Intermenstrual Bleeding

Oncology > Oncology > Intermenstrual Bleeding

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Intermenstrual Bleeding

1 Care map information

Quick info:

Scope:

- primary care management of:
  - abnormal menstrual bleeding, including heavy menstrual bleeding (HMB), irregular menstrual bleeding, and intermenstrual bleeding

Out of scope:

- emergency management of clinically unstable patients with acute uterine bleeding
- specific management of bleeding problems caused by contraceptive devices
- treatment of conditions underlying HMB, such as endometriosis and adenomyosis

Definitions:

- HMB, or menorrhagia is excessive menstrual blood loss over several consecutive cycles, which interferes with the woman's physical, emotional, social, and material quality of life
- irregular menstrual bleeding is defined as a range of varying lengths of bleeding-free intervals exceeding 20 days within one 90-day reference period [1]
- oligomenorrhoea is defined as menses occurring less frequently than every 35 days
- PMB is defined as unexplained vaginal bleeding more than 12 months after menstruation has stopped because of the menopause
- intermenstrual bleeding is defined as bleeding between periods [1]
- PCB is defined as bleeding that occurs after intercourse [1]

References:

1. National Institute for Health and clinical Excellence (NICE), National Collaborating Centre for Women's and Children's Health. Long-acting reversible contraception: the effect and appropriate use of long-acting reversible contraception. London: royal college of Obstetricans and Gynaecologists (RCOG) Press; 2005. Available from: http://www.nice.org.uk/nicemedia/live/10974/29909/29909.pdf [G]

2 Information and resources

Quick info:

Information resources for people and carers:

- The New Zealand Gynaecological Cancer Foundation
- Cancer Society (NZ)
- Gynaecology Cancers - Information for all Women

3 Updates to this care map

Quick info:

Date of publication December 2017

Review date: December 2018

This care map has been developed in line with consideration to evidenced based guidelines. For further information on contributors and references please see the Pathway's Provenance Certificate.

NB: This information appears on each page of this care map.

4 Hauora Maori

Quick info:

Maori are a diverse people and whilst there is no single Maori identity, it is vital practitioners offer culturally appropriate care when working with Maori whanau. It is important for practitioners to have a baseline understanding of the issues surrounding Maori health. This knowledge can be actualised by (not in any order of priority):

- considering the importance of introductions ('whanaungatanga') - a process that enables the exchange of information to support interaction and meaningful connections between individuals and groups. This means taking a little time to ask where this person is from or to where they have significant connections
- asking Maori people if they would like their whanau or significant others to be involved in assessment and treatment
- asking Maori people about any particular cultural beliefs they or their whanau have that might impact on assessment and treatment of the particular health issues

Maori health services

HBDHB contracts Maori health providers to deliver community based nursing and social support services. Practitioners should discuss, where appropriate, information about relevant Maori health services. A referral to one of these providers may assist Maori people to feel more comfortable about receiving services following discussions.

***Central Hawke's Bay**:*

Central Health
Cnr Herbert & Ruataniwha Streets, Waipukurau
Phone: 06 858 9559 Fax: 06 858 9229
Email: reception@centralhealth.co.nz
Referral Form

***Hastings**:*

Te Taiwhenua o Heretaunga
821 Orchard Road, Hastings 4156
Phone: 06 871 5350 Fax: 06 871 535
Email: taiwhenua.heretaunga@ttoh.iwi.nz
Referral Form

Kahungunu Health Services (Choices)
500 Maraekakaho Road, Hastings
Phone: 06 878 7616
Email: kahungunu@paradise.net.nz
Referral Form

***Napier**:*

Te Kupenga Hauora
5 Sale Street, Napier
Phone: 06 835 1840
Email: info@tkh.org.nz
Referral Form

***Wairoa**:*

Kahungunu Executive (no website)
65 Queen Street, Wairoa 4108
Phone: 06 838 6835 Fax: 06 838 7290
Email: kahu-exec@xtra.co.nz

Secondary care Maori Health Services:

Hawke's Bay DHB - Te Wahanga Hauora Maori Health Services
Phone: 06 878 8109 ext. 5779, 06 878 1654 or 0800 333 671 Email: admin.maorihealth@hawkesbaydhb.govt.nz

Further Information

Practitioners should be versed in the knowledge of:

- historical overview of legislation that impacted on Maori well-being
- Maori models of health, such as Te Whare Tapa Wha and Te Wheke when working with Maori whanau

- national Maori Health Strategies:
  - **Mai Maori Health Strategy 2014-2019 -** Full file or Summary diagram
  - **He Korowai Oranga**: Maori Health Strategy - sets the Government's overarching framework to achieving the best health outcomes for Maori
- local Hawke's Bay health sector's strategies and initiatives for improving Maori health and wellbeing
- Medical Council of New Zealand competency standards

Cultural Competency Training

Training is available through the Hawke's Bay DHB to assist you to better understand Maori culture and to better engage with Maori people. Contact the coordinator

Email: education@hbdhb.govt.nz to request details of the next courses.

