is not possible to address any concerns at the time, or if the complaint is of a serious nature, the patient's complaint should be discussed with the consultant in charge for the day, or the patient should be given details of how to raise a formal complaint via the local governance department.

Introduction

It is common for HRT to cause unscheduled bleeding.

Unscheduled bleeding on hormone replacement therapy (HRT) is defined as “irregular bleeding which occurs after initiating or changing continuous combined hormone replacement therapy (ccHRT) or which occurs in addition to the scheduled monthly withdrawal bleed in persons taking sequential preparations (sHRT)”.

Unscheduled bleeding within the first six months of initiating HRT or, within three months of a change in dose or preparation in those already established on HRT can affect up to 38% of people using sHRT and 41% using ccHRT. It is a major factor leading to repeat consultations and cessation of HRT.

Over the past decade, HRT prescriptions have increased annually by 13.6% in women aged 50 years or older. In parallel with this increase in prescribing there has been a rapid rise in unscheduled bleeding on HRT leading to a 43% increase in referrals to the Urgent Suspicion of Cancer Pathway (USCP) over the past 3 years. In spite of this, cancer diagnoses have only increased by 2% over the same interval.

An increase in referrals, for those who appear to be at lower risk of endometrial cancer, may impact our ability to attain the national ‘28-day faster cancer diagnosis recommendations’, as well as increasing anxiety in women awaiting assessment.

Following recent guidance from the British Menopause Society, in partnership with the British Society of Gynaecological Endoscopy, British Gynaecological Cancer Society, Faculty of Sexual & Reproductive Healthcare, Getting It Right First Time (GIRFT) and the Royal College of Obstetricians & Gynaecologists, our local guidance has now been updated. This updated guideline serves to stratify management for unscheduled bleeding according to risk of endometrial cancer, ensuring best outcomes for all women whilst using NHS resources appropriately.

Initial Assessment

The aim of the initial assessment in primary care is to assess risk factors for endometrial pathology as well as optimise usage of HRT.

Important points to note in history:

- Bleeding pattern, including any precipitating factors
- Any other associated symptoms eg. pain, discharge, urinary symptoms
- HRT
 - Preparation
 - Dose
 - Duration since initiation or change in preparation
 - Compliance
- Smear history
- Risk factors for infections including. sexual history
- Risk factors for endometrial cancer (see below)

Major Risk Factors	Minor Risk Factors
<ul style="list-style-type: none"> • BMI \geq 40 • Genetic predisposition- Lynch/Cowden Syndrome • Oestrogen-only preparations for $>$ 6 months in women with a uterus • Tricycling HRT for $>$12 months • sHRT use for $>$5 years started in women \geq 45 years old • \geq 12 months of norethisterone/MPA for $<$10 days/ month • \geq 12 months of micronised progesterone for $<$12 days/ month 	<ul style="list-style-type: none"> • BMI 30-39 • Unopposed oestrogen for 3-6 months • Tricycling HRT for 6-12 months • 6-12 months of norethisterone/MPA for $<$10 days/month • 6-12 months of micronised progesterone for $<$12 days/month • Progesterone dose not in proportion to oestrogen dose for $>$12 months (see below) • Anovulatory cycles eg. PCOS • Diabetes

Oestrogen dose classification:

	Ultra-low	Low	Standard	Moderate	High
Oestrogel	½ pump	1 pump	2 pumps	3 pumps	4 pumps
Sandrena	0.25mg	0.5mg	1mg	1.5-2mg	3mg
Lenzetto	1 spray	2 sprays	3 sprays	4-5 sprays	6 sprays
Patch	12.5mcg	25mcg	50mcg	75mcg	100mcg
Oral oestradiol	0.5mg	1mg	2mg	3mg	4mg

Required progestogen dose for proportional protection

Oestrogen Dose	Micronised Progesterone	Medroxy Progesterone	Norethisterone	LNG-IUS
Ultra/Low	100mg continuous 200mg sequential	2.5mg continuous 10mg sequential	5mg	Present $<$ 5 years
Standard	100mg continuous 200mg sequential	2.5-5mg continuous 10mg sequential	5mg	Present $<$ 5 years
Moderate	100mg continuous 200mg sequential	5mg continuous 10mg sequential	5mg	Present $<$ 5 years
High	200mg continuous 300mg sequential	10mg continuous 20mg sequential	5mg	Present $<$ 5 years

Important points to note on examination:

- Evidence of fibroids or ovarian mass
- Vulvovaginal atrophy, ulceration or prolapse
- Cervical appearance
- Pregnancy test (if appropriate)
- BMI

Investigation and Management of Unscheduled Bleeding on HRT

1. If unscheduled bleeding occurs within 6 months of commencing HRT or within 3 months of changing HRT preparation/dose, and there are no risk factors for Endometrial Cancer, offer adjustments in the progestogen or HRT for 6 months after initial presentation in total. Ensure progestogen dose is in proportion to oestrogen dose.
2. If unscheduled bleeding continues beyond this point in women without risk factors for endometrial cancer, either:
 - a) Request urgent (within 6 weeks) transvaginal ultrasound to measure endometrial thickness
 - b) Wean off HRT and consider non-hormonal alternatives

This will depend on the preference of the woman, and her desire to continue HRT.

