Provincial Post-Menopausal Bleeding Primary Care Clinical Pathway

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Patient profile:
- >40 years old
- ≥12 continuous months of no bleeding followed by new onset of vaginal bleeding

1. History

- Evaluate bleed (pattern, quantity and non-gynecological sources)
- Pregnancy risk/sexual activity
- Risk factors for gynecological cancers

Risk factors for endometrial cancer:
- Age > 40 years
- Nulliparity
- PCOS
- Irregular cycles
- Lynch syndrome
- Obesity (BMI > 30 kg/m^2)
- Diabetes
- Current tamoxifen use
- Unopposed estrogen exposure

2. Assessment

Trauma Informed Exam Guide

- Vitals / general appearance
- Vulva / vagina / cervix: Atrophic change, trauma, ulcer or mass
- **Pelvic exam**

3. Red Flags

- Patient looks unwell
- Tachycardia / hypotension
- Soaking through >1 high protection product consistently per hour (pad/ tampon/ menstrual cup)
- Fever

Yes → **6. Urgent Advice or Referral**

4. Investigations

If due, Pap Test	If abnormal	Manage as per guidelines
If relevant, STI Screening	If positive	Treat as per guidelines
If relevant, Pregnancy Test	If positive	Manage pregnancy
CBC/Ferritin	If low	Consider transfusion as per guidelines Follow iron deficiency anemia pathway

If urgent abnormal results → **6. Urgent Advice or Referral**

Transvaginal ultrasound
(If not available/ appropriate complete trans abdominal pelvic ultrasound)

5. Manage

Endometrial polyp or submucosal fibroid → **7. Refer to Gynecology**
Follow Provincial Referral Pathway

Endometrial thickness < 5mm
- Reassure patient, no need to refer
- Treat atrophy if necessary
- If recurrent, ongoing bleeding → **7. Refer to Gynecology**

Endometrial thickness ≥ 5mm

Obtain endometrial biopsy. Do not stop hormone therapy prior to biopsy.

If not available in community → **7. Refer to Gynecology**

- Inadequate sample → **7. Refer to Gynecology**
- Proliferative endometrium or hyperplasia without atypia → Consider levonorgestrel IUD or progesterone → Repeat endometrial sampling in 3-6 months. Reassess and if persistent or reoccurring symptoms then refer → **7. Refer to Gynecology**
- Hyperplasia with atypia or malignancy → **7. Refer to Gyne-Oncology**

This primary care pathway was co-developed by primary and specialty care and includes input from multidisciplinary teams from all five zones. It is intended to be used in conjunction with specialty advice services, when required, to support care within the medical home.

EXPANDED DETAILS

Pathway Primer

- Recent updates to this pathway were made **March 2025**; see Pathway Update Notes for details.
- This clinical pathway was created to provide primary care clinicians with guidance on evidence-based diagnosis, investigations, medical management, and appropriate referral to gynecology for patients with postmenopausal bleeding. This pathway does not apply to premenarchal persons with a uterus who have abnormal uterine bleeding - please refer to the Provincial Adult Abnormal Uterine Bleeding Primary Care Pathway instead for that guidance.
- Post-menopausal bleeding is defined as new onset bleeding that occurs after at least one year of amenorrhea an individual with a uterus older than 40 years of age. Post-menopausal bleeding occurs in between 4% -11%of women and is usually attributable to an intrauterine source [1]. However, bleeding can occur from the cervix, vagina, vulva, fallopian tubes, the bladder, or bowel.
- Abnormal uterine bleeding should be evaluated promptly, as it is the presenting sign of endometrial cancer in 90% of women [2]. Endometrial cancer is a very common gynecological malignancy, with an incidence in Canada of 19 cases per 100,000 women [3].

1. History

The patient history obtained from the individual who presents with vaginal bleeding after menopause should focus on a review of risk factors for gynecological cancers and on eliminating other possible causes for bleeding as listed in the differential diagnosis. Use pronouns and names appropriate to the patient's gender identity and use gender-inclusive language throughout the interaction.

