Investigation and Management of Post-Coital Bleeding UHL Gynaecology Guideline

University Hospitals of Leicester NHS Trust

Trust ref: C11/2022

1. Introduction and Who Guideline applies to

Post-coital bleeding (PCB) refers to spotting or bleeding that occurs after intercourse and is not related to menstruation. The point prevalence ranges from 0.7 to 9.0% with one report indicating that the annual cumulative incidence is 6% among menstruating women [1]. In women under the age of 35 years, the most important cause to exclude is chlamydial infection whilst in women over the age of 35 years it is cervical cancer. Post-coital bleeding is commonly caused by cervical or endometrial polyps, cervicitis as a result of chlamydia or gonorrhoea and vaginitis associated with trichomoniasis or candidiasis. Endometritis in the presence of an intrauterine contraceptive device (IUCD) can occasionally cause post-coital bleeding. PCB is rarely caused by cervical intraepithelial neoplasia and cervical cancer [2]. Reassuringly, 60% of naturally menstruating women with post-coital bleeding will have spontaneous resolution of symptoms within six months and half of these women will maintain resolution for two years [1].

This guideline supports medical and nursing staff working within gynaecology services at UHL but is also a useful point of reference for the community based Leicestershire GP and sexual health practices.

Contents

Table 1. Aetiology of PCB by anatomical location.

Anatomical location	Cause of PCB
Vaginal	Vaginitis Vaginal atrophy Vaginal cancer Vaginal endometriosis
Cervical	Ectropion Polyp Infection Cervical Intraepithelial Neoplasia Cervical cancer Cervical endometrioisis Vascular malformation
Uterine	Endometrial polyp Endometritis Endometrial cancer
Other	Trauma Foreign Body

2. Guideline Standards and Procedures

The primary role of a PCB clinic is to exclude pre-cancerous or cancerous changes in the cervix. Post-coital bleeding is the presenting complaint in 11% of women with cervical cancer [5], however, PCB is a common symptom and the majority of women with post-coital bleeding will not have pre-invasive or invasive cervical disease. Reassuringly, 97.7% of women presenting with post-coital bleeding whose last cervical screening was negative or inadequate were found to have no significant pathology identified at colposcopy however, around 2% of women were found to have pre-invasive or invasive cancer justifying assessment by a gynaecologist in secondary care for women presenting with PCB [8]. Table 2 outlines the risk of cervical cancer in women presenting with post-coital bleeding stratified by age at presentation.

3,152 women are diagnosed with cervical cancer in the UK each year with the highest incidence rates found in women aged 30-34 [6]. Risk factors for cervical cancer include failure to participate in cervical screening, HPV infection, smoking, prolonged COCP use and immunosuppression [5]. A family history of cervical cancer is associated with an increase in risk of cervical cancer although no specific genetic mutations have been identified suggesting shared risk factors may be primarily responsible for any familial association [5]. Incidence rates of cervical cancer are expected to fall following the introduction of the HPV vaccination programme [5].

Age (years)	Risk of cervical cancer
20-24	1: 44,000
25-34	1: 5,600
35-44	1: 2,800
45-54	1: 2,400

Table 2. Risk of cervical cancer in women presenting with post coital bleeding [7]

Scope of PCB Clinics

There are no established guidelines from the American College of Obstetricians and Gynaecologists or the Royal College of Obstetricians and Gynaecologists or evidence from randomized clinical trials to base recommendations on diagnosis and treatment of post-coital bleeding. The National Health Service cervical screening programme recommends women with post coital bleeding should be referred for examination by a gynaecologist experienced in the management of cervical disease (for example a cancer lead gynaecologist) once common causes (infection and contraception) have been excluded in primary care [3]. Gynaecologists may refer such individuals for symptomatic colposcopic examination outside the cervical screening programme if cancer is suspected [3]. NICE recommendations for suspected cervical cancer referrals do not include symptoms but recommend referral if the appearