Intermenstrual Bleeding

See also:

- Heavy or Irregular Menses
- Postcoital Bleeding
- Post Menopausal Bleeding

Disclaimer

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Background

About Intermenstrual Bleeding

➢ Intermenstrual bleeding (IMB) refers to vaginal bleeding that occurs at any point during the menstrual cycle other than postcoital bleeding or normal menstruation.
➢ IMB is a symptom that always needs further investigation.
➢ Postcoital bleeding (PCB) refers to vaginal bleeding within 24 hours of vaginal intercourse.
➢ Breakthrough bleeding refers to irregular bleeding from the use of hormonal contraception (iatrogenic).

Assessment

Practice Point - Check endometrial cancer risk

Look for concerning pathology in patients aged > 40 years or with risk factors for endometrial cancer.

1. Take a history, and:
   • ask about menstrual, gynaecological, and obstetric history.

Menstrual, gynaecological, and obstetric history

➢ Menstrual history, including:
   o Regularity
   o Cycle length
   o Dysmenorrhoea
   Consider advising the patient to use a menstrual diary (printable version) or suggest patient download an app.
   ➢ Duration, frequency, and severity of IMB symptoms
   ➢ Postcoital bleeding
   ➢ Cervical screening and gynaecological history
   ➢ Type, method, and correct use of hormonal contraception
   ➢ Obstetric history, and if currently breastfeeding

   • assess for causes of breakthrough bleeding if using combined hormonal contraceptives (CHC).

Causes of breakthrough bleeding

➢ Recently started CHC (within 3 to 4 months)
➢ Recent missed pills, vomiting, or diarrhoea
➢ Continuous use of active pills without having regular withdrawal bleeding
- Medicines or supplements that affect hormonal contraceptive metabolism e.g., St John’s wort, grapefruit juice, anticonvulsants

- check for risk factors for cancer.

**Risk factors for endometrial cancer**

- Weight 90 kg or more, often with hypertension and diabetes
- History of chronic anovulation, PCOS, or infertility
- Nulliparity
- Exposure to unopposed oestrogen, either prescribed over-the-counter (OTC) or bioidentical
- Exposure to tamoxifen
- Endometrial thickness over 4 mm in postmenopausal women
- Pelvic ultrasound showing cystic endometrial changes
- Strong family history of endometrial or colon cancer

- consider differential diagnosis.

**Differential diagnosis**

- Physiological – 1 to 2% of women get spotting around ovulation
- Pregnancy-related bleeding
- Breakthrough bleeding from hormonal contraceptive use
- Intrauterine device (IUD)
- Anovulatory menstrual cycle e.g., adolescence, perimenopause, polycystic ovarian syndrome (PCOS)
- Pelvic inflammatory disease e.g., cervicitis, endometritis
- Cervical screening
- Bleeding lesion of vulva or vagina
- Cervical or endometrial polyp
- Cervical cancer
- Endometrial cancer

2. Perform examination.

**Examination**

- Abdominal examination – check for masses or tenderness.
- Speculum examination and cervical screening/co-test – inspect the vulva, vagina, and cervix appearance.
- Pelvic examination – bimanual palpation, cervical excitation.

3. Arrange investigations if indicated:

- Pregnancy test
- **Cervical co-test** (HPV and LBC) – repeat if previous cervical screening > 6 months ago, if previous result was abnormal or if only HPV screen (and not co-test) at previous test
- Offer sexually transmitted infection (STI) screen.
- Transvaginal ultrasound:
  - Best performed on day 5 to 10 of menstrual cycle.
  - Transabdominal pelvic ultrasound can be performed for patients who have not become sexually active, or have declined a transvaginal pelvic ultrasound.
- Consider the need for additional **pathology tests**

**Pathology tests**

*If significant bleeding, consider:*

- FBE
- Iron studies
- Coagulation studies

*If irregular menstrual cycles and not on hormonal contraceptive, consider other hormone studies:*

- Thyroid-stimulating hormone (TSH)
- Prolactin
- Luteinizing hormone (LH), follicle-stimulating hormone (FSH), and estradiol – all best performed on day 2 to 3 of menstrual cycle
- Others as indicated based on clinical presentation e.g., PCOS

**Management**

1. If patient is pregnant (this is not intermenstrual bleeding), consider *Early Pregnancy Bleeding*.
2. If present, manage *postcoital bleeding* (PCB).
3. If suspected or risk factors for malignancy (cervical or endometrial), refer for *urgent gynaecology assessment*.
4. If abnormal cervical screening or co-test, manage according to *Cervical Screening* pathway.
5. If any relevant infection, manage as Sexual Health Screening.
6. If **features suspicious of endometrial cancer** on pelvic ultrasound, refer for *urgent gynaecology assessment*.

**Features suspicious of endometrial cancer**

*Irregular endometrium, cystic, or focal lesion on ultrasound.*

*Note: endometrial thickness depends on the stage of the menstrual cycle and may vary between individual patients. It is not generally used for diagnosis in premenopausal women.*

7. Be aware that normal investigations are not reassuring if bleeding persists. If persistent or unexplained intermenstrual bleeding:

   - If patient aged < 40 years, with normal investigations and no risk factors, and IMB episode of recent onset:
     - Observe for 1 to 2 cycles to see if IMB resolves.
     - If IMB persists, refer for *urgent or routine gynaecology assessment*. 

*South Eastern Melbourne Intermenstrual Bleeding pathway*
• If patient aged > 40 years, or with risk factors for endometrial cancer, ensure early referral for gynaecology assessment even if investigations are normal.

8. If patient taking hormonal contraception:
   • ensure normal cervical screening/co-test, negative results for STI screening, and negative results for pregnancy test.
   • always consider other pathological causes of IMB, especially if bleeding persists.
   • manage according to contraception type:
     • **Combined hormonal contraceptives (CHC)** – if symptoms persist despite a 3 month trial of hormonal manipulation, refer for urgent or routine gynaecology assessment.

     **Combined hormonal contraceptives (CHC)**
     - Ask the patient to take CHC strictly as prescribed, with no missed tablets or skipped periods, for at least one full cycle.
     - If IMB persists, consider trial of a CHC with a higher oestrogen dose e.g., 35 micrograms of ethinyloestradiol.
     - Trial different progestogen.
     - Consider stopping CHC to see if IMB resolves, with the patient using condoms instead. This may place sexually active patients at unacceptably high risk of unplanned pregnancy, and is not recommended in many cases.

     • **Progestogen-only contraception** – a change in usual pattern is concerning and needs further investigation. Request non-acute gynaecology assessment.

     **Progestogen-only contraception**
     - Irregular bleeding is common and expected with progestogen-only contraception e.g., POP, Implanon, DMPA, or mirena.
     - For advice on how to manage troublesome bleeding patterns, see Family Planning NSW – Factsheet.

**Referral**

- Refer for urgent gynaecology assessment if:
  • persistent or unexplained intermenstrual bleeding.
  • suspected or risk factors for malignancy (cervical or endometrial).
  • features suspicious of endometrial cancer found on ultrasound.
  • patient taking CHC, and not responding to trial of hormonal manipulation.
  • patient taking progestogen-only contraception, and has a change in usual pattern requiring further investigation.
Information

For health professionals

Further information

- Cancer Australia – Abnormal Vaginal Bleeding in Pre- and Peri-Menopausal Women
- Patient – Intermenstrual and Postcoital Bleeding
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) – Investigation of Intermenstrual and Postcoital Bleeding

For patients

- Better Health Channel – Vaginal Bleeding: Irregular
- HealthDirect – Irregular Periods
- Jean Hailes – Is Your Period Regular?

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