Back so soon?

Postmenopausal and Perimenopausal Bleeding

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Disclosures

Relevant Disclosures:

The Menopause Society Board of Directors

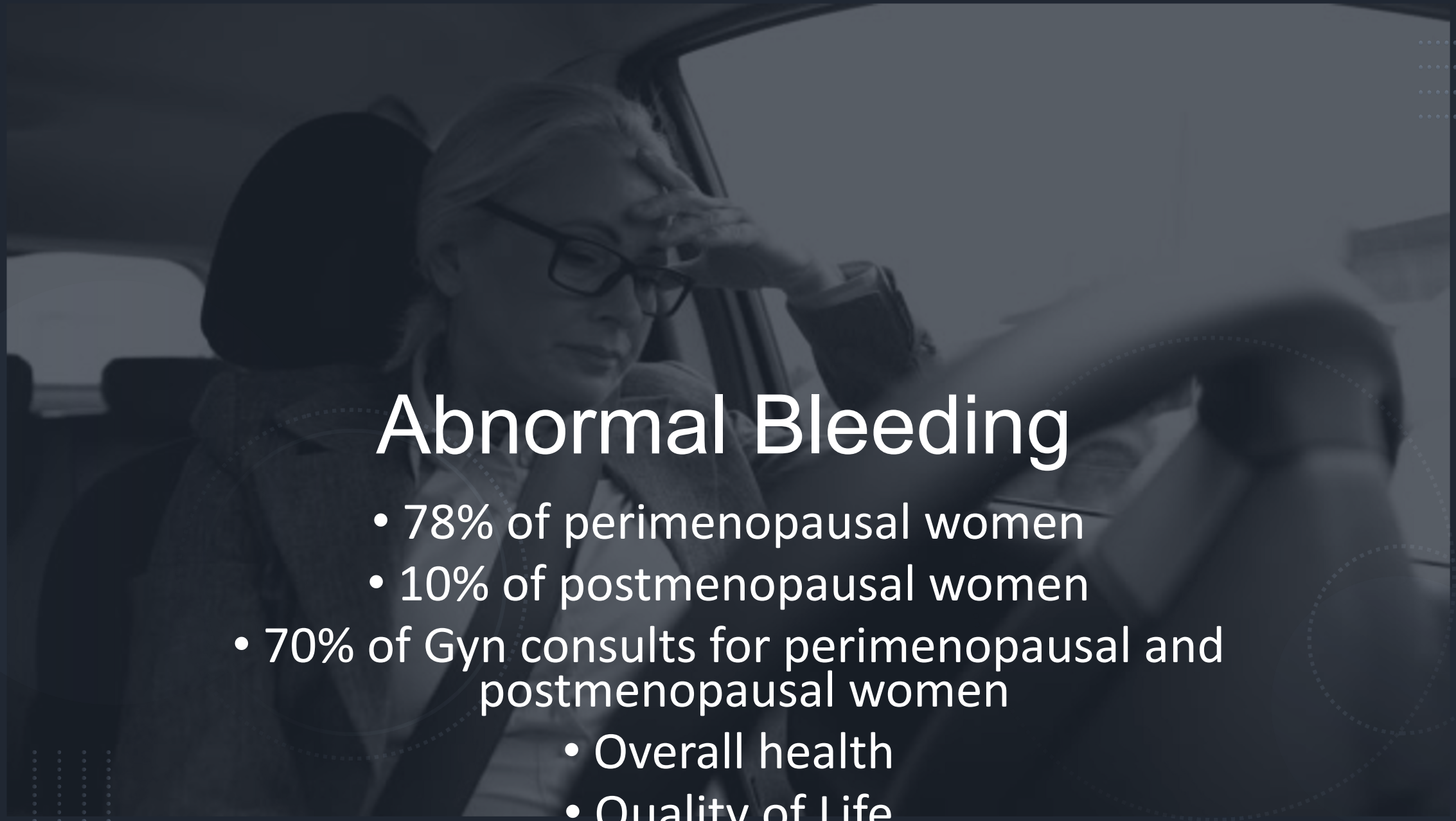
Consultant: Astellas

No conflicts of interest

References:

I will discuss clinical studies of off label use of pharmaceuticals for vasomotor symptoms.

This presentation references people born with ovaries. I may use the terms women, she, and her. These terms may not capture the diversity of all those experiencing menopause. We need more research to explore how diverse people experience menopause.



Abnormal Bleeding

- 78% of perimenopausal women
- 10% of postmenopausal women
- 70% of Gyn consults for perimenopausal and postmenopausal women
- Overall health
- Quality of Life

Learning Objectives

01

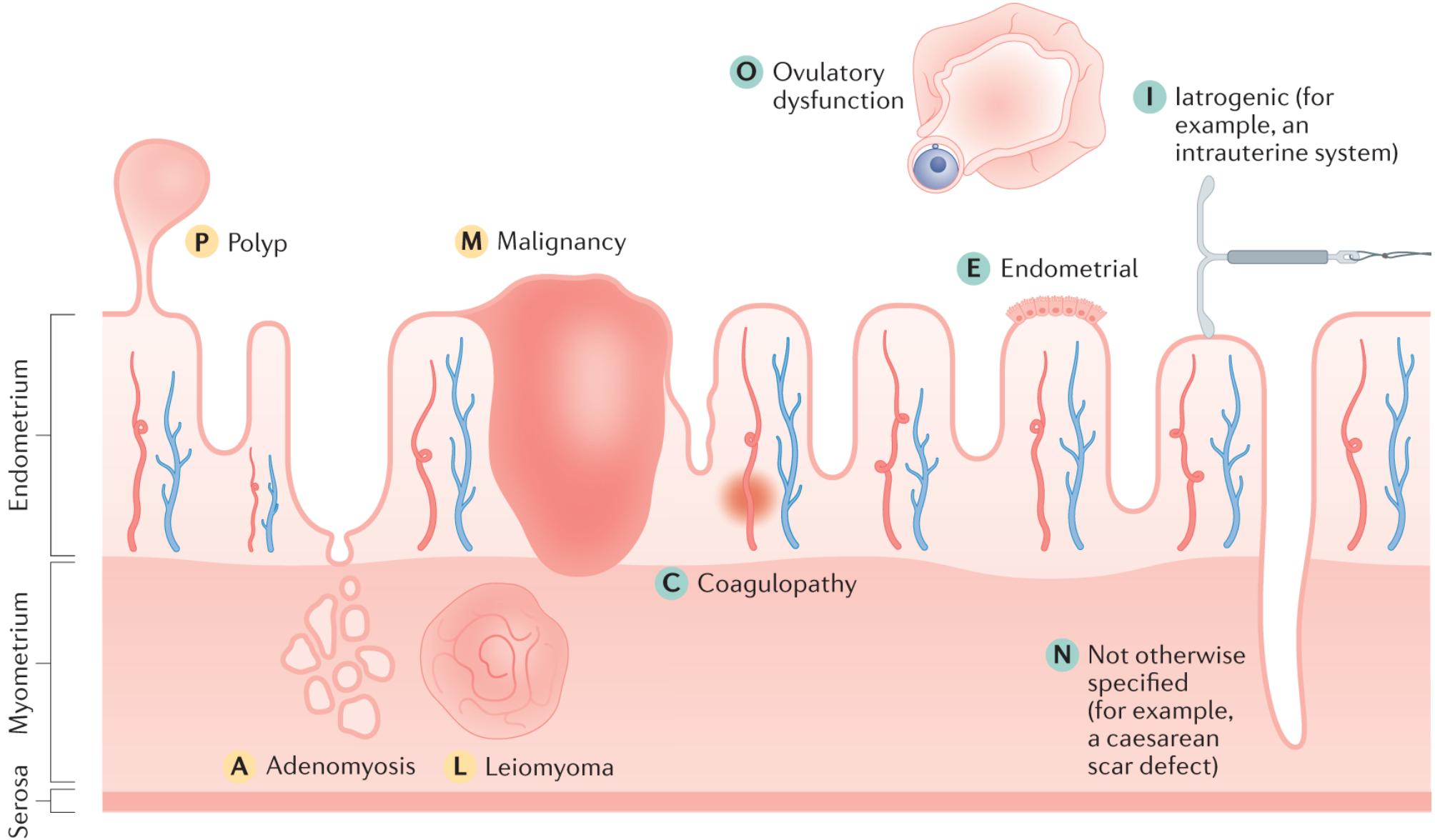
Describe the physiology and pathophysiology of perimenopausal and postmenopausal bleeding