5 Pasifika

Quick info:

Pacific people value their culture, language, families, education and their health and wellbeing. Many Pacific families have a religious affiliation to a local church group.

The Pacific people are a diverse and dynamic population:

- more than 22 nations represented in New Zealand
- each with their own unique culture, language, history, and health status
- share many similarities which we have shared with you in order to help you work with Pacific people more effectively
- for many families language, cost and access to care are barriers

Pacific ethnic groups in Hawke's Bay include Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau, Kiribati and Tuvalu. Samoan and Cook Island groups are the largest and make up two thirds of the total Pacific population. There is a growing trend of inter-ethnic relationships and New Zealand born Pacific populations.

Acknowledge The FonaFale Model (Pacific model of health) when working with Pacific people and families.

General guidelines when working with Pacific people and families (information developed by Central PHO, Manawatu):

- Cultural protocols and greetings
- Building relationships with your Pacific people
- Involving family support and religion during assessments and in the hospital
- Home visits

Hawke's Bay-based resources:

- HBDHB interpreting service website **or** phone 06 8788 109 ext. 5805 (no charge for the hospital; charges may apply for community-based translations) **or** contact coordinator at interpreting@hbdhb.govt.nz
- Pacific Navigation Services Ltd Phone: 027 971 9199
- services to assist Pacific people to access healthcare (SIA)
- Improving the Health of Pacific People in Hawke's Bay - Pacific Health action Plan

Ministry of Health resources:

- Ala Mo'ui Pathways to Pacific Health and wellbeing 2014-2018
- Primary Care for Pacific people: a Pacific and health systems approach
- Health education resources in Pacific languages (links to a web page where you can download resources)

6 Advance care planning

Quick info:

Advance Care Planning:

Advance Care Planning is a voluntary process of discussion and shared planning for future health care. It involves the person who is preparing the plan, and usually involves family/whanau and health care professionals.

Advance Care Plan:

An Advance Care Plan is the outcome of Advance Care Planning. It is formulated by the person and sets out their views about care towards the end of their life. It may also include views about medical care and a wide range of other matters. An Advance Care Plan may include an Advance Directive.

Advance Directive:

An Advance Directive is a statement a person makes about their medical care in the future and becomes effective if a person ceases to be competent to make decisions for themselves. An Advance Directive is legally binding if made in appropriate circumstances.

Competency and Advance Care Planning:

Competent people have the right to make autonomous decisions that as medical professionals we may regard as imprudent, and sometimes such decisions are a reflection of the person's longstanding personality, beliefs or lifestyle. This right is described in the Health and Disability Consumers Rights Acts.

According to ACP - A Guide for the NZ Health Care Workforce - "in the context of ACP, competency relates to an individual's ability to make a decision regarding their own health care (that is, competence at decision-making or decision-capacity). At a minimum, decision making capacity requires the ability to understand and communicate, to reason and deliberate, and the possession of a set of values".

Helpful websites:

- The code of rights
- Advance care planning guide Ministry of Health
- Advance care planning resources

7 Faster cancer treatment time frames

Quick info:

Ministry of Health Faster Cancer Treatment (FCT) time frames:

- FCT is a person's pathway approach to ensuring timely clinical cancer care and is measured by the following agreed indicators:
  - for people referred urgently with a high suspicion of cancer they receive their first cancer treatment (or other management) within 62 days
  - for people referred urgently with a high suspicion of cancer they have their first specialist assessment within 14 days
  - for people with a confirmed diagnosis of cancer they receive their first cancer treatment (or other management) from decision-to-treat within 31 days

Ministry of Health National Tumour standards

Faster Cancer Treatment: High suspicion of cancer definitions This document outlines the red flags for high suspicion of cancer.

8 Irregular non-menstrual vaginal bleeding

Quick info:

Irregular non-menstrual vaginal bleeding

Intermenstrual bleeding is defined as [1]:

- irregular episodes of bleeding, often light and short, occurring between otherwise fairly normal menstrual periods

Post-coital bleeding is defined as [1]:

- bleeding post-intercourse

Epidemiological evidence suggests that an alteration in the menstrual cycle, intermenstrual bleeding, or post-coital bleeding may be the first symptoms of gynaecological cancer and indicate the need for a pelvic examination – persistent intermenstrual bleeding requires investigation to exclude malignancy [5].