3. If unscheduled bleeding continues after 6 months of dose adjustments, refer in for urgent (within 6 weeks) transvaginal ultrasound for assessment of endometrial thickness

When to refer for Ultrasound:

Urgent Pathway (within 6 weeks)

If the first presentation with unscheduled bleeding occurs more than 6 months after initiating or more than 3 months after changing HRT preparation/dose, request urgent TVS (within 6 weeks) transvaginal ultrasound assessment of endometrial thickness.

If bleeding is heavy, persistent, or prolonged, or if patient has 2 minor risk factors for endometrial cancer, request urgent (within 6 weeks) transvaginal ultrasound for assessment of endometrial thickness.

- Prolonged: >7 days of withdrawal bleeding
- Heavy: Flooding &/or clots
- Persistent: Occurring most days for 4 weeks or more

Following urgent (within 6 weeks) transvaginal ultrasound assessment, refer to secondary care on USC pathway (2 week wait) if:

- ET >4mm in patients on continuous combined HRT (ccHRT)
- ET >7mm in patients on sequential HRT (sHRT)

If endometrium cannot be fully visualised, but the areas visualised are within normal limits, refer in to secondary care on an urgent basis (within 6 weeks) for endometrial assessment.

If ET is within normal limits on transvaginal ultrasound, offer adjustments to HRT for 6 months. If bleeding persists or reoccurs more than 6 months after ultrasound, or if bleeding increased in intensity or frequency during this timeframe, refer in to secondary care on USC basis (2 week wait) for endometrial assessment.

Urgent Suspicion of Cancer Pathway: (within 2 weeks)

If patient has 1 major or 3 minor risk factors for endometrial cancer, refer in to secondary care on USC basis (2 week wait). Adjust progestogen or stop HRT whilst awaiting review.

Secondary Care Assessment

Women with 1 major or 3 minor risk factors for endometrial cancer, will be seen in a conventional PMB clinic for assessment of endometrial thickness via transvaginal ultrasound.

In the case of thickened endometrium (>4mm on ccHRT, >7mm on sHRT) the patient should be offered hysteroscopic assessment of the endometrium with endometrial biopsy.

Patients referred in to secondary care following urgent transvaginal ultrasound organised by primary care will proceed directly to hysteroscopic assessment of the endometrium with endometrial biopsy.

Patients who decline hysteroscopy should be offered a blind pipelle biopsy. Inform patients that the failure rates for blind sampling is 12% and inadequate sampling is seen in 22%. By comparison, hysteroscopy has a failure rate of 3.4%.

Endometrial ultrasound reporting and referral criteria for unscheduled bleeding with HRT Referral criteria for endometrial thickness (ET) on ultrasound.

HRT preparation	≤ 4 mm	> 4 to ≤ 7 mm	> 7mm	Incomplete endometrial assessment but visualised ET within normal limits
ccHRT (Postmenopausal – daily estrogen and progestogen)	Result considered normal but interpreted by referring clinician in context of patient's cancer risks	USCP	USCP	Endometrial assessment on an urgent pathway (within 6 weeks)
sHRT (Perimenopausal – daily estrogen and a progestogen for 10 to 14 days of the month)	Result considered normal but interpreted by referring clinician in context of patient's cancer risks	Result considered normal but interpreted by referring clinician in context of patient's cancer risks	USCP	Endometrial assessment on an urgent pathway (within 6 weeks)

Management of Histology Results

If hysteroscopy and biopsy are both normal, the woman should be reassured that any further bleeding within the next 6 months does not need investigation.

Offer adjustments to the progestogen component of HRT. If bleeding persists or reoccurs after 6 months of adjustments, offer repeat (TVS) transvaginal ultrasound on an urgent basis (within 6 weeks).