02

Review diagnostic considerations for perimenopausal and postmenopausal bleeding

03

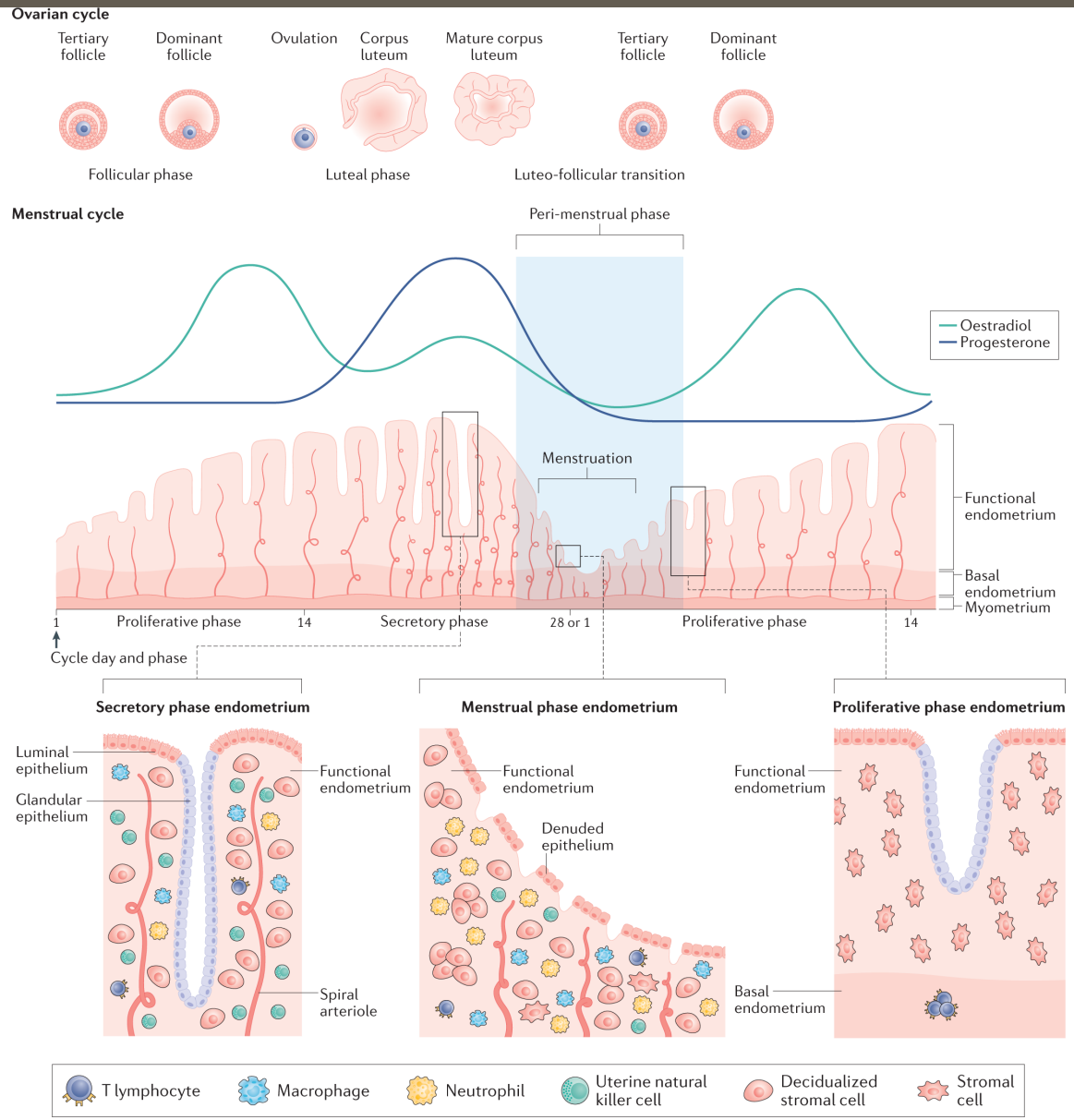
Discuss treatment options for abnormal bleeding in the menopause transition and menopause