References:

1. National Institute for Health and clinical Excellence (NICE), National Collaborating Centre for Women's and Children's Health. Long-acting reversible contraception: the effect and appropriate use of long-acting reversible contraception. London: royal college of Obstetricans and Gynaecologists (RCOG) Press; 2005. Available from: http://www.nice.org.uk/nicemedia/live/10974/29909/29909.pdf [G]

5. National Institute for Health and clinical Excellence (NICE). Heavy menstrual bleeding CG44. London: NICE; 2007. Available from: http://guidance.nice.org.uk/nicemedia/live/11002/30401.pdf[G]

9 History

Quick info:

History

Ask about:

- the amount, frequency, and regularity of bleeding
- if cervix view normal, check documentation from cervical screening
- the presence of:
  - post-coital bleeding
  - intermenstrual bleeding
  - dysmenorrhoea
  - abdominal or pelvic pain
  - dyspareunia
  - heavy menstrual bleeding
  - premenstrual symptoms
  - possibility of pregnancy
- symptoms suggestive of anaemia:
  - light-headedness
  - shortness of breath with activity
- sexual and reproductive history:
  - contraception
  - risk for pregnancy
  - sexually transmitted infections (STIs)
  - desire for future pregnancy
  - infertility
  - cervical screening
- risk of STI – risk is higher if:
  - < 25 years; or
  - new partner; or
  - more than one partner in the last year
- impact on social and sexual functioning and quality of life
- symptoms suggestive of systemic causes of bleeding, such as:
  - hypothyroidism
  - hyperprolactinemia
  - coagulation disorders
  - polycystic ovary syndrome
  - adrenal or hypothalamic disorders
- any associated symptoms, such as:
  - vaginal discharge
  - odour
  - pelvic pain or pressure
- medications that may interfere with bleeding or contraception
- contraception history:
  - method used
  - duration of use
  - compliance
  - illness or a condition that may affect absorption of orally administered hormones

10 Intermenstrual bleeding

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Quick info:
Intermenstrual bleeding

11 Consider possible causes

Quick info:
Consider the following potential causes:

- very regular mid-cycle periovulatory light bleeding that causes unnecessary anxiety and does not require gynaecological assessment if the ultrasound is normal
- ovulation less than normal, PCOS investigation
- cervical ectropion
- endometrial polyps
- endometrial hyperplasia
- hormonal contraception
- pregnancy, also including:
  - ectopic pregnancy
  - miscarriage
- fibroids
- cancers of the cervix or endometrium:
- sexually transmitted infection (STI):
  - pelvic inflammatory disease
  - *Chlamydia trachomatis* is a common bacterial STI and is a likely cause of post-coital and irregular bleeding
  - risk factors for STIs include [2]:
    - <25 years of age; or
    - a new sexual partner; or
    - more than one partner in the last year
- coagulopathy
- iatrogenic

References:
2. Faculty of Sexual and Reproductive Healthcare (FSRH). Management of Unscheduled Bleeding in Women Using Hormonal Contraception. London: Royal College of Obstetricians and Gynaecologists (RCOG); 2009. Available from: http://www.fsrh.org/pdfs/UnscheduledBleedingMay09.pdf[G]

12 Examination

Quick info:
Examination
If there is no suspected contraceptive problem, a speculum and pelvic examination is recommended:
Examination may also include:

- weight/body mass index
- thyroid exam
- skin exam, eg:
  - pallor
  - bruising
- abdominal exam – to check for mass or hepatosplenomegaly
- gynaecological exam

13 Women using hormonal contraception

Quick info:

Women using hormonal contraception:

- Endometrial cancers are rare in women of reproductive age who are using hormonal contraception and who do not have risk factors [2]

Reference:

2. Faculty of Sexual and Reproductive Healthcare (FSRH). Management of Unscheduled Bleeding in Women Using Hormonal Contraception. London: Royal College of Obstetricicans and Gynaecologists (RCOG); 2009. Available from: http://www.fsrh.org/pdfs/UnscheduledBleedingMay09.pdf[G]

14 Woman not using hormonal contraception

Quick info:

Woman not using hormonal contraception

15 Expected bleeding patterns

Quick info:

Expected bleeding patterns.

Before starting hormonal contraception, women should be advised about the bleeding patterns expected both initially and in the longer term [2]:

- if bleeding patterns fall outside of the expected 'normal' patterns associated with different contraceptive methods, examination, investigation, or treatment may be indicated

Expected bleeding patterns when using the following contraceptives are as follows [2]:

