NHS University Hospitals Bristol and Weston NHS Foundation Trust

NHS North Bristol NHS Trust

UNSCHEDULED BLEEDING ON HRT

1. Assess cancer risk factors and bleeding pattern
2. Identify HRT regimen, duration, compliance
3. Recommend abdominal, pelvic and speculum examination
4. Offer investigations if indicated e.g. cervical screening/genital swabs

1 major or 3 minor risk factors for endometrial cancer?

NO

- Heavy / persistent bleeding, or
- 2 minor cancer risk factors, or
- More than 6 months since starting HRT, or
- More than 3 months after a change in dose or preparation

No

Optimise HRT for 6 months

If bleeding improved but ongoing after 6 months **OR** no improvement in intensity/frequency during the 6 months.
Consider repeat examination including speculum.

Yes

Yes

Urgent TVS within 6 weeks

ULTRASOUND

a) sHRT ET >7mm? (aim for directly after bleed)
b) ccHRT ET ≥4mm?
c) endometrium incompletely visualised (preventing assessment of the endometrium)
d) Features suspicious of endometrial polyp

No

OPTIMISE HRT
If bleeding improved but ongoing after 6 months OR no improvement in intensity/frequency during the 6 months refer urgently for endometrial assessment.
Offer speculum if no prior examination.

YES

1. Refer on urgent suspicion of cancer pathway (2ww)
2. Request 2ww priority USS for NBT&WGH (NOT for UHB)
3. Discuss ongoing HRT use (see BMS 'Management of Unscheduled bleeding on HRT guidance)
4. Provide information on 52mg LNG-IUD

Yes

Endometrial biopsy +/- hysteroscopy

1. Discuss 52mg LNG-IUD insertion at USC (2WW) review
2. If declines 52mg LNG-IUD, optimise HRT regimen (see below)

Primary care

USCP (2ww)

Primary / Secondary care

MAJOR risk factors for endometrial cancer
• BMI ≥ 40
• Genetic predisposition (Lynch / Cowden syndrome)
• Estrogen-only HRT for > 6 months in women with a uterus
• Tricycling HRT (quarterly progestogen) for > 12 months
• Prolonged sHRT regimen: use for more than 5 years when started in women aged ≥ 45
• 12 months or more of using norethisterone or medroxyprogesterone acetate for < 10 days / month or, micronised progesterone for < 12 days / month, as part of a sequential regimen

MINOR risk factors for endometrial cancer
• BMI 30-39
• Unopposed estrogen > 3 months but < 6 months
• Tricycling HRT (quarterly progestogen) for > 6 but < 12 months
• > 6 months but < 12 months of using norethisterone or medroxyprogesteorne acetate for < 10 days / month or, micronised progesterone for < 12 days / month, as part of a sequential regimen
• Where the progestogen dose is not in proportion to the estrogen dose for > 12 months (including expired 52 mg LNG-IUD)
• Anovulatory cycles, such as Polycystic Ovarian Syndrome (PCOS)
• Diabetes

Authors: S Cowey, A Slater, G Beard, T Appleyard, K Manley

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Optimising HRT regimens

Please refer to the 'Management of Unscheduled Bleeding on HRT' guidance from the British Menopause Society for comprehensive advice

Unscheduled Bleeding on HRT would include withdrawal bleeds lasting >7 days, heavy bleeding with clots and flooding, daily bleeding for >4 weeks.

General principles

- Assess compliance + / – order of pills or patches if using sHRT
- At initiation of HRT, consider starting with a low dose preparation
- At initiation of HRT, offer a sequential preparation if women are still menstruating and < 55
- Time the start of sHRT to their natural cycle (start within 5 days days of bleed)
- Offer ccHRT if a) initiating HRT and are postmenopausal or b) have been using sHRT for 5 years and are aged more than 50
- Offer the 52 mg LNG-IUD, if appropriate, to women initiating HRT, particularly if contraception is also required
- Offer change of 52 mg LNG-IUD if new onset unscheduled bleeding at 4 years of use and investigations are normal (particularly if BMI ≥ 40)
- Offer vaginal estrogen if atrophic findings on examination.

How to manage poor compliance of non-combined preparations

- Change to a combined patch
- Change to a combined oral preparation – consider one containing preparations micronised progesterone if synthetic progestogens not acceptable
- Take micronised progesterone at the same time as applying the daily gel
- Offer the 52 mg LNG-IUD.

Submucosal/intramural fibroids

- Offer the 52 mg LNG-IUD (if submucosal < 3cm and cavity < 10 cm)
- Trial an increase in the micronised progesterone dose
- Switch to a synthetic progestogen (NET/MPA) or give additional progestogens
- Consider referral to gynaecology (non-cancer pathway) for resection if submucosal fibroid and progestogen adjustments are not acceptable or prevents LNG-IUD insertion
- Reduce to a lower dose estrogen preparation and supplement with non-hormonal options if required.

BMI ≥ 30

- Offer weight management strategies
- Offer the 52 mg LNG-IUD
- Increase micronised progesterone to 200 mg continuous or 300 mg sequential
- Reduce to a lower dose estrogen preparation and supplement with non-hormonal options if required.

Perimenopausal and unscheduled bleeding with sHRT

- Desogestrel can suppress endogenous ovarian activity
- If < 50 and low thrombotic (VTE) risk consider switching HRT to a COCP
- Change to an oral preparation (if BMI < 30 and low risk of VTE)
- Offer the 52 mg LNG-IUD
- Increase the micronised progesterone dose or change to a synthetic progestogen
- 3-month trial of an additional progestogen on top of the current preparation
- Reduce the estrogen dose and offer non-hormonal alternatives.
- Increase duration of progestogen intake (can take progestogen for 14 days a month or for 21 days out of a 28- day HRT intake cycle).

Unscheduled bleeding with ccHRT

- Change to an oral preparation (if BMI < 30 and low risk of VTE)
- Offer the 52 mg LNG-IUD
- Increase the micronised progesterone dose or change to a synthetic progestogen
- 3-month trial of an additional progestogen on top of the current preparation (including women already using a 52 mg LNG-IUD)
- Consider a 6-month trial of sHRT if recently postmenopausal
- Reduce the estrogen dose and offer non-hormonal alternatives.

Complex cases can be discussed via the gynae eRS Advice and Guidance service (mark as urgent)

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