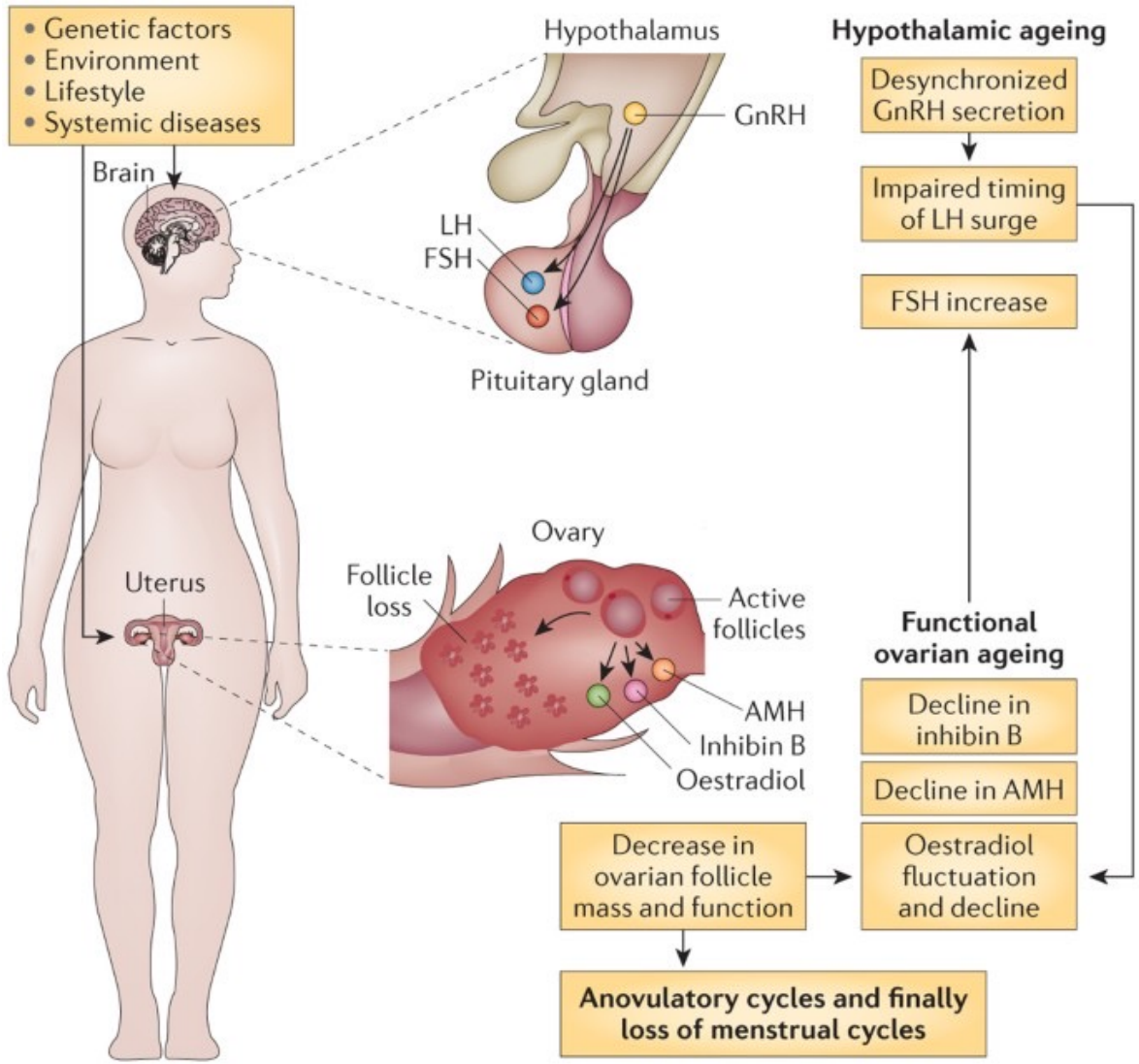


Nature Reviews Endocrinology (*Nat Rev Endocrinol*) ISSN 1759-5037 (online) ISSN 1759-5029 ()

Ovulatory Bleeding

- ORDERLY, PREDICTABLE
  - Endometrial proliferation, stromal stabilization
  - Hormone withdrawal
  - Endometrial shedding, coagulation and blood vessel repair
- Cycle resets


Ovarian cycle
Tertiary follicle
Dominant follicle
Ovulation
Corpus luteum
Mature corpus luteum
Tertiary follicle
Dominant follicle
Follicular phase
Luteal phase
Luteo-follicular transition
Menstrual cycle
Peri-menstrual phase
Oestradiol
Progesterone
Menstruation
Functional endometrium
Basal endometrium
Myometrium
1
Proliferative phase
14
Secretory phase
28 or 1
Proliferative phase
14
Cycle day and phase
Secretory phase endometrium
Menstrual phase endometrium
Proliferative phase endometrium
Luminal epithelium
Glandular epithelium
Functional endometrium
Spiral arteriole
Functional endometrium
Denuded epithelium
Functional endometrium
Basal endometrium
T lymphocyte
Macrophage
Neutrophil
Uterine natural killer cell
Decidualized stromal cell
Stromal cell



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Anovulatory Bleeding

UNCOORDINATED, UNPREDICTABLE

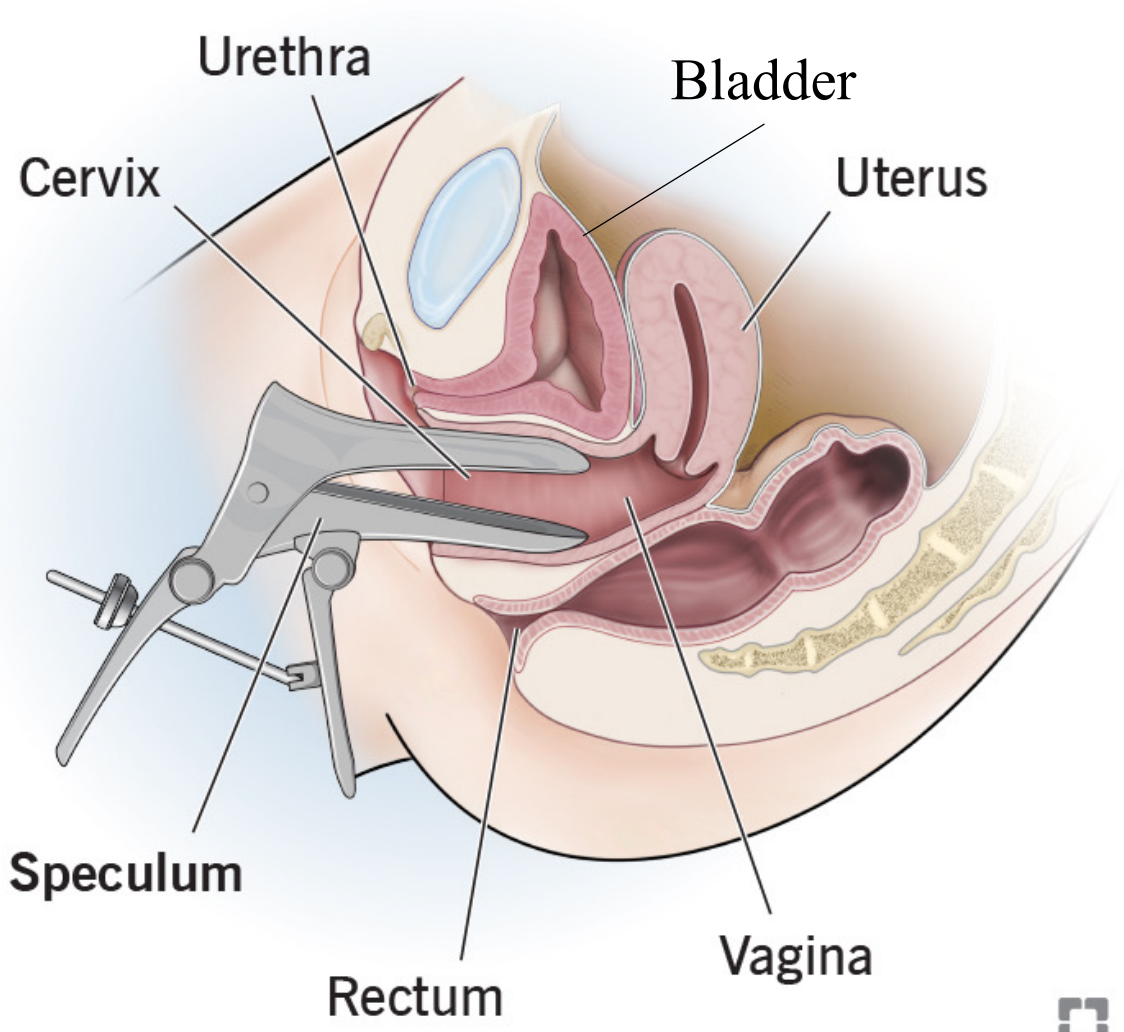
- Uncoordinated Hormone withdrawal
- Fragile endometrium, no stromal support:
- Irregular endometrial shedding, sloughing
- Erratic bleeding

