Joint RCOG, BSGE and BGCS guidance for the management of abnormal uterine bleeding in the evolving Coronavirus (COVID-19) pandemic

This consensus statement provides a framework for the management of women with abnormal uterine bleeding (heavy menstrual bleeding (HMB), inter-menstrual (IMB), postmenopausal bleeding (PMB) or post coital bleeding (PCB)) during the current pandemic. These are frequent symptoms that raise concerns about gynaecological cancer.

It provides national guidance for contingency planning for individual health care practitioners, service managers and commissioners to mitigate the effects of reductions in human and physical resources on our service.

Our objectives are:

1. To reduce the risk of person to person (horizontal) transmission of the virus SARS-CoV-2, which causes COVID-19.

2. To make the best use of very limited human and physical resources.

Heavy Menstrual Bleeding

- Women with HMB should initially be managed by remote communication. They should be reassured that the risk of malignancy is negligible[1].

- A relevant clinical history should be taken to elucidate the severity of the symptoms, the possibility of anaemia and the likely cause.

- If there are no symptoms of anaemia, or if present anaemia is likely to be mild, oral medication should be prescribed after exclusion of contraindications[2].

- Women should be referred to secondary care for further management if:
    - The HMB is torrential and / or prolonged.
    - Ongoing HMB that has been resistant to NICE recommended oral treatments and is considered unmanageable by the woman.
    - Severe anaemia is suspected.

- Women referred to secondary care should have the following examination and investigations:
    - A pelvic examination to identify rectifiable causes (e.g. prolapsed cervical fibroid) and detect significant uterine fibroids and genital tract cancer.
    - An endometrial biopsy to exclude endometrial cancer or atypical endometrial hyperplasia.
    - A full blood count to diagnose anaemia.

- Women referred to secondary care should be managed according to the likely cause and their preferences. Consider:
    - Oral or intravenous iron infusion according to the severity of the anaemia and associated symptoms.
    - Tranexamic acid and a course of high dose oral progestogens to rapidly supress acute bleeding.
    - NICE recommended medical treatments that have not been used including the levonorgesterol- releasing intrauterine system.
    - Gonadotrophin releasing hormone (GnRH) analogues for refractory bleeding despite use of recommended NICE medical treatments and / or in the presence of significant uterine fibroids. Consider moving to a 3-month duration injection once patient tolerance of GnRH analogues has been established or delivery via the nasal route (nafarelin acetate spray). Addback hormone replacement therapy (HRT) should be considered, once HMB is controlled if GnRH analogue treatment is to be continued beyond 3-6 months.

- Endometrial hyperplasia and cancer should be managed according to local protocols and national guidance.

Intermenstrual Bleeding

- Women with IMB should initially be managed by remote communication. Women should be reassured that IMB is common and symptoms often spontaneously resolve and that underlying cancer is rare[1].

- A relevant clinical history should be taken to elucidate the severity of the symptoms and the likely cause. Pregnancy should be excluded.

- Where the likelihood of sexually transmitted infection or genital tract cancer is considered negligible, then management options to discuss include:
    - Reassurance.
    - Observation with phone follow up to see if the IMB subsides.
    - Change in hormonal contraceptives in current users.
    - Trial of hormonal contraceptives in non-users.

- Women should only be asked to come for a pelvic examination, preferably in primary care, if:
    - There is a risk of sexually transmitted infection (take genital tract swabs).
    - Cervical cancer is suspected because of associated post-coital bleeding and / or offensive vaginal discharge.

- Women should be referred to secondary care for further investigation if:
    - Cervical cancer is suspected on pelvic examination.
    - Endometrial cancer is suspected because of persistent IMB (i.e. occurring for at least 3 consecutive months) in women over 40 years of age who are not using hormonal contraceptives.

- Women referred to secondary care may have the following investigations:
  - A cervical biopsy.
  - A pelvic ultrasound scan and blind endometrial biopsy.

Postmenopausal bleeding

- PMB is a red flag symptom because 5 - 10% of women will have endometrial cancer[3]. Clinical management of PMB should be focused on identifying cancer.

- Women with PMB should initially be managed by remote communication to:
  - Confirm the symptom.
  - Determine if they have any symptoms of COVID-19.
  - Be informed that a 2 week wait referral to secondary care will be made.
  - Highlight women who have suspected or confirmed COVID-19 and inform them that they will not be seen in secondary care until they are no longer infectious (14 days from the onset of symptoms) to avoid horizontal transmission.
  - Assess whether hospital assessment can be deferred for COVID-19 vulnerable patients (for example but not limited to women above 70 years old and women with underlying health conditions) to reduce the risk of horizontal transmission. This risk needs to be balanced against the risk of delay in diagnosis or exclusion of a gynaecological cancer on a case by case basis.