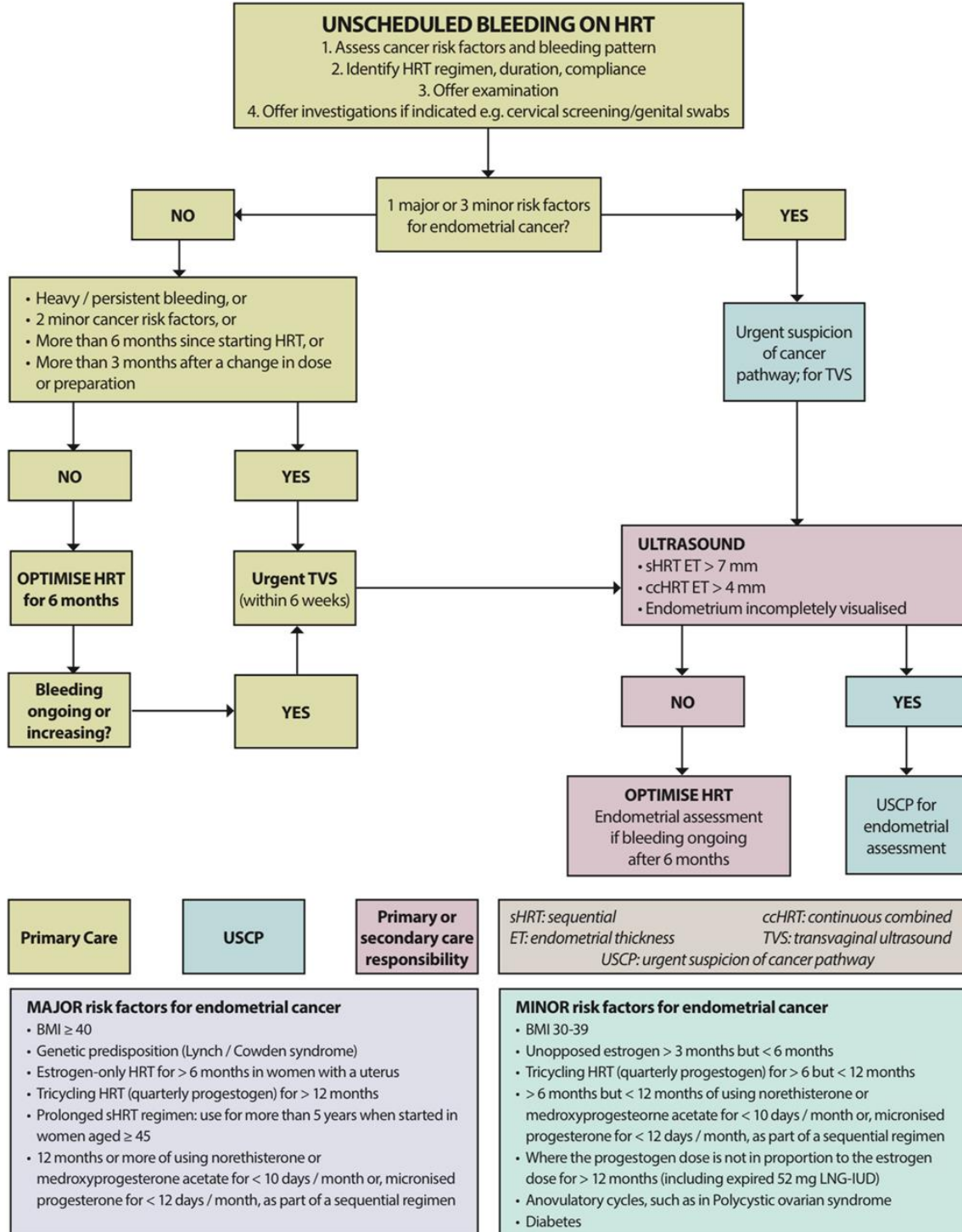
If blind endometrial biopsy is reported as normal, the woman should be reassured that any further bleeding within the next 3 months does not need investigation. Offer adjustments to the progestogen component of HRT. If bleeding persists or reoccurs past 3 months, offer hysteroscopic assessment on an urgent basis (within 6 weeks).

Incidental Finding of Thickened Endometrium without Unscheduled Bleeding

In the absence of unscheduled bleeding, refer women in under the following circumstances:

- Women with an ET >4mm on cHRT with 1 major or 2 minor risk factors for endometrial cancer. This should be on a USC pathway (within 2 weeks)
- Women with an ET >7mm on sHRT with 1 major or 2 minor risk factors for endometrial cancer. This should be on a USC pathway (within 2 weeks)
- Women with an ET >9.9mm without any major risk factors for endometrial cancer. This should be on an urgent basis (within 6 weeks).

Appendix 1- Quick Reference Flow Chart



References

1. Management of unscheduled bleeding on hormone replacement therapy (HRT). Joint BMS guidelines in partnership with the British Society of Gynaecological endoscopy, British Gynaecological Cancer Society, Faculty of Sexual & Reproductive Healthcare, Getting It Right First Time (GIRFT), Royal College of General Practitioners and the Royal College of Obstetricians & Gynaecologists.

[BMS-GUIDELINE-Management-of-unscheduled-bleeding-HRT-JULY2024-A.pdf](#)

2. British Gynaecological Cancer Society Uterine Cancer Guidelines: Recommendations for Practice. 2021

3. Management of bleeding problems with HRT, Journal of Family Planning and Reproductive Health. 2002 28(4): 182-184

4. BRITISH MENOPAUSE SOCIETY Tool for clinicians

<https://thebms.org.uk/wp-content/uploads/2021/10/14-BMS-TfC-Progestogens-and-endometrial-protection-01H.pdf>