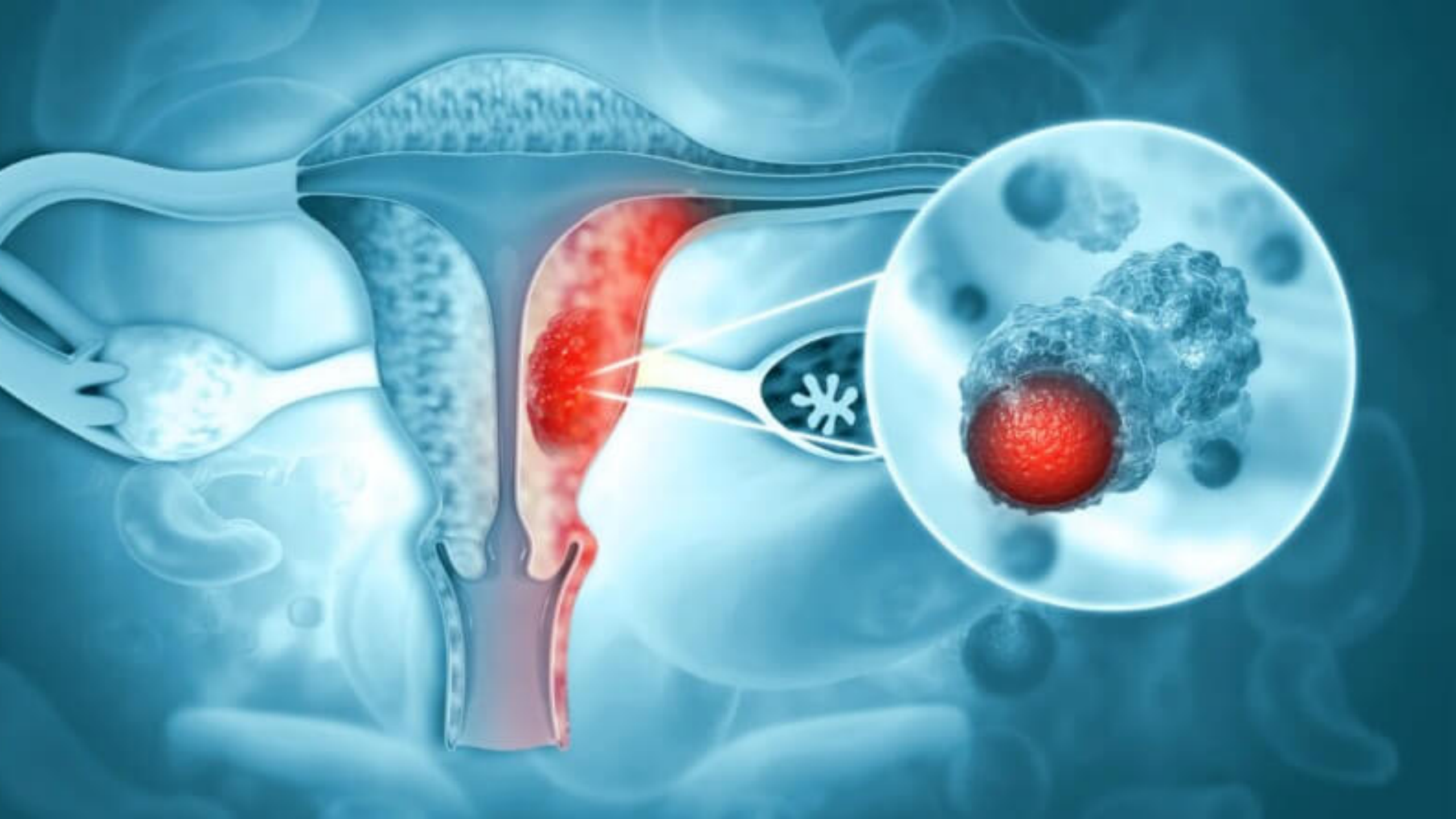
HISTORY

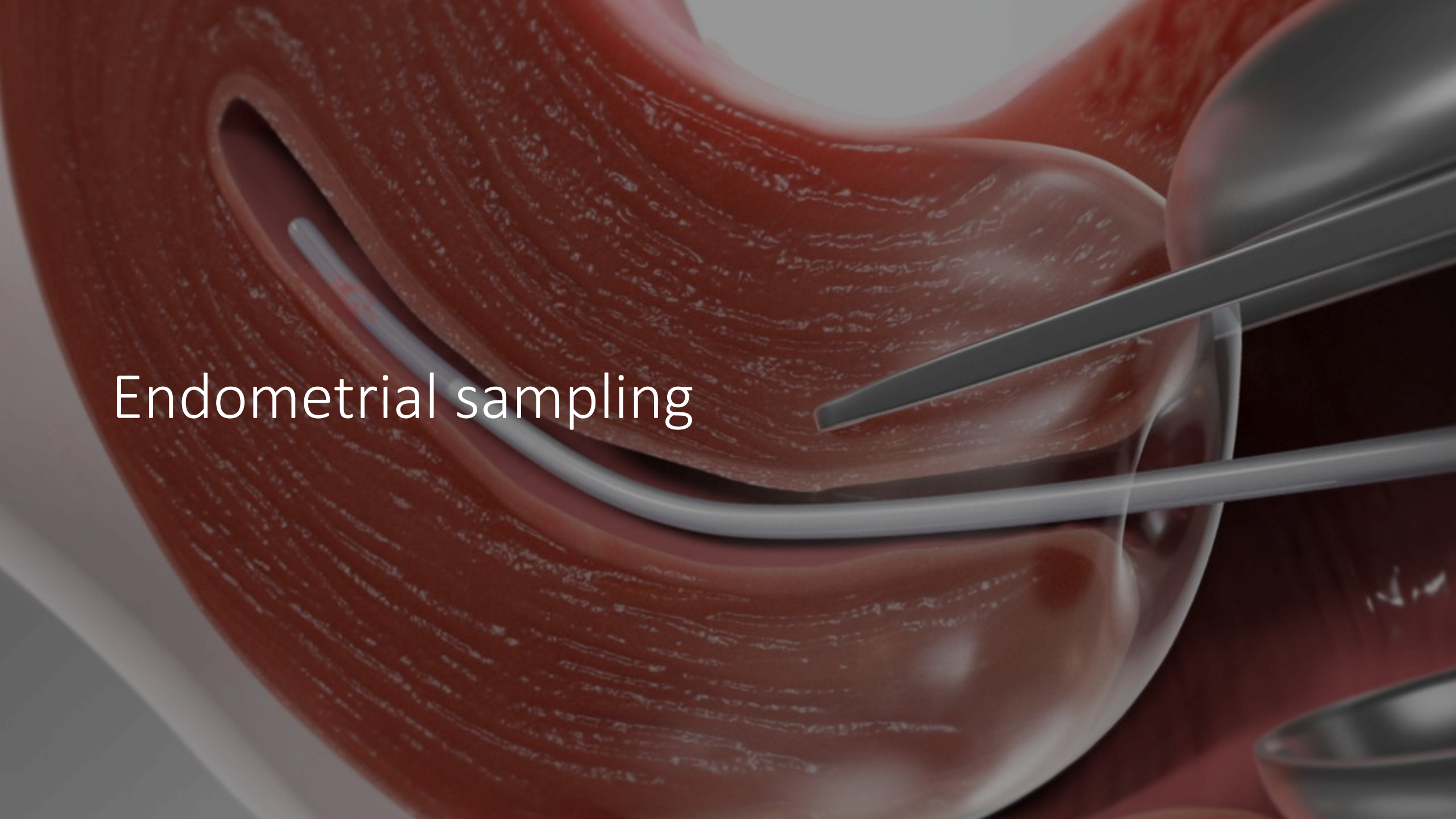
- Last or Final Menstrual Period
- Contextual factors of present bleeding
  - Onset, Duration, Frequency, volume
  - Absence of systemic symptoms such as breast tenderness, mucus, cramping, bloating, pain
- Menstrual history
  - Age at menarche
  - Age at menopause
- Gynecologic history
  - Infections
  - Abnormal Paps/HPV
- Past medical history: Obesity, PCOS, DM, Thyroid disorders, coagulopathies
- Surgical history
  - Prior pelvic procedures
- Social history
- Family history
  - Inherited mutations
- Medications
  - Hormones, Endocrine therapies, anticoagulants