- **Evaluate the bleeding pattern, including quantity and timing**
- **Assess pregnancy risk and sexual activity**
- **Review the risk factors for gynecological cancers:**
  Endometrial Cancer Risk Factors
  The average age for women with endometrial cancer is 61 years, but 5% - 30% of cases can occur in premenopausal women [4]. Women younger than 50 years of age can share many of the same risk factors for endometrial cancer as older women.
  - Age > 40 years
  - Obesity (BMI > 30 kg/m^2)
  - Nulliparity
  - PCOS (polycystic ovarian syndrome)
  - Irregular cycles
  - Diabetes
  - Lynch syndrome or HNPCC (hereditary non-polyposis colorectal cancer)- the most common hereditary form of hereditary colorectal cancer
  - Current tamoxifen use
  - Unopposed estrogen exposure

Cervical Cancer Risk Factors

- Suboptimal cervical screening
- Multiparity
- HPV infection
- Sexual activity:
  - Becoming sexually active at a young age (especially younger than 18 years old)
  - Multiple sexual partners
  - Having one partner who is considered high risk (someone with HPV infection or who has many sexual partners)
- Weakened immune system
- Chlamydia infection
- Long-term use of oral contraceptives
- Family history of cervical cancer

Ovarian Cancer Risk Factors

- Hereditary
  - Family history of ovarian cancer
  - Personal history of breast cancer
  - Alteration in BRCA1 or BRCA2
  - Lynch syndrome
- Reproductive
  - Advanced age
  - Nulligravity
  - Infertility
- Hormonal
  - Early age at menarche
  - Late age at natural menopause
  - Hormone replacement therapy
  - Estrogen
  - Androgens
- Inflammatory
  - Perineal talc exposure
  - Endometriosis
  - Pelvic inflammatory disease
- Lifestyle
  - Obesity
- Geography
  - Extremes in latitude

- **Review Differential Diagnoses**

  Other potential causes for post-menopausal bleeding include:
  - Non-gynecologic sources of bleeding: bladder/kidney, urethral caruncle, and bowel as a source
  - Endometrial or cervical polyp
  - Proliferative endometrium, or endometrial hyperplasia (with atypia and without atypia)
  - Endometrial carcinoma
  - Cervical dysplasia or cervical cancer
  - Vulvar, vaginal, or endometrial atrophy
  - Submucosal fibroid
  - Sexually transmitted infection
  - Foreign body in the vagina (e.g., a retained pessary)

2. Assessment

The physical examination should identify evidence of systemic conditions or anatomical causes of bleeding.

- Providing Trauma-Informed Care is critical. Providers are encouraged to refer to the Canadian Public Health Association Guide for providing trauma informed exams.
- **It is highly recommended that patients should receive a pelvic exam, including inspection of external genitalia, speculum and bimanual exams.**
- Examine the external genitalia for ulcers or atrophic tissue, which could be the source of the bleeding.
    - If ulcers are present, initiate an urgent referral to gynecology for biopsy and medical management. A biopsy can be taken by the primary care provider if skilled in this area.
- Inspect and palpate internally for abnormalities such as fibroids, masses or cervical polyps. If concerning lesion or mass present, initiate an urgent referral to gynecology for biopsy and medical management. A biopsy can be taken by the primary care provider if skilled in this area.

3. Red Flags

- Patient looks unwell
- Tachycardia/ hypotension
- Flooding through >1 high protection product consistently per hour (pad/ tampon/ menstrual cup)
- Fever

If red flags are present or the patient is medically unstable, call RAAPID for an urgent referral to gynecology for immediate hospital evaluation, or call 911.

4. Investigations

- If the patient is due, include a **PAP test** (TOP Cervical Cancer Screening Guideline).
- If there is post-coital bleeding or vaginal discharge, initiate testing for:
    - Chlamydia
    - Gonorrhea
    - Trichomonas
    - Bacterial Vaginosis
    - Yeast
- If **STI testing is positive**, treat as per provincial guidelines (Alberta STI Treatment Guidelines).
- If **STI testing is negative**, but the cervix appears friable, initiate a trial treatment for mucopurulent cervicitis (Alberta STI Treatment Guidelines). Persistent symptoms that do not respond to treatment should be referred to gynecology.
- **Rule out and/or manage pregnancy**:
    - Perform a sensitive urine or serum pregnancy test if there is any possibility of pregnancy.
        - If the patient has a positive pregnancy test and is bleeding, ensure the pregnancy is viable and intrauterine with a pelvic ultrasound.
        - If the pregnancy is NOT viable and intrauterine and the patient is stable, link to early pregnancy loss clinic, if available or local hospital. You can search the Alberta Referral Directory to find an early pregnancy loss clinic in your zone.
    - If this is a possible ectopic pregnancy or the patient is bleeding heavily or is medically unstable, call RAAPID for referral to gynecology.