- combined hormonal contraception:
  - up to 20% of combined oral contraceptive (COC) users experience irregular bleeding in the first 3 months of use
  - in the longer term:
    - irregular bleeding usually settles
    - there are no significant differences in bleeding between pill and patch use
    - the combined vaginal ring may afford better cycle control, eg less unscheduled bleeding when compared to the pill
    - NB: users of estradiol COC have reported shorter, lighter bleeds and a higher rate of absent withdrawal bleeds than women using an ethinylestradiol (EE)-containing COC
- progestogen-only pill (POP):
  - bleeding is unpredictable – 1/3 of women have a change in bleeding when using traditional POPs
  - in the longer term bleeding may not settle with time:
    - NB: traditional POP users can be advised that frequent and irregular bleeding are common, while prolonged bleeding and amenorrhoea are less likely
- progestogen-only injectable:
  - bleeding disturbances, eg spotting, light, heavy, or prolonged bleeding are common
  - around 1 in 10 women may be amenorrhoeic
  - in the longer term – rates of amenorrhoea increase with duration of use
  - specify depo provera
- progestogen-only implant:
  - bleeding disturbances are common in the first 3 months of use:
    - NB: the bleeding pattern in the first 3 months is broadly predictive of future bleeding patterns for many women
  - in the longer term, around:
    - 2 in 10 women are amenorrhoeic
    - 3 in 10 women have infrequent bleeding
    - fewer than 1 in 10 women have frequent bleeding
    - 2 in 10 women have prolonged bleeding

- levonorgestrel releasing intrauterine system (LNG-IUS) – Mirena®:
  - infrequent and erratic bleeding/spotting is common after insertion in the first few months
  - in the longer term:
    - there is a decrease over time in the number of bleeding and spotting days with all doses of LNG-IUS
    - a 90% reduction in menstrual blood loss has been demonstrated over 12 months of 52mg LNG-IUS use
    - at 1 year, infrequent bleeding is usual with the LNG-IUS and some women will be amenorrhoeic
    - 24% of 52mg LNG-IUS users are amenorrhoeic at 3 years
- LNG-IUS – Jaydess®:
  - frequent bleeding/spotting is common in the first few months after insertion
  - in the longer term:
    - there is a decrease over time in the number of bleeding and spotting days with all doses of LNG-IUS
    - users of the 13.5mg LNG-IUS report more spotting days than bleeding days over the duration of licensed use
    - fewer women (13% at 3 years) will experience amenorrhoea with this dose of LNG-IUS compared to the 52mg LNG-IUS

References:

2. Faculty of Sexual and Reproductive Healthcare (FSRH). Management of Unscheduled Bleeding in Women Using Hormonal Contraception. London: Royal College of Obstetricians and Gynaecologists (RCOG); 2009. Available from: http://www.fsrh.org/pdfs/UnscheduledBleedingMay09.pdf[G]

16 < 3 months since starting method - initial assessment

Quick info:

Test for chlamydia and gonorrhoea if at risk of sexually transmitted infection, ie:

- <25 years of age; or
- new partner; or
- more than one partner in the last year
- a history of drug or alcohol abuse; or
- domestic abuse

Carry out:

- a cervical smear if eligible for, but has not been participating in, a cervical screening programme
- a pregnancy test if sexually active:
  - the test may need to be repeated depending on the last menstrual period

In all cases a speculum examination to visualise the cervix and a bimanual is warranted if:

- a woman has not participated in a national screening programme
- requested by the woman
- there are symptoms, such as:
  - pain
  - dyspareunia
  - post-coital bleeding

NB: these symptoms would also warrant a bimanual examination:

- If a structural abnormality, such as polyps, fibroids, or ovarian cysts, is suspected [2]
- a transvaginal ultrasound scan and/or hysteroscopy may be indicated

References:

2. Faculty of Sexual and Reproductive Healthcare (FSRH). Management of Unscheduled Bleeding in Women Using Hormonal Contraception. London: Royal College of Obstetricians and Gynaecologists (RCOG); 2009. Available from: http://www.fsrh.org/pdfs/UnscheduledBleedingMay09.pdf[G]

17 > 3 months since starting method - initial assessment or reassessment

Quick info:

Test for chlamydia and gonorrhoea if at risk of sexually transmitted infection, ie:

- <25 years of age; or
- new partner; or
- more than one partner in the last year
- a history of drug or alcohol abuse; or
- domestic abuse

Carry out:

- a cervical smear if eligible for, but has not been participating in, a cervical screening programme
- a pregnancy test if sexually active:
  - the test may need to be repeated depending on the last menstrual period

In all cases a speculum examination to visualise the cervix and a bimanual is warranted if:

- a woman has not participated in a national screening programme
- requested by the woman
- there are symptoms, such as:
  - pain
  - dyspareunia
  - post-coital bleeding

NB: these symptoms would also warrant a bimanual examination:

- If a structural abnormality, such as polyps, fibroids, or ovarian cysts, is suspected [2]
- a transvaginal ultrasound scan and/or hysteroscopy may be indicated

References:

2. Faculty of Sexual and Reproductive Healthcare (FSRH). Management of Unscheduled Bleeding in Women Using Hormonal Contraception. London: Royal College of Obstetricians and Gynaecologists (RCOG); 2009. Available from: http://www.fsrh.org/pdfs/UnscheduledBleedingMay09.pdf[G]

18 Consider further investigation/referral

Quick info:

In all women, if the appearance of the cervix is suspicious of cervical cancer, consider an urgent suspected cancer pathway referral for an appointment within 2 weeks:

- a smear test result is not required before referral, and referral should not be delayed by a previous negative result
- if there is uncertainty about whether a referral is needed, consider asking for advice and guidance from a specialist

If findings are normal, but symptoms include pain, dyspareunia, and/or heavy bleeding consider referral for further assessment, eg ultrasound, biopsy, hysteroscopy [2].