Pelvic Exam

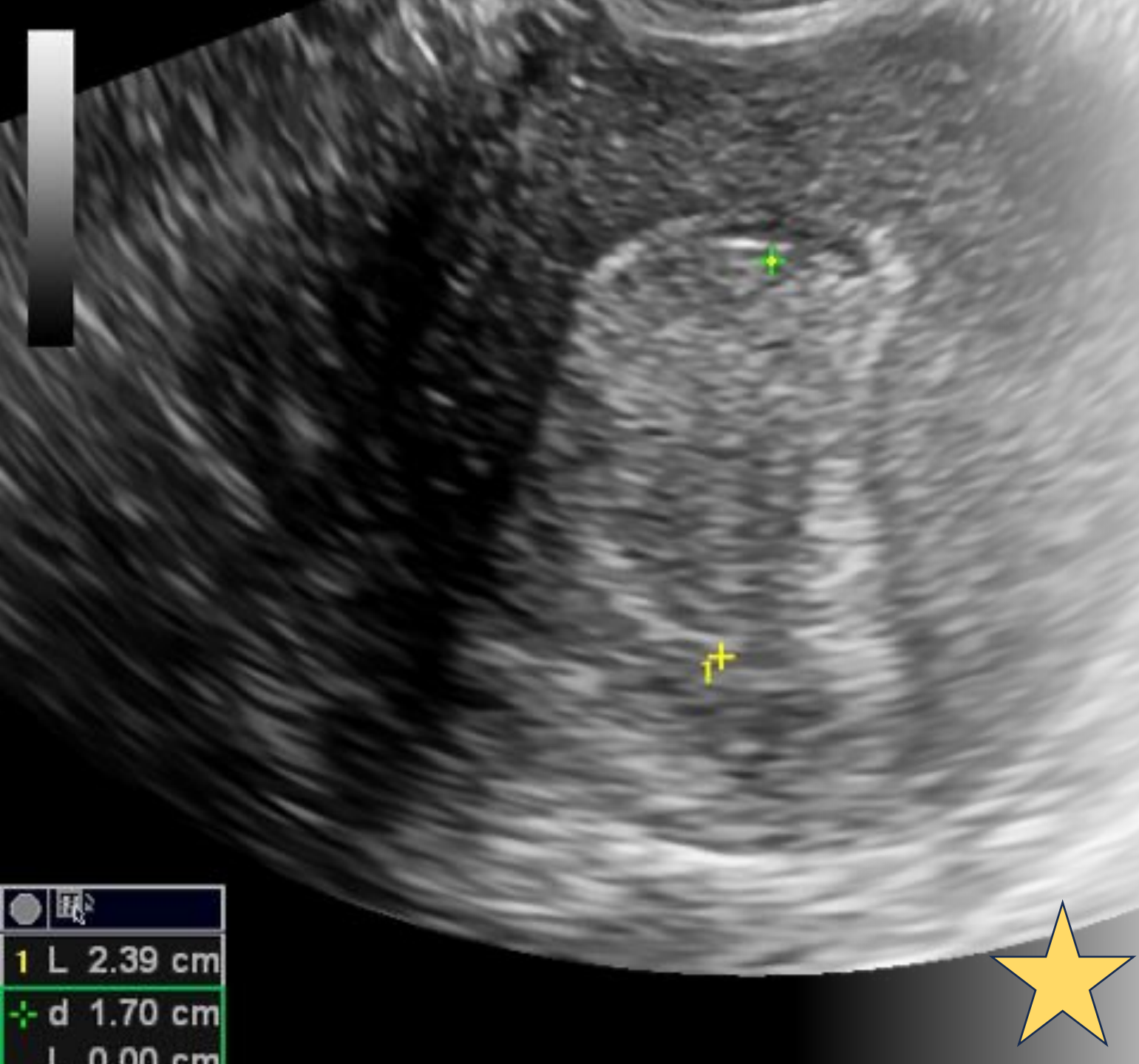
Exclude non-uterine bleeding







Endometrial sampling



Imaging

TVUS

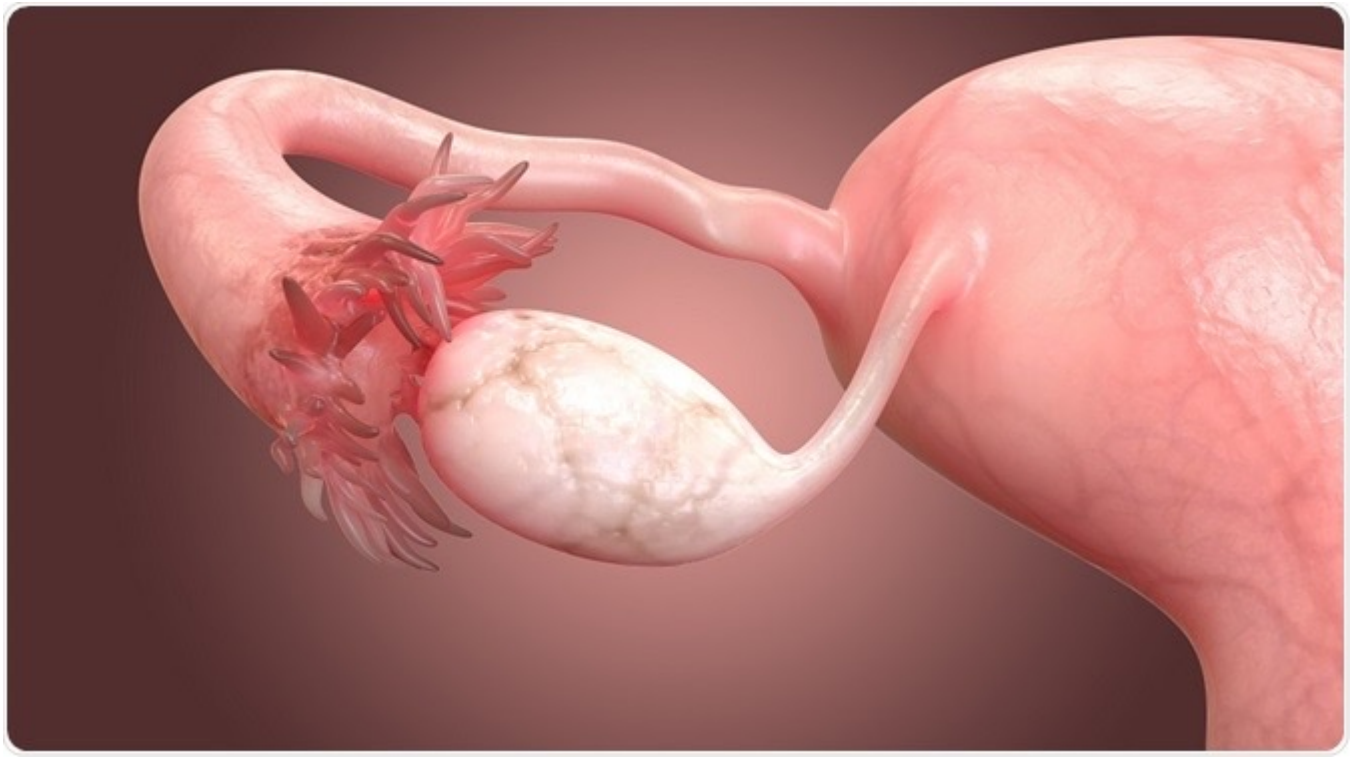
- First line assessment in low-risk women
- Measure Endometrial Thickness on long-axis views
- An endometrial thickness of ≤4 mm has a negative predictive value >99% for endometrial carcinoma