- **CBC/ Ferritin**: For all stable patients, consider ordering a CBC/Ferritin. Treat as appropriate:
  - Follow the Using Blood Wisely Guidelines when considering a transfusion
  - Follow the Iron deficiency anemia pathway
  - There is no utility to requesting FSH/ LH/ estradiol or progesterone levels [5]
- **Thyroid testing**: Thyroid functioning testing is not indicated unless there are clinical findings suggestive of an index of suspicions of thyroid disease [3].
- **Coagulation disorders:** Testing for coagulation disorders should only be considered in women with heavy bleeding since menarche or who have a family history/personal history of abnormal bleeding.
- **Transvaginal pelvic ultrasound:** For all stable patients, perform transvaginal pelvic ultrasound to rule out uterine structural causes for abnormal bleeding (e.g., polyp).
  - You can refer to the Canadian Public Health Association Guide for providing trauma informed exams.
  - If a transvaginal pelvic ultrasound is not available or appropriate for the patient, please complete a trans abdominal ultrasound.

5. Management

A post-menopausal endometrial thickness assessment is best evaluated with a transvaginal ultrasound, so please encourage the patient to be prepared for this assessment.

Ultrasound findings

- **Fibroids / Polyps:**
  - If a polyp or submucosal fibroid is present, these findings may cause post-menopausal bleeding and a referral to gynecology is indicated.
  - Intramural fibroids and serosal fibroids do not usually cause post-menopausal bleeding, but if your patient is experiencing pressure symptoms or pain, a referral to gynecology is indicated.
- **Endometrial Thickness Assessment:**

  Endometrial thickness <5mm
  - If endometrial thickness <5mm with vaginal bleeding due to atrophy, attempt medical therapy.
  - Trial of topical moisturizer (e.g., Replens®).
  - Trial of topical vaginal estrogen (insertion):
    - For 14 days, applied at night daily, then two to three times/week for maintenance if symptoms improve.
  - If the patient is taking tamoxifen, initiate a referral to gynecology for any vaginal bleeding. Do not prescribe vaginal estrogens for atrophy, but you may trial Replens® or a non-hormonal vaginal moisturizer while awaiting referral.

  Endometrial thickness ≥5mm
  - There is no need to stop hormone therapies prior to biopsy.
  - If endometrial thickness ≥5mm with vaginal bleeding, refer to gynecology or skilled community primary care physician for endometrial sampling.
    - **Hyperplasia without atypia [6]**
      - If sampling suggests hyperplasia without atypia, begin progesterone treatment (levonorgestrel IUD or progesterone 200mg PO QHS).
      - A minimum treatment duration of 6 months is usually necessary. Repeat endometrial sampling is indicated in three to six months to ensure resolution of endometrial hyperplasia even if bleeding has ceased. If IUD is in place, endometrial sampling can be completed. Consider referral to gynecology if collection of repeat endometrial sampling support is needed.
      - If bleeding persists, refer to gynecology.

- **Proliferative endometrium**
  - No hyperplasia or malignancy, start medical treatment with Progesterone-only methods (e.g., Progesterone 100-200mg or levonorgestrel IUD).
- **Hyperplasia with atypia or malignancy:** If sampling suggests hyperplasia with atypia or endometrial carcinoma, make an urgent referral to Gyne-ONCOLOGY (Gynecological Oncology).

Follow-up

- If there is successful cessation of bleeding on progesterone therapy, discontinue the therapy after 1 year.
- If there is successful cessation of bleeding with levonorgestrel IUD, remove after duration of device (~5 years).
- If the patient has any further bleeding, they will need to be re-assessed again with transvaginal ultrasound, endometrial sampling, and should have a referral to gynecology for consideration of hysteroscopic sampling.

6. Advice Options

Severe bleeding or medical instability (i.e., soaking through a protective product per hour or abnormal vital signs). This patient needs to be directed to hospital through RAAPID or the ER. Call RAAPID for on-call gynecologist or 911.