Consider referral for endometrial biopsy and/or hysteroscopy in women with persistent problematic bleeding after the first 3 months of use of a hormonal contraceptive method if they have the following risk factors for endometrial cancer eg [2]:

- obesity
- polycystic ovary syndrome
- diabetes

If a structural abnormality, such as polyps, fibroids, or ovarian cysts, is suspected [2]:

- a transvaginal ultrasound scan and/or hysteroscopy may be indicated

References:

2. Faculty of Sexual and Reproductive Healthcare (FSRH). Management of Unscheduled Bleeding in Women Using Hormonal Contraception. London: Royal College of Obstetricians and Gynaecologists (RCOG); 2009. Available from: http://www.fsrh.org/pdfs/UnscheduledBleedingMay09.pdf[G]

19 Management

Quick info:

Management.

Provided causes other than the method of contraception have been considered and excluded (see <3 months since starting method - initial assessment care point), reassure and arrange a follow-up:

- it is not generally recommended that a combined oral contraceptive pill is changed within the first 3 months of use, as bleeding disturbances often settle in this time [2]
- if requested, medical management can be considered [2] – see 'Consider medical management' care point
- consider ALL IUD's

In all women, if the appearance of the cervix is suspicious of cervical cancer, consider an urgent referral for high suspicion of cancer:

- a smear test is not required before referral, and referral should not be delayed by a previous negative result
- if there is uncertainty about whether a referral is needed, consider discussing with a specialist

NB: levonorgestrel releasing intrauterine system (LNG-IUS) users with pain, discharge, or non-visible threads in addition to bleeding require investigation to exclude expulsion, perforation, or infection [2] – symptoms of perforation can include:

- severe pelvic pain after insertion – worse than period cramps
- pain or heavy bleeding after insertion, which continues for more than a few weeks
- sudden changes in periods
- pain during intercourse
- not being able to feel the threads

References:

2. Faculty of Sexual and Reproductive Healthcare (FSRH). Management of Unscheduled Bleeding in Women Using Hormonal Contraception. London: Royal College of Obstetricians and Gynaecologists (RCOG); 2009. Available from: http://www.fsrh.org/pdfs/UnscheduledBleedingMay09.pdf[G]

20 Consider further investigations and/or referral

Quick info:

Consider further investigations and/or referral.

In all women:

- if there is any possibility of pregnancy, a test should be performed:
  - the test may need to be repeated depending on the last menstrual period
- test for chlamydia and gonorrhoea if at risk of sexually transmitted infection, ie:
  - <25 years of age; or
  - new partner; or
  - more than one partner in the last year
  - a history of drug or alcohol abuse; or
  - domestic abuse
- thyroid function tests are not indicated unless there are clinical findings suggestive of thyroid disease
- consider increasing progestogen or adding brevinol 1
- combine Jadelle and COC for 3 month trial

Refer:

- to gynaecology services for biopsy if intermenstrual bleeding is persistent
- to gynaecology services if on examination a local, benign cause is found, such as a polyp or ectropion
- to gynaecology/genito-urinary medicine (GUM) according to local guidance if infection is found and treated but symptoms persist:
  - NB: it is always beneficial to refer to GUM in cases of sexually transmitted infection for contact tracing
- using an urgent suspected cancer pathway referral, for an appointment within 2 weeks, if the appearance of the cervix is suspicious of cervical cancer [4]:
  - a smear test result is not required before referral and referral should not be delayed by a previous negative result
  - if there is uncertainty about whether a referral is needed, consider asking a specialist for advice and guidance [4]

References:

Please see the care map's Provenance.

21 Consider medical management

Quick info:

Consider medical management.