- Probability of endometrial cancer ~0.3%
- Limitations
  - Not diagnostic
  - Questionable accuracy in certain populations
  - Consider SIS or HSG

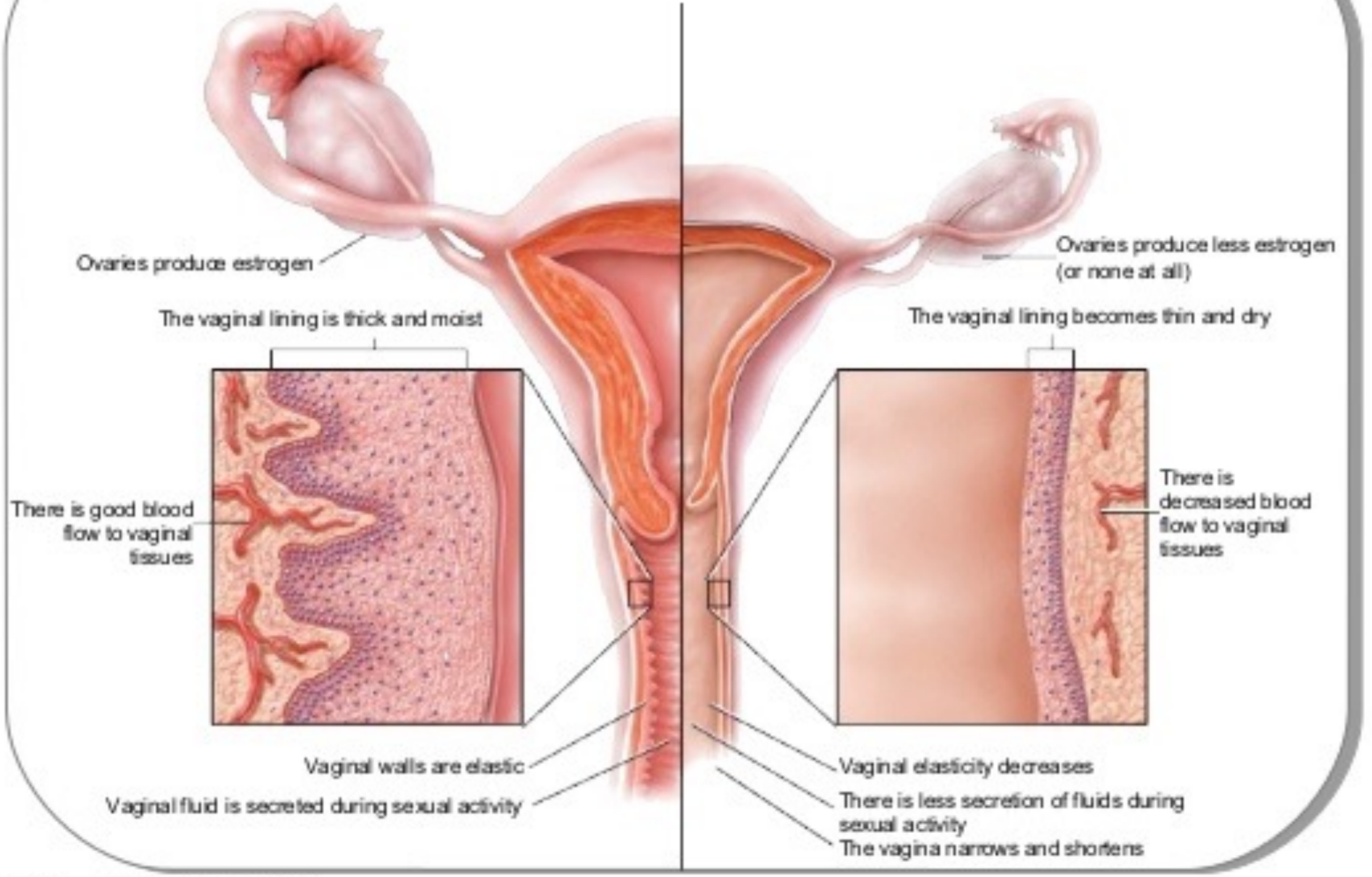
Hysteroscopy with D&C

Management

- Goal directed
  - Stop acute bleeding
  - Avoid irregular or heavy bleeding
  - Prevent complications: anemia, surgical interventions, diminished QOL
  - Contraception

