NHS Dorset- Unscheduled bleeding on HRT pathway FAQs

1. Who is eligible for this pathway?

The eligibility criteria for this pathway are:

- Postmenopausal women (defined as absence of menstruation for at least 12 months)
- Currently taking systemic HRT (either sequential or continuous combined)
- Has been established on HRT for at least 6 months
- No changes to HRT dose within the last 3 months
- No major risk factors for endometrial cancer: BMI>40 or genetic predisposition (Lynch or Cowden Syndrome)

All of the above criteria must apply for the patient to be eligible for referral.

2. Who should not be referred on this pathway?

Examples of who would not meet the criteria for referral for this pathway are:

- Perimenopausal women (showing symptoms of menopause but still having periods)
- Has stopped taking their HRT
- Has been on HRT for less than 6 months
- Has had a change in their HRT dose (within the last 3 months)
- Has already been scanned within the last 3 months
- Has major risk factors for endometrial cancer
- Has had a hysterectomy

If your patient fulfils any of these in the list the GP direct access pathway should not be used, and the patient should be managed in primary care in line with BMS guidelines. An advice and guidance referral can be made if you require specialist support from gynaecology.

3. Who does not require an ultrasound?

Bleeding within the first 6 months of initiation or within 3 months of changing HRT is normal and expected and an ultrasound is not required.

You should consider referral if heavy bleeding (flooding) or persistent (almost daily) bleeding arise within 6 months of initiation of HRT, or within 3 months of change in dose/ preparation. Adjustments to comorbidities and progestogen dose should be considered prior to referral to scan and whilst awaiting ultrasound scan.

4. What are the prerequisites for referring on this pathway?

The key prerequisites for this pathway are:

- The patient must have had a vaginal and speculum examination prior to referral for a scan. This is to rule out any vaginal or cervical pathology that may mean they require a more urgent assessment under an urgent suspected cancer pathway.
- A review of the patient's history must have been undertaken to rule out any major risk factors that may mean they require a more urgent assessment under an urgent suspected cancer pathway.

- The referrer must assess patient adherence and understanding of how to use the prescribed preparation including dose and duration of progestogen, and rule this out as a cause for the bleeding before requesting a scan.

5. Are patients with mirena coils (IUS) suitable for this pathway?

In line with BMS guidelines, patients with mirena coils are eligible to be referred via this pathway.

Unscheduled bleeding with a mirena coil is a challenging situation but equally an uncommon one. Based on our local audit only 7% of patients with unscheduled bleeding on HRT used a mirena as part of their HRT. An ultrasound scan is valuable to assess if the mirena is correctly positioned. Equally, although difficult, we are usually able to see the endometrial thickness to provide reassurance to patients.

When patients have bleeding without pathology seen on ultrasound with a mirena, the principles of unscheduled bleeding on HRT are the same. Advice is to consider reducing oestrogen and consider changing or adding further progesterone. If pathology is seen or bleeding continues despite a reassuring scan and adaption of HRT then the expectation of the pathway is for an urgent suspected cancer referral. In situations where the endometrial thickness cannot be assessed on the initial scan the default should be referral onto the urgent suspected cancer pathway.

6. What should I communicate to my patient when making a referral to this pathway?

When making a referral to the unscheduled bleeding on HRT pathway, the primary care referrer should make the patient aware that they should expect a scan within 4 weeks. They should also advise that if the scan shows an abnormality the patient may be referred directly on to gynaecology for further investigations.

The patient should also be provided with a copy of the Unscheduled bleeding on HRT patient information leaflet, which can be found in the resources section for this pathway on C the Signs.

7. Who is responsible for actioning the results of the ultrasound scan?

In line with national GP direct access guidance, we have built in a mechanism for automatic onward referral to gynaecology for abnormal ultrasound findings on this pathway for both UHD & DCH. This means that any patient with endometrial thickness of more than 4mm, ill-defined endometrium, or concerning ovarian pathology, will be referred directly to gynaecology following their scan via an agreed internal process. Any other findings will need to be actioned by the referrer.

The ultrasound report should communicate to the referrer whether an onward referral has been made.

Please be aware that if patients are referred for an ultrasound outside of the agreed pathway (such as to a private provider or another Trust) then an automatic gynaecology referral will not be made, and the referrer will need to action this on receipt of the result.

8. Where can I find further information about this pathway?

All resources for this pathway in Dorset are available via C the Signs.

Standard Operating Procedures and Pathway Flowcharts are also available via a link on the ICE request forms.

The British Menopause Society Guidelines on management of Unscheduled bleeding on HRT can be found here: Management of unscheduled bleeding on hormone replacement therapy (HRT) - British Menopause Society

Queries around this pathway can also be sent to the following email addresses:

- UHD: **ubonhrt@uhd.nhs.uk**
- DCH: **gynae.mdt@dchft.nhs.uk**

9. What should I do if the ultrasound comes back normal and the patient is still experiencing bleeding?

Bleeding issues on HRT are common and the risk of cancer is very low. Often adapting patients HRT by either changing or increasing the progesterone component or lowering the oestrogen where appropriate will improve bleeding. The information provided in the appendix is a helpful guide on how to do this.

