Bleeding on HRT: Management and Referral Pathway

The following investigations are important prior to referral:

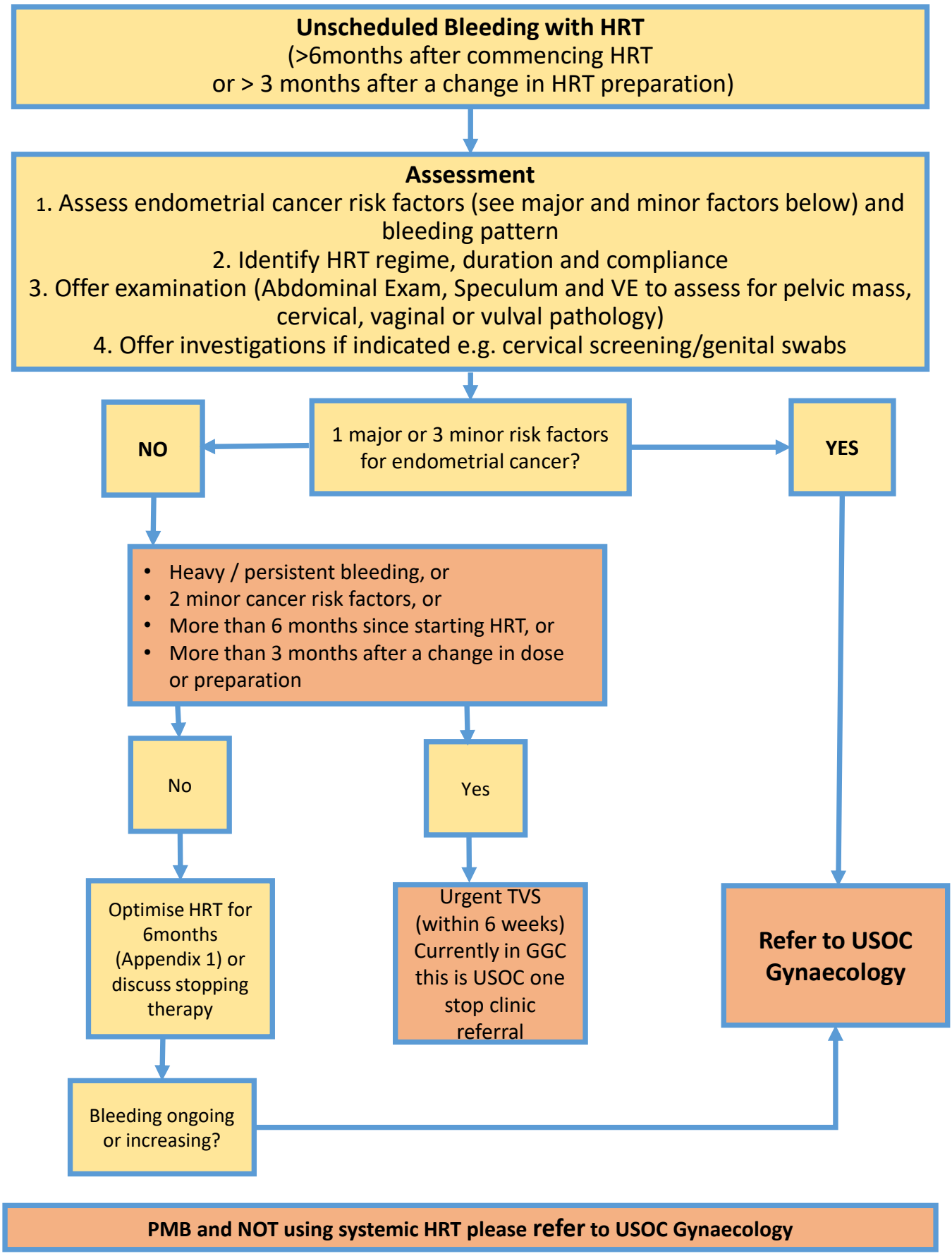
- Abdominal Exam, Speculum and VE (to rule out pelvic mass, cervical, vaginal or vulval pathology)
- Please check compliance prior to referral as missed doses or incorrect application on sequential preparations can result in bleeding.
- If PMB and NOT on HRT please make an Urgent USOC (gynaecology) referral