Management: Anovulatory Bleeding in Perimenopause



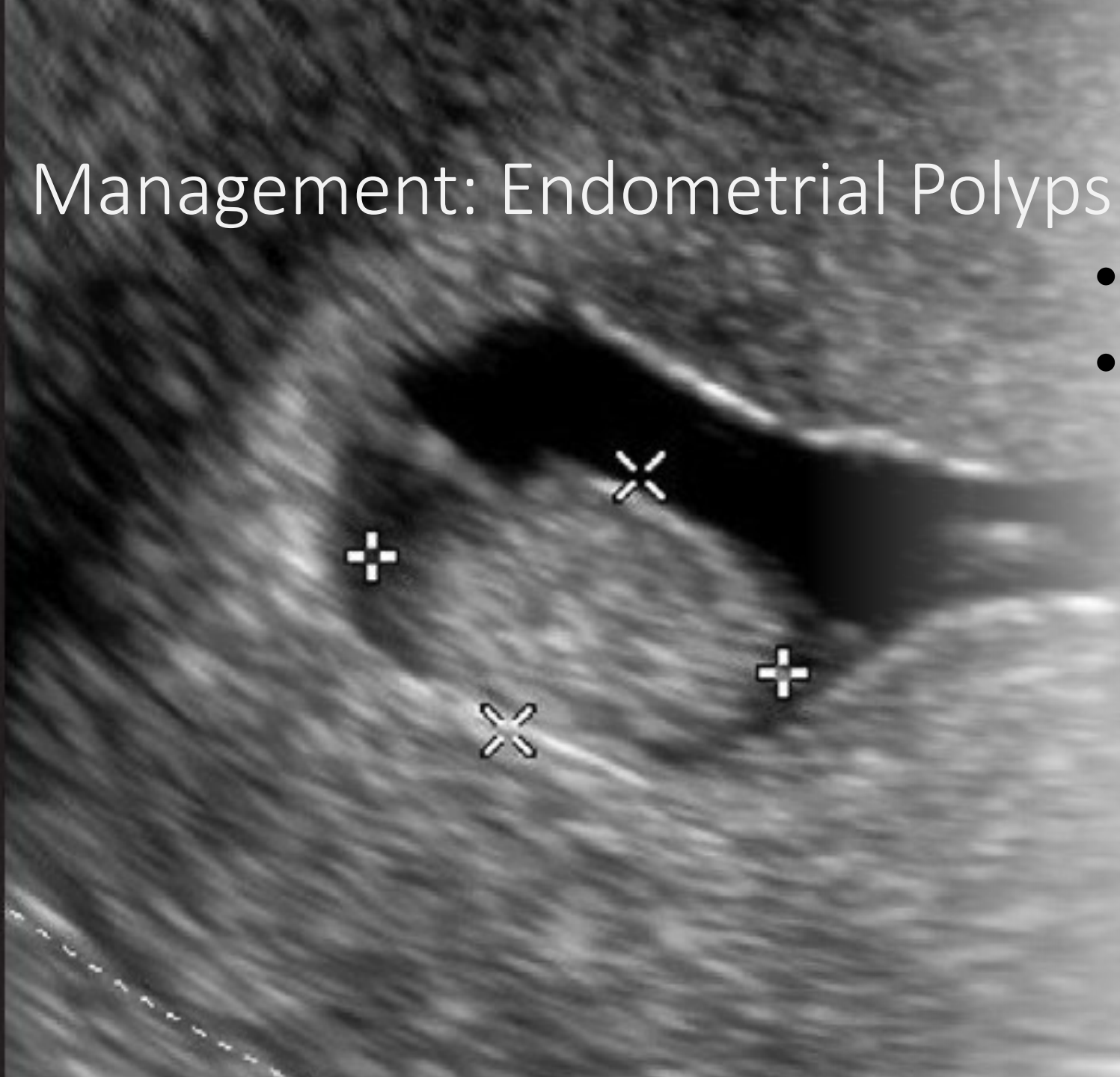


Johnston SL. *Geriatrics & Aging*. 2002;5(7):9-15.

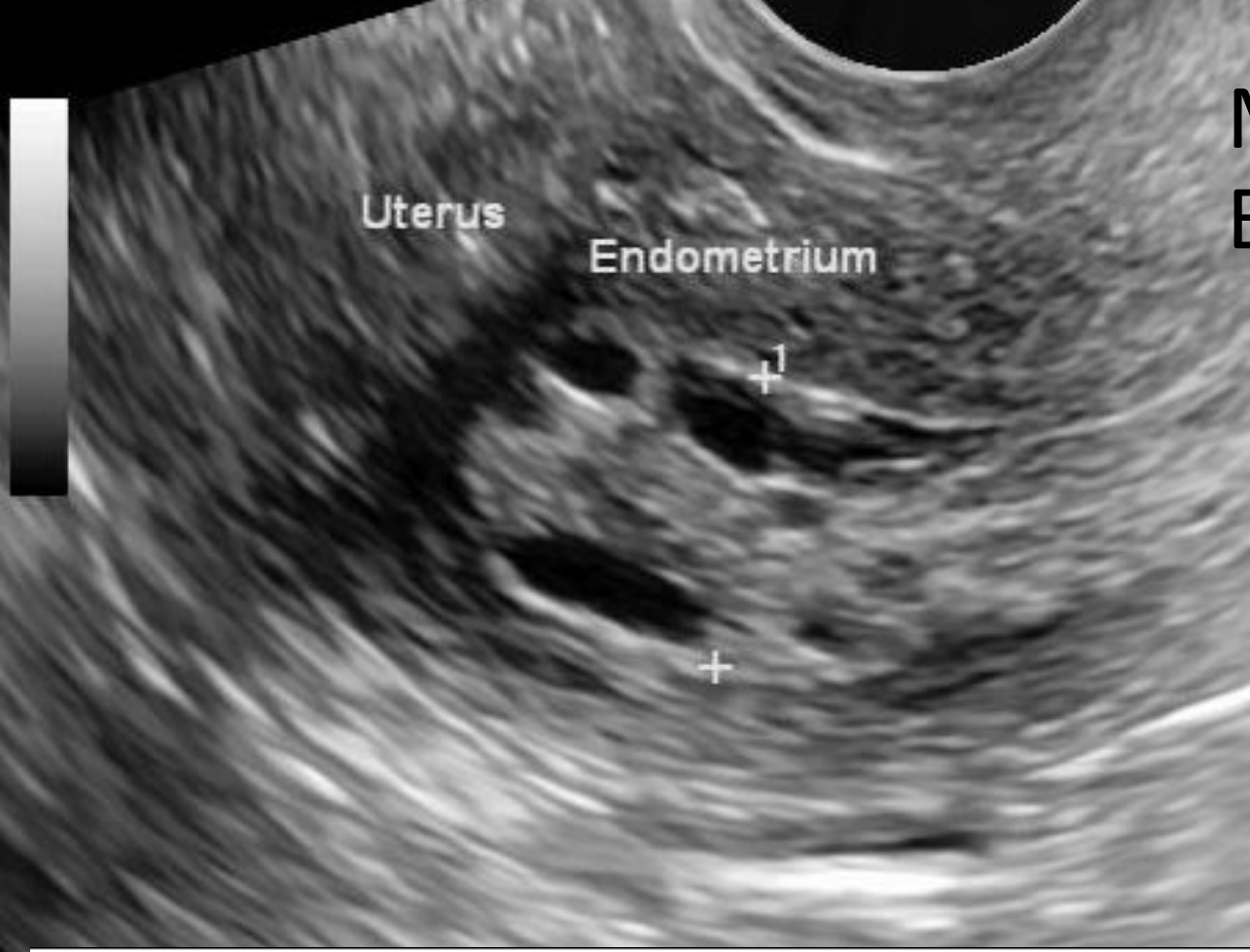
Endometrial Atrophy

- Thickness <4 mm
- Causes chronic inflammation
- Treat for chronic endometritis
- Doxycycline 100 mg BID x 10-12 days