If bleeding is still a concern despite these changes, please consider routine advice and guidance or routine referral to gynaecology clinic.

The advice from the BMS on appropriate progesterone dosing can also be found below:

Key: Prescribed estrogen dose for ultra-low, low, standard, moderate and high dose regimens

	Ultra-low dose	Low Dose	Standard dose	Moderate dose	High dose
Oestrogel	½ pump	1 pump	2 pumps	3 pumps	4 pumps
Sandrena	0.25 mg	0.5 mg	1 mg	1.5-2 mg	3 mg*
Lenzetto spray	1 spray	2 sprays	3 sprays	4-5 sprays*	6 sprays*
Patch	12.5 µg	25 µg	50 µg	75 µg	100 µg
Oral estradiol	0.5 mg	1 mg	2 mg	3 mg^	4 mg^

* Off-license use
mg = milligrams
^ Off-license use – rarely required to achieve symptom control
µg = micrograms

Progestogen dose per licensed estrogen dose in the baseline population

Estrogen dose	Micronised Progesterone		Medroxy progesterone		Norethisterone		LNG-IUD (52mg)
	continuous	sequential	continuous	sequential	continuous	sequential	
Ultra/Low	100 mg	200 mg	2.5 mg	10 mg	5 mg*	5 mg*	One – for up to 5 years of use
Standard	100 mg	200 mg	2.5-5 mg	10 mg	5 mg*	5 mg*	
Moderate	100 mg	200 mg	5 mg	10 mg	5 mg	5 mg	
High	200 mg+	300 mg+	10 mg^	20 mg^	5 mg	5 mg	

*1 mg provides endometrial protection for ultra-low to standard dose estrogen but the lowest stand-alone dose currently available in the UK is 5 mg (off-license use of three noriday POP i.e 1.05 mg, could be considered if 5 mg is not tolerated).
^There is limited evidence in relation to optimal MPA dose with high dose estrogen; the advised dose is based on studies reporting 10 mg providing protection with up to moderate dose estrogen.
+There are limited evidence in relation to optimal micronised progesterone dose for moderate or high dose estrogen; until evidence is available to guide practice, the advised dose is based on studies reporting 100 mg/day providing protection with up to standard dose estrogen. If unscheduled bleeding occurs with ultra-low to moderate dose estrogen, and other progestogens are not acceptable, offer micronised progesterone at the dosage recommended for high dose estrogen.

Appendix: HRT guidance for GPs

For advice on HRT preparations and equivalent doses please see following link to the British Menopause Society: www.Thebms.org.uk/publications/tools-for-clinicians

GP to consider the following management:

- If on sequential HRT regimens, consider increasing dose of progesterone to 300mg micronised progesterone (Utrogestan) for 12 days a month instead of 200mg, or switch to a different progesterone, or increase duration of progesterone intake (can take progestogen for 14 days a month or for 21 days out of a 28-day HRT intake cycle)
- If on continuous combined HRT regimens, consider increasing the dose of progestogen (e.g. increase micronised progesterone daily dose from 100mg to 200mg daily on a continuous basis), particular when combined with higher dose estrogenic regimens or raised BMI
- For continuous HRT regimens in a combined preparation or have the levonorgestrel intrauterine system consider adding micronised progesterone/ medroxyprogesterone acetate or norethisterone
- If breakthrough bleeding occurs after 3 to 6 months after switching from sequential to continuous HRT they can be switched back to sequential for at least one year
- Unscheduled bleeding is higher with transdermal preparations than oral preparations
- If evidence of urogenital atrophy (despite those on systemic HRT) consider vaginal oestrogens

Consider scan if heavy bleeding (flooding) or persistent (almost daily) bleeding arises within 6 months of initiation of HRT, or within 3 months of change in dose/ preparation. Adjustments to comorbidities and progestogen dose should be considered prior to referral to scan and whilst awaiting ultrasound scan.

Consider Advice & Guidance route if additional advice required.

Progestogen in HRT recommended doses

Micronised progesterone
200mg PO 12 days/cycle (cyclical)
100mg PO daily (continuous combined)
Preparations: Utrogestan 100mg PO

Dydrogesterone
10mg for 12-14 days a month (cyclical)
5mg a day (continuous combined)
2.5mg a day (low dose continuous combined)

Medroxyprogesterone acetate (MPA)
10mg for 12 days a month (cyclical)
2.5mg a day (continuous combined)

Norethisterone
5mg for 12 days a month (cyclical)
0.5-1mg a day (continuous combined)

Levonorgestrel IUS
Licensed for 4 years in the UK

Vaginal oestrogen preparations for vaginal atrophy

Intravaginal cream
Ovestin (1 mg estriol in 1 gram cream) - insert one applicatorful daily for a maximum of 4 weeks, reducing to one applicatorful twice a week)

Vaginal tablets
Vagifem vaginal tablets
(estradiol 10 micrograms) -insert one vaginal tablet daily for 2 weeks then reduce to one vaginal tablet twice a week.

Vaginal gel
Blissel® (50 micrograms estriol in 1 gram vaginal gel) -insert one applicator dose daily for 3 weeks, reducing to one applicator dose twice a week. Reassess after 12 weeks.