- In secondary care:

  - A speculum examination should be performed because a normal cervix on speculum examination in women who have a negative cervical smear excludes cervical cancer.
  - Measurement of the endometrial thickness (ET) by transvaginal ultrasound scan (TVS) should be the first line test in accordance with local protocols and national guidance[4].
  - An endometrial thickness (ET) of < 4mm on TVS excludes endometrial cancer, and these women can be discharged[4].
  - Blind endometrial biopsy alone should be preferred to hysteroscopy if the ET is > 4 mm[4] because hysteroscopy requires specific skills and greater use of human and material resources, including cleaning and sterilising of equipment.
  - A blind endometrial biopsy that produces an “insufficient sample” should be considered as normal provided the biopsy device was inserted more than 4 cm beyond the cervical canal[4], although this conclusion should be considered on a case by case basis (e.g. where the endometrium is markedly thickened, bleeding is heavy and / or there are increased risk factors for endometrial cancer).
  - Hysteroscopy may be necessary as part of diagnostic work up for suspected endometrial cancer where a blind endometrial biopsy has failed or is non-diagnostic, or to obtain a directed biopsy or conduct an endometrial polypectomy. These decisions should be made on a case by case basis.

- Hysteroscopy, blind endometrial biopsy and polypectomy using electrosurgical or tissue removal systems do not pose an increased risk of transmission of SARS-CoV-2 to health care workers because the virus has not been identified in the genital tract in women with COVID-19[5]. Best practice should be followed to minimise contamination from blood, urine, genital tract fluids and faeces when conducting any genital tract procedure.
- Infection control practices, including the use of personal protective equipment (PPE) during diagnostic and operative hysteroscopy procedures should comply with local and national protocols.
- Whilst all women should be offered a choice of anaesthesia and treatment settings for hysteroscopic procedures, they should be aware that an outpatient setting avoids hospital admission, thereby minimising the risk of exposure to SARS-CoV-2. Where an inpatient procedure is to be undertaken, consider the use of conscious sedation and regional anaesthesia rather than general anaesthesia to prevent the generation of aerosols.
- Consideration should be given to insertion of a LNG-IUS at the time of blind endometrial biopsy or hysteroscopy where there is considered a high risk of endometrial hyperplasia or cancer. This decision should be made on a case by case basis.
- Minimise the number of attendances at health care facilities for women with postmenopausal bleeding, by offering TVS, clinical history taking, pelvic examination, outpatient hysteroscopy and / or blind endometrial biopsy at the same visit.
- Defer endometrial surveillance for non-atypical endometrial hyperplasia in women without abnormal uterine bleeding because the risk of progression to endometrial cancer is low.
- Women in whom a cancer is diagnosed should be referred to a gynaecological oncology MDT for further management.
- Women in whom a cancer is diagnosed should be sensitively informed of the diagnosis. Ideally, this should be in a face to face consultation. However, the extent of the pandemic and patient factors may make it necessary to do so in a non-face-to-face consultation.

Post coital bleeding

- Women with PCB should initially be managed by remote communication to:
  - Reassure them that a cervical cancer is extremely unlikely if they have an in-date negative cervical screening test.
  - Elucidate whether they have any risk factors for a sexually transmitted disease. If such risk factors exist, they should be seen in primary care or a Sexual Health Clinic for further investigation and management.
  - Women who do not have an in-date negative cervical screening test need to be seen for a speculum examination to exclude cervical cancer and for a smear to be taken; depending on local circumstances, this could be in primary or secondary care.

References

1. Pennant ME, Mehta R, Moody P, Hackett G, Prentice A, Sharp SJ, Lakshman R. Premenopausal abnormal uterine bleeding and risk of endometrial cancer. BJOG 2017; 124: 404 – 411.
2. National Institute for Health and Care Excellence (NICE) 2018. Heavy Menstrual Bleeding: Assessment and Management. NICE NG88.
3. Gredmark T, Kvint S, Havel G, Mattson L. Histopathological findings in women with postmenopausal bleeding. BJOG 1995;102:133-136.
4. https://www.bgcs.org.uk/wp-content/uploads/2019/05/BGCS-Endometrial-Guidelines-2017.pdf
5. Potential for SARS-CoV-2 virus exposure during gynaecological procedures**.** Dr Claire Shannon-Lowe[1], Dr Heather M Long[1], Prof Sudha Sundar[2*], Dr Graham S Taylor[1*]. Personal communication.

This statement has been produced rapidly to meet a need without undergoing the usual level of peer review scrutiny due to the current emergency. It does not form a directive but should be used by individual health care practitioners to inform their practice.