Guest Editorial

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Postmenopausal Bleeding

Postmenopausal bleeding (PMB) describes the occurrence of vaginal bleeding following a woman's last menstrual cycle. No consensus exists regarding the appropriate interval of amenorrhea before an episode of bleeding that allows for the definition of postmenopausal bleeding. An episode of bleeding 12 months or more after the last period is accepted as postmenopausal bleeding.

Abnormal bleeding may be considered if a woman experiences heavy or prolonged bleeding at the end of or after the progestogen phase or if bleeding occurs at an unscheduled time during the cycle. For women on tibolone or continuous combined hormone replacement therapy (HRT), it can take up to 6 months for amenorrhea to develop. Therefore, in these women, bleeding should be considered abnormal after 6 months of treatment or if it occurs after amenorrhea has been established.

Postmenopausal bleeding is often caused by abnormalities of the endometrium, whether they are benign or malignant, 10 to 15% of postmenopausal women with vaginal bleeding have endometrial carcinoma. Prevalence of endometrial polyps in patients with PMB and an increased endometrial thickness is estimated to be around 40%.

Risk Factors of Carcinoma Endometrium

The absolute risk of endometrial cancer in nonusers of HRT who present with PMB ranges from 5.7 to 11.5% (Astrup and Olivarius, 2004).

Age

- Probability of endometrial cancer being present in women with PMB increases with age.
- Hereditary nonpolyposis colorectal cancer (HNPCC)
- Tamoxifen
- Risk groups, i.e. obese women with diabetes, women with hypertension
- A history of hyperestrogenism (endogenous or exogenous)
- Like women with early menarche and late menopause
- Hormone replacement therapy (HRT)
- Older HRT regimens that utilise unopposed estrogen increase the relative risk of endometrial cancer.
- Transvaginal ultrasound measures the double thickness measurement of both endometrial surfaces at the thickest point in the mid-sagittal view. If there is fluid in the cavity separating the two layers of endometrium, then the layers are measured individually and summated. Use of the endometrial thickness cut-off assumes that the endometrial morphology is normal.
- The probability of endometrial pathology is strongly reduced in the presence of an endometrial thickness of ≤ 3 mm.

This cut-off should be considered in women who have never used HRT, in women who have not used any form of HRT for a year or more and in women using continuous combined HRT. The mean endometrial thickness in women on sequential HRT with PMB is greater than in those with PMB who are not on sequential HRT.

In women on sequential combined HRT, the probability of endometrial pathology is reduced in the presence of an endometrial thickness of ≤ 5 mm. Postmenopausal bleeding along with increased endometrial thickness should undergo more invasive testing to exclude endometrial pathology. If other abnormalities, such as endometrial polyps, are present further evaluation should be done. A small case series where D and C was carried out before a hysterectomy showed that in up to 10% of instances endometrial lesions were overlooked by the D and C (Guner et al, 1996). Another drawback of D and C is that this procedure is performed under general anesthesia.

Endometrial sampling with both the pipelle device and the vabra device is a very sensitive technique for the detection of endometrial carcinoma, with detection rates of 99.6 and 97.1% respectively (Gull et al, 2001). However, sometimes the amount of tissue obtained by office sampling varies considerably and is insufficient for reliable histological diagnosis. A prospective study found that in four (6%) out 66 women, where there was insufficient tissue obtained from office sampling, subsequent invasive testing detected endometrial pathology (Granberg et al, 1997). This finding implies that, in women with an insufficient sample from office sampling and where a scan suggests thickened endometrium, the clinician must not be reassured and more invasive.

Hysteroscopy

As the false negative rate of endometrial sampling is significant, it is recommended that endometrial sampling is combined with a hysteroscopic examination of the endometrial cavity. Women with breast cancer who take tamoxifen on a long-term basis are at increased risk of endometrial cancer (Clark et al, 2006). However, ultrasonography is poor at differentiating potential endometrial pathology from tamoxifen induced thickening because of the distorted endometrial architecture associated with long-term use of tamoxifen.

Women with a normal vaginal and speculum examination and normal transvaginal ultrasound can be reassured that no further investigation is needed, unless bleeding recurs.

Women with recurrent or persistent PMB may need to be reinvestigated in view of the false negative rate associated with all methods of diagnosis.

REFERENCE

1. Clinical practice guideline 26. Investigation of Postmenopausal Bleeding 2013.

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