Management: Endometrial Polyps



- Benign 99% of the time
- Surgical Excision if:
  - Symptomatic: bleeding
  - Risk factors present
    - Tamoxifen use
    - Obesity
    - Diabetes



Management: **Benign** Endometrial Hyperplasia

- D&C ± Hysteroscopy
- Hormone therapy
- Endometrial sampling
- Risk reduction strategies: weight loss
- Refer to ONCOLOGY?: EIN, Cancer

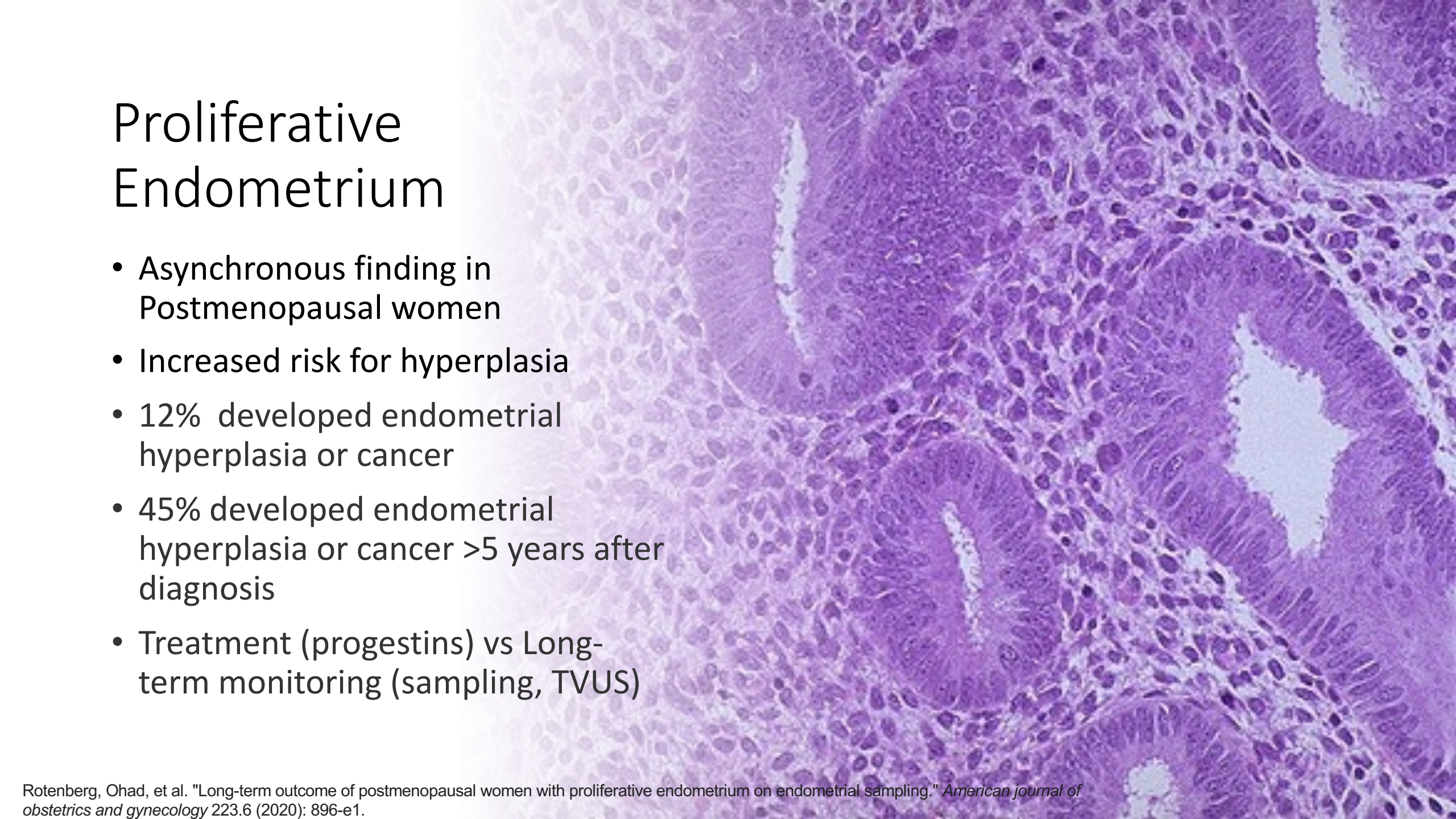
Hormonal Agent	Dosage and Length
Medroxyprogesterone acetate	10–20 mg/d (preferred) or cyclic 12–14 d/mo
Depot medroxyprogesterone	150 mg intramuscularly every 3 mo
Micronized vaginal progesterone	100–200 mg/d (preferred) or cyclic 12–14 d/mo
Megestrol acetate	80 mg twice/d (standard dose), range 40–200 mg/d
Levonorgestrel intrauterine system	52 mg in steroid reservoir over 5 y

Modified from Trimble CL, Method M, Leitao M, Lu K, Ioffe O, Hampton M, et al. Management of endometrial precancers. Obstet Gynecol 2012;120:1160–75. doi: 10.1097/aog.0b013e31826bb121

, Radiopaedia.org, rID: 30100

Proliferative Endometrium

- Asynchronous finding in Postmenopausal women
- Increased risk for hyperplasia
- 12% developed endometrial hyperplasia or cancer
- 45% developed endometrial hyperplasia or cancer >5 years after diagnosis
- Treatment (progestins) vs Long-term monitoring (sampling, TVUS)



Rotenberg, Ohad, et al. "Long-term outcome of postmenopausal women with proliferative endometrium on endometrial sampling." *American journal of obstetrics and gynecology* 223.6 (2020): 896-e1.

Management: Bleeding with Hormone Therapy Use

- No consensus guidelines
- Check the endometrial protection agent
  - Formulation
  - Compliance
- When to evaluate

Case 1

- A 63-year-old woman with well-controlled hypertension
- BMI: 25
- Social: nonsmoker, active but does not exercise
- Transdermal estrogen patch and micronized progesterone since age 49 and does not bleed while on HT
- Increased work travel in the last 4 years: misses 1 to 3 months of HT a few times a year
- Feels better while taking HT, does not experience hot flashes or mood or sleep disturbances
- Sexually active without any issues I
- In the last 6 months, when she is without her HT, she experiences sporadic spotting or bleeding but has not paid much attention to it because it stops when she restarts the HT
- Annual exam: PCP ordered TVUS and referred to GYN
  - EMS 6 mm
- Presents GYN office for HT refill

What do you do?

Case 2

- A healthy 55-year-old postmenopausal woman
- Uterine fibroids and no prior hysterectomy
- Transdermal estradiol with daily oral micronized progesterone for severe VMS with good response and strongly desires continuing
- Bothersome breakthrough bleeding

What do you do?