Combined hormonal contraception users [2]:

- review pill taking (if the person is continuously pill taking without a monthly pill free interval ,putting back the pill free interval will reduce intermenstrual bleeding)
- continue with the same pill for at least 3 months, as bleeding may settle in time
- use a combined oral contraceptive (COC) with a higher dose of ethinylestradiol (EE) to provide the best cycle control
- could consider increasing the EE dose up to a maximum of 35 micrograms
- although there is no evidence for switching pills or changing the progestogen dose or type, it may help the individual
- consider increasing progesterone e.g. Brevinor 1
- combine Jadelle and COC for 3 month trial

Progestogen-only contraception [2]:

- bleeding is common in the initial months of a progestogen-only method
- however, treatment can be considered if it encourages the person to continue with the method
- progestogen-only pill (POP):
  - although there is no evidence that changing the POP will improve bleeding problems, patterns may vary with different preparations and so may help individuals
  - there is no evidence to support the following to improve bleeding patterns:
    - the use of two POPs per day
    - the routine use of estrogen supplementation or tranexamic acid
- progestogen-only injectable:
  - mefenamic acid taken for 5 days may reduce the length of a bleeding episode
  - a first-line COC can be considered for up to 3 months continuously or in the usual cyclical regime (unlicensed):
  - there is no evidence that reducing the injection interval improves bleeding:
  - however, depot medroxyprogesterone acetate (DMPA) may be given after a 10-week interval:
  - progestogen-only implant and intrauterine system
  - a first-line COC can be considered for up to 3 months continuously or in the usual cyclical regime (unlicensed)

NB: persistent bleeding is common in the first 6 months of use with these methods.

References:

2. Faculty of Sexual and Reproductive Healthcare (FSRH). Management of Unscheduled Bleeding in Women Using Hormonal Contraception. London: Royal College of Obstetricians and Gynaecologists (RCOG); 2009. Available from: http://www.fsrh.org/pdfs/UnscheduledBleedingMay09.pdf[G]

22 Level of understanding and engagement

Quick info:

1. Apply health literacy principles

Ask what the person understands:

- build on what the person already knows
- translate medical terminology into lay language
- draw diagrams or write key phrases and messages down and give it to the person to take with them
- provide educational material
- check the person’s understanding to confirm that they understand the key messages

- encourage people to bring trusted support people to future consultations
- consider other health literacy resources as appropriate:
  - Interpreter Services – Language Line (Nationwide) 0800 656 656 Monday to Friday, 9am to 6pm, and Saturday 9am to 2pm
  - maori navigational services
  - pasifika health services
  - cancer nurse coordination services
  - cancer society
  - LETS PLAN is a resource to help plan your next health care visit. It will help you understand more about your health andtreatment for an illness or injury

2. Consider any barriers to effective care:

- complexity of cancer care pathway – not knowing when or where to go next
- whanau, family and social network dynamics
- whanau support, family history
- family obligations including dependents
- work responsibilities
- whanau, hapu, and iwi obligations
- community engagement and obligations or responsibilities
- locality and geographical access to health and hospital services
- socio-economic factors, including source of income

23 High suspicion of Cancer

Quick info:

High Suspicion of Cancer

Rule out cervical cancer. Always view the cervix and refer if abnormal appearance even if the cervical smear is normal. Consider endometrial causes e.g., endometrial cancer or hyperplasia.

The following symptoms and signs may be the first symptoms of cancer and indicate the need for further investigation:

- persistent intermenstrual bleeding
- post-coital bleeding
- post-menopausal bleeding (PMB)
- visible haematuria
- unexplained vaginal discharge
- palpable abdominal mass that is not obviously fibroids
- unexplained vulval lump, ulceration or bleeding
- pelvic pain or pressure symptoms
- anaemia

Ministry of Health

View the Gynaecological definition(including red flags and risk factors) for high suspicion of cancer:

- Faster Cancer Treatment: High suspicion of cancer definitions April 2016

24 Refer for Ultrasound Scan

Quick info:

Refer for Ultrasound Scan.

Review results.

25 Follow-up - reassess

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Quick info:

Follow-up - reassess.

Speak to the woman about reassessment and timeframes.

Continue with the method of contraception if the bleeding settles.

If a young woman, consider possibility of **NOT** delaying examination.

Carry out a speculum examination to visualise the cervix if [2]:

- bleeding persists beyond the first 3 months of use
- there are new symptoms or a change in bleeding after the first 3 months of use
- medical treatment fails

References:

2. Faculty of Sexual and Reproductive Healthcare (FSRH). Management of Unscheduled Bleeding in Women Using Hormonal Contraception. London: Royal College of Obstetricians and Gynaecologists (RCOG); 2009. Available from: http://www.fsrh.org/pdfs/UnscheduledBleedingMay09.pdf[G]

26 Referral to support services

Quick info:

Referral to support services:

1. Gynaecology Clinical Nurse Specialist can improve the experience for people including:
   - their family and whanau, with cancer or suspected cancer
   - they also help improve overall access and timeliness of access to diagnostic and treatment services for people with cancer
   - Contact:
     - Attention: HBDHB Gynaecology Clinical Nurse SpecialistPrivate Bag 9014Hastings
     - Phone 06 878 8109 ext 6315Mobile 027 3535 298
2. Cancer Society:
   - an information guide for women with gynecological cancer
   - for additional support services phone the cancer information nurses on the Cancer Information Helpline 0800 226 237
   - referral Referral can be made before a diagnosis as Cancer Society also offers support for diagnosis treatment
3. Central Region Cancer Services Directory

This directory provides a list of some of the cancer support services available in Hawke's Bay including:

- accommodation
- disability support
- government health services
- medication
- legal advice
- ethnic and cultural

4. Check the Hauora Maori and Pasifika nodes for further information on available support services.

27 Urgent referral to Gynaecology services

Quick info:

Refer to Gynaecology services via form. An example of the form. Fax the form to outpatient referral centre 06 878 1328

The urgent referral for Suspected Gynaecological Cancer form can be found in the Patient Management system as an outbox document.

