Royal College of Obstetricians & Gynaecologists

BSGE BRITISH SOCIETY for GYNAECOLOGICAL ENDOSCOPY

BRITISH GYNAECOLOGICAL CANCER SOCIETY

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 impair quality of life and raise concerns about gynaecological cancer.

The statement provides national guidance on reinstating gynaecological services for the assessment and management of AUB according to the clinical priority framework produced by the RCOG[1]. It also affords a framework to aid 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 limited human and physical resources.

3. To provide access to timely, safe and effective management of abnormal uterine bleeding during times of disruption to normal healthcare provision.

For planned and elective care outpatient or inpatient care, only patients who are asymptomatic should attend, ensuring they can comply with normal social distancing requirements. This may require alternative ways of scheduling appointments, restructuring of waiting areas and wards and / or reducing outpatient, testing and surgical capacity. Local protocols and national guidance should be followed[2].

Heavy Menstrual Bleeding

- Women with HMB should initially be managed by remote communication. They should be reassured that the risk of malignancy is negligible[3].

- 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, NICE recommended medical treatment should be prescribed after exclusion of contraindications[4]. To reduce the need for face to face interaction, consider the use of oral medications initially in preference to intrauterine hormonal devices.

- Women should be referred as an emergency to secondary care for further management if:

  - The HMB is torrential and / or prolonged such that:
    - Severe anaemia is suspected
    - Symptoms suggestive of haemodynamic compromise.

- Women should be referred to secondary care for further management, and seen within 30 days, if:
  - Ongoing HMB that has been resistant to NICE recommended oral treatments and is:
    - Considered unmanageable by the woman
    - Associated with significant risk factors for endometrial disease (atypical hyperplasia or cancer) e.g. morbid obesity (BMI >/= 40), obesity (BMI >/= 35) in women over 40 years of age, Lynch syndrome.
  - Significant anaemia is suspected

- Women should be referred to secondary care for further management, and may be seen beyond 30 days, if:
  - Ongoing HMB that has been resistant to NICE recommended oral treatments[3] is considered manageable by the woman.
  - Significant anaemia is not suspected

- Women referred to secondary care should undergo diagnostic work up (history, examination and investigations) according to the NICE HMB assessment and management guideline[4], with the following exceptions where access to outpatient testing modalities is restricted:
  - If access to pelvic ultrasound is limited then a pelvic examination should be offered to all, rather than selected, women to identify rectifiable causes (e.g. prolapsed cervical fibroid) and detect significant uterine fibroids.
  - If access to hysteroscopy is limited, then a blind endometrial biopsy should be taken to exclude endometrial cancer and endometrial hyperplasia.

- Women referred to secondary care as an emergency with acute bleeding should be managed according to local protocols. In the absence of a cause requiring a specific surgical intervention (e.g. a prolapsed cervical fibroid) or haematological intervention (e.g. known bleeding disorder), Consider:
  - Tranexamic acid and a course of high dose oral progestogens to rapidly supress acute bleeding.
  - Gonadotrophin releasing hormone (GnRH) analogues
  - Oral or intravenous iron infusion or blood transfusion according to the severity of the anaemia and associated symptoms.

- Women referred to secondary care should be managed according to the NICE HMB assessment and management guideline[4], with the following exceptions where access to surgical and / or radiological treatments are restricted:
    - 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.
    - High dose systemic progestogens (e.g. norethisterone 5 mg t.d.s; medoxyprogesterone acetate 5-10 mg t.d.s) to be administered to arrest acute episodes of bleeding (single 10-14 day course), to regulate bleeding (cyclical courses e.g. from day 5-26 of the menstrual cycle) or to induce amenorrhoea (continuous dosing).

- Endometrial hyperplasia and cancer should be managed according to local protocols and national guidance[5].

Intermenstrual Bleeding

- Women of 40 years of age or over with persistent IMB (> 3 consecutive months who are not using hormonal contraceptives) should be referred to secondary care and seen within 30 days.

- Women under 40 years of age, or women of 40 years of age or over who are using hormonal contraceptives, with persistent IMB (> 3 consecutive months) should be referred to secondary care and may be seen beyond 30 days. If resources for assessment in hospital are limited then consider the following alternative management strategy:
    - Manage by remote communication. Women should be reassured that IMB is common and symptoms often spontaneously resolve and that underlying cancer is rare[2].
    - 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 an earlier 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 referred to secondary care may have any of the following investigations according to local protocols and testing resources:
  - A cervical biopsy.
  - A pelvic ultrasound scan
  - A blind endometrial biopsy
  - A hysteroscopy +/- a directed endometrial biopsy

Postmenopausal bleeding

- PMB is a red flag symptom because 5 - 10% of women will have endometrial cancer[6]. 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.
  - Women who have suspected or confirmed COVID-19 should be advised to self-isolate and informed that they will not be seen in secondary care until they are no longer likely to be infectious (e.g. 14 days from the onset of symptoms) and arrangements should be made for re-testing (viral clearance) in line with local policies. Women with suspected COVID-19 should be advised to self-isolate and arrange a SARS-COV-2 viral testing via NHS 111 or online via https://www.gov.uk/apply-coronavirus-test
  - This risk of horizontal viral transmission from hospital assessment for COVID-19 vulnerable / shielding patients' needs to be balanced against the risk of delay in diagnosis of a gynaecological cancer on a case by case basis. SARS-COV-2 viral testing of asymptomatic vulnerable patients to mitigate risk should be considered in accordance with local protocols and national guidance[2].

- 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[7].
  - Women can be discharged with an endometrial thickness (ET) of < 4mm on TVS because the risk of endometrial cancer is very low[7].
  - Further endometrial evaluation is indicated if the ET is > 4 mm[7] in accordance with local protocols and national guidance. If local practice is to undertake a hysteroscopy but access to

this test is limited (e.g. reduced capacity due to staff lack of human and material resources, or due to the need for social distancing in clinical areas), then a blind endometrial biopsy alone should be undertaken.

- A blind endometrial biopsy that produces an "insufficient sample" can be considered as normal provided the biopsy device was inserted more than 6 cm beyond the cervical canal[7], although this conclusion should be considered on a case by case basis, taking into account individual patient risk factors and ultrasound findings. Women should be told to contact their GP if their bleeding symptoms recur so that further referral and investigation can be promptly arranged.
- 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 live virus has not been identified in the genital tract in women with COVID-19[8]. 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[9].
- 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.
- Women with hyperplasia should undergo endometrial surveillance according to national guidance[5].
- 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 in selected cases.

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.

- Women with PCB should be referred to secondary care and seen within 14 days if:
  - The appearance of the cervix is consistent with cervical cancer
  - They are aged 35 years or under with abnormal, absent or overdue cervical screening
  - They are aged >35 years, regardless of smear history

- Women with PCB aged <35 years, should be referred to secondary care and seen within 42 days

- Women referred to secondary care should be investigated according to local protocols and testing resources.

References

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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.