Zone	Program	Online Request	Phone Number
Urgent Telephone			
All Zones	RAAPID	N/A	**North:** 1-800-282-9911 or 780-735-0811 **South:** 1-800-661-1700 or 403-944-4486
Non-Urgent Electronic			
Calgary, Central, North, South	Netcare eReferral		N/A
Non-Urgent Telephone			
Edmonton, North	ConnectMD	Online Request	1-844-633-2263
Calgary	Specialist Link	Online Request	403-910-2551

You can request non-urgent advice at any point when uncertain about medications, next steps in treatment, investigations, or resources available.

7. Referral Process

Referral pathways are guidelines to help referring providers know what information, labs and diagnostic imaging are required with their referral to a specialty.

Referral pathways are co-designed with Primary and Specialty Care, AHS Operations, and patients to ensure the right amount of information is included throughout the referral process to triage the patient as quickly as possible.

To ensure referring providers have referral information at their fingertips, referral pathways may link to clinical pathways when available. AHS manages referral pathways and extensive work is ongoing as part of the Alberta Surgical Initiative. If you have questions or want to know more about the referral pathway development process, please email access.ereferral@ahs.ca.

- **Urgent Referral** – Call gynecologist on call via RAAPID or call 911.
- For all referrals to gynecology please ensure to follow the Provincial Gynecology, Adult Referral Pathway.
- For hyperplasia with atypia or malignancy, send referral to Gyne-**Oncology** (Gynecological Oncology):
  - **Calgary:** Send referral to the **Arthur J.E. Child Comprehensive Cancer Care Centre**
  - **Edmonton:** Send referral to the **Cross Cancer Institute New Patient appointment office**
- Alberta Referral Directory is also a helpful resource for all referral information.

BACKGROUND

About this pathway

- This pathway was initially developed under the auspices of the Calgary Zone Department of Gynecology in 2020 by a multidisciplinary team led by family physicians and gynecologists.
- Condition-specific clinical pathways are intended to offer evidence-based guidance to support primary care providers in caring for patients with a range of clinical conditions.

Authors and conflict of interest declaration

- In March 2023, in collaboration with gynecologists, primary care physicians, patient and family advisors, and the Provincial Pathways Unit (PPU), the Calgary Zone pathway was reviewed and revised in order to make it a provincial primary care clinical pathway for use in Alberta.
- Names of participating reviewers and their conflict-of-interest declarations are available on request.

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Pathway review process, timelines

Primary care pathways undergo scheduled review every three years, or earlier if there is a clinically significant change in knowledge or practice. The next scheduled review is **May 2027**. However, we welcome feedback at any time. Please provide your feedback here or email comments to albertapathways@primarycarealberta.ca.

Copyright information

DISCLAIMER

This pathway represents evidence-based best practice but does not override the individual responsibility of healthcare professionals to make decisions appropriate to their patients using their own clinical judgment given their patients' specific clinical conditions, in consultation with patients/alternate decision makers. The pathway is not a substitute for clinical judgment or advice of a qualified healthcare professional. It is expected that all users will seek advice of other appropriately qualified and regulated healthcare providers with any issues transcending their specific knowledge, scope of regulated practice or professional competence.

PROVIDER RESOURCES

Resources	Link
TOP Guideline – Cervical Cancer Screening	actt.albertadoctors.org/CPGs/Lists/CPGDocumentList/Cervical-Cancer-Screening-Summary.pdf
Alberta STI Treatment Guidelines	open.alberta.ca/publications/treatment-guidelines-for-sti-2018

PATIENT RESOURCES

This section is intended to list resources that primary care providers may find useful to share with patients to help support self-management and care in the medical home.

Resources	Link
Patient Pathway on MyHealth Alberta > A webpage and two PDF formats are available to allow for easy printing, download, or scanning a QR code with the patient's smart phone for more information at their convenience.	Your Journey with Post-Menopausal Bleeding: myhealth.alberta.ca/HealthTopics/post-menopausal-bleeding-pathway/Documents/post-menopausal-bleeding-pathway-summary.pdf
MyHealth Alberta - Menopause and Perimenopause: Information on causes, symptoms, treatments and resources for women	myhealth.alberta.ca/health/pages/conditions.aspx?Hwid=hw228763#hw228868

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PATHWAY UPDATE NOTES

March 2025

- Gynecology-Oncology referral information updated