Include relevant information:

- reason for referral
- expectation of referral
- history and co-morbidities
- current management and/or options already pursued

- examination findings
- investigation results
- current medication
- allergies and adverse drug reactions
- any other relevant clinical information

If clinically unstable refer to Emergency Department and phone Oncall O & G registrar via HBDHB switchboard 06 878 8109

NB: Refer to gynaecological services do not wait for smear results

Referral will not be accepted unless the form has been completed.

28 Refer to Gynaecology services

Quick info:

Refer:

- to gynaecology services for biopsy if intermenstrual bleeding is persistent
- to gynaecology services if on examination a local, benign cause is found, such as a polyp or ectropion
- to gynaecology/genito-urinary medicine (GUM) according to local guidance if infection is found and treated but symptoms persist:
  - NB: it is always beneficial to refer to GUM in cases of sexually transmitted infection for contact tracing

Include relevant information:

- reason for referral
- expectation of referral
- history and co-morbidities
- current management and/or options already pursued
- examination findings
- investigation results
- current medication
- allergies and adverse drug reactions
- any other relevant clinical information

Refer to Gynaecology services via HBDHB e-referral system

29 Consider medical management

Quick info:

Consider medical management.

If examination findings are normal, no other symptoms are present, and there are no indications for further investigation/referral, consider medical management [2].

Combined hormonal contraception users [2]:

- continue with the same pill for at least 3 months, as bleeding may settle in time
- use a combined oral contraceptive (COC) with a higher dose of ethinylestradiol (EE) to provide the best cycle control
- could consider increasing the EE dose up to a maximum of 35 micrograms
- although there is no evidence for switching pills or changing the progestogen dose or type, it may help the individual

Progestogen-only contraception [2]:

- bleeding is common in the initial months of a progestogen-only method
- however, treatment can be considered if it encourages the patient to continue with the method
- progestogen-only pill (POP):
  - although there is no evidence that changing the POP will improve bleeding problems, patterns may vary with different preparations and so may help individuals
  - there is no evidence to support the following to improve bleeding patterns:

- the use of two POPs per day
- the routine use of estrogen supplementation or tranexamic acid

progestogen-only injectable:

-
  - mefenamic acid taken for 5 days may reduce the length of a bleeding episode
  - a first-line COC can be considered for up to 3 months continuously or in the usual cyclical regime (unlicensed):
  - there is no evidence that reducing the injection interval improves bleeding:
    - however, depot medroxyprogesterone acetate (DMPA) may be given after a 10-week interval
- progestogen-only implant and intrauterine system:
- a first-line COC can be considered for up to 3 months continuously or in the usual cyclical regime (unlicensed):
- **persistent bleeding is common in the first 6 months of use with these methods**
- **NB: longer-term use of the COC for managing problematic bleeding in women using progestogen-only methods has not been studied:**
  - **if bleeding recurs after 3 months, longer-term use is a matter of clinical judgement**

References:

2. Faculty of Sexual and Reproductive Healthcare (FSRH). Management of Unscheduled Bleeding in Women Using Hormonal Contraception. London: Royal College of Obstetricians and Gynaecologists (RCOG); 2009. Available from: http://www.fsrh.org/pdfs/UnscheduledBleedingMay09.pdf[G]

30 Follow-up - reassess

Quick info:

Follow-up - reassess.

A speculum examination to visualise the cervix is warranted if [2]:

- there are new symptoms or a change in bleeding after the first 3 months of use
- medical treatment has failed

In all women, if the appearance of the cervix is suspicious of cervical cancer, consider an urgent suspected cancer pathway referral for an appointment within 2 weeks:

- a smear test result is not required before referral, and referral should not be delayed by a previous negative result
- if there is uncertainty about whether a referral is needed, consider asking for advice and guidance from a specialist

If findings are normal, but symptoms include pain, dyspareunia, and/or heavy bleeding, or patient is age 45 years and over, consider referral for further assessment, eg ultrasound, biopsy, hysteroscopy [2].