MAJOR RISK FACTORS

- BMI ≥ 40
- Genetic predisposition (Lynch / Cowden syndrome)
- Oestrogen-only HRT for > 6 months in women with a uterus
- Tricycling HRT (quarterly progestogen) for > 12 months
- Prolonged sequential HRT regime (use for more than 5 years when started in women aged ≥ 45)
- 12 months or more of using norethisterone or medroxyprogesterone acetate for < 10 days / month or, micronised progesterone for < 12 days / month, as part of a sequential regimen

MINOR RISK FACTORS

- BMI 30-39
- Unopposed oestrogen > 3 but < 6 months
- Tricycling HRT (quarterly progestogen) for > 6 but < 12 months
- >6 months but < 12 months of using norethisterone or medroxyprogesteorne acetate for < 10 days / month or, micronised progesterone for < 12 days / month, as part of a sequential regimen
- Where the progestogen dose is not in proportion to the oestrogen dose for > 12 months (including expired 52 mg LNG-IUD)
- Anovulatory cycles, such as in Polycystic ovarian syndrome
- Diabetes


Unscheduled Bleeding with HRT
(>6months after commencing HRT
or > 3 months after a change in HRT preparation)
Assessment
1. Assess endometrial cancer risk factors (see major and minor factors below) and bleeding pattern
2. Identify HRT regime, duration and compliance
3. Offer examination (Abdominal Exam, Speculum and VE to assess for pelvic mass, cervical, vaginal or vulval pathology)
4. Offer investigations if indicated e.g. cervical screening/genital swabs
1 major or 3 minor risk factors for endometrial cancer?
NO
YES
Heavy / persistent bleeding, or
2 minor cancer risk factors, or
More than 6 months since starting HRT, or
More than 3 months after a change in dose or preparation
No
Yes
Optimise HRT for 6months (Appendix 1) or discuss stopping therapy
Urgent TVS (within 6 weeks) Currently in GGC this is USOC one stop clinic referral
Refer to USOC Gynaecology
Bleeding ongoing or increasing?
PMB and NOT using systemic HRT please refer to USOC Gynaecology

Appendix 1 Optimisation of HRT regime

Continuous combined (ccHRT)
- Change to alternative HRT with different progestogen, or
- If on moderate to high dose Oestrogen, increase progestogen
- Decrease Oestrogen dose
- Consider levonorgestrel IUS
- If using LNG IUS, or combined preparation, add progestogen
- Change to sequential HRT if within 6-12 months of starting

Sequential HRT regime (sHRT)
- Change to alternative HRT with different progestogen
- Increase progestogen ie Utrogestan from 200mg to 300 mg
- Increase the duration of progestogen to 14/28 days or 21/28 days.
- Decrease Oestrogen dose
- Consider levonorgestrel IUS

Recommended Progestogen doses

Drug	Continuous Preparation	Sequential Preparation
Micronised progesterone	100 mg PO daily (increase to 200mg if bleeding)	200 mg orally 12 days/cycle (increase to 300mg if bleeding)
Medroxyprogesterone acetate (MPA)	2.5 mg a day	10 mg for 12 days a month
Dydrogesterone	5 mg a day	10 mg for 12-14 days a month
Norethisterone	0.5-1 mg a day enough but 5mg is usual prescribing dose	5 mg for 12 days a month
Levonorgestrel IUS	Can be used for 5 years (Mirena IUS has a license for 4 years in the UK but BMS recommendations up to 5 years use)	

References

British Menopause Society BMS Guidelines, Management of unscheduled bleeding on hormone replacement therapy (HRT), April 2024. 01-BMS-GUIDELINE-Management-of-unscheduled-bleeding-HRT-MAY2024-G.pdf (thebms.org.uk)

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Furness S, Roberts H, Marjoribanks J, Lethaby A. Hormone therapy in postmenopausal women and risk of endometrial hyperplasia. Cochrane Database Syst Rev. 2012 Aug 15;2012(8):CD000402. doi: 10.1002/14651858.CD000402.pub4. PMID: 22895916; PMCID: PMC7039145.

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