Consider referral for endometrial biopsy and/or hysteroscopy in women with persistent problematic bleeding after the first 3 months of use of a hormonal contraceptive method if they are [2]:

- aged 45 years or older
- younger than age 45 years with risk factors for endometrial cancer eg:
  - obesity
  - polycystic ovary syndrome
  - diabetes

If a structural abnormality is suspected [2]:

- a transvaginal ultrasound scan and/or a hysteroscopy may be indicated

References:

2. Faculty of Sexual and Reproductive Healthcare (FSRH). Management of Unscheduled Bleeding in Women Using Hormonal Contraception. London: Royal College of Obstetricians and Gynaecologists (RCOG); 2009. Available from: http://www.fsrh.org/pdfs/UnscheduledBleedingMay09.pdf[G]

31 Secondary care clinic

Quick info:

Discuss appropriate management plan with the woman.

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A clinic letter to be written to the referrer/GP indicating the outcomes and a planned approach of ongoing care (transfer of care).
NB: If the woman has been advised that she has cancer then a urgent letter is sent to the GP.

32 Discharge back to Primary care

Quick info:
A letter to be written to the referrer indicating the outcomes and a planned approach of ongoing care (transfer of care).
A phone call to the referrer is preferred when there are short time frames for care planning/ intervention.

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Provenance Certificate

Intermenstrual Bleeding

Overview
This document describes the provenance of Hawke's Bay Region Gynaecological Cancer Pathways.

The purpose of implementing cancer pathways in our District is to:

- Reduce barriers so that all people with cancer are able to access the same quality care within the same timeframes, irrespective of their ethnicity, gender, locality or socio-economic status
- Achieve the faster cancer treatment (FCT) health target – 85% of patient receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90% by June 2017
- Implement the national tumour standards of service provision, developed as part of the FCT programme, to support the delivery of standardised quality care for all people with cancer
- Improve equity along the cancer pathway
- Clarify expectations across providers
- Improve communications and follow up care for cancer patients

To cite these pathways, use the following format:
Map of Medicine – Hawke's Bay View / Oncology /Gynaecological / Intermenstrual Bleeding

Editorial methodology
This care map has been based on a Map of Medicine Care Map developed according to the Map of Medicine editorial methodology. The content of the Map of Medicine care map is based on high quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience (see contributors section of this document). This localised version of the evidence-based, practice informed care map has been peer-reviewed by the HBDHB and Collaborative Clinical Pathways Director and with stakeholder groups.

References

1	National Institute for Health and clinical Excellence (NICE), National Collaborating Centre for Women's and Children's Health. Long-acting reversible contraception: the effect and appropriate use of long-acting reversible contraception. London: royal college of Obstetricians and Gynaecologists (RCOG) Press; 2005. Available from: http://www.nice.org.uk/nicemedia/live/10974/29909/29909.pdf [G]
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	Faster Cancer Treatment (FCT): High Suspicion of Cancer Definitions 2016. Ministry of Health
	Canterbury Health Pathways

Contributors
The following individuals have contributed to this local care map:

- Elaine White, Consultant, Obstetrics and Gynaecology, Hawke's Bay DHB
- Catherine Kelsey, CNS Gynaecology, Hawke's Bay DHB
- Dr Lisa Kleinert, General Practitioner, Greendale Family Health Centre
- Leigh White, Strategic Services Portfolio Manager, Hawke's Bay DHB
- Wendy Wasson, Collaborative Pathways Facilitator/Editor, Hawke's Bay DHB

The following individuals have contributed to the sub-regional care maps:

- Digby Nang Kee, Gynaecologist MidCentral DHB
- Gillian Forsyth, CNS Gynaecology, MidCentral DHB
- Tray Haddon, Quality and Service Improvement Manager, Pae Ora Māori Health, MidCentral DHB
- Rebecca James, Clinical Nurse Manager Māori Health, MidCentral DHB
- Stephanie Fletcher, Project Manager, Central Cancer Network, MidCentral DHB
- Katherine Gibbs, Project Manager, MidCentral DHB
- Catherine Kelsey, CNS Gynaecology, Hawke's Bay DHB
- Elaine White, Consultant, Obstetrics and Gynaecology, Hawke's Bay DHB
- Keven Nevil, Consultant, Obstetrics and Gynaecology Whanganui DHB (Secondary Care Clinical Lead)
- Ruth Carter, General Practitioner, Whanganui Regional Health Network (Primary Care Clinical Lead)
- Ray Jackson, Project Director, Collaborative Clinical Pathways (Facilitator)
- Kim Vardon, Project Assistant, Collaborative Clinical Pathways (Editor)

Disclaimers
Clinical Pathways Steering Group, Hawke's Bay DHB and Health Hawke's Bay – Te Oranga Hawke's Bay.

It is not the function of the Clinical Pathways Steering Group, Hawke's Bay DHB and Health Hawke's Bay – Te Oranga Hawke's Bay to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge.

Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the person receives the best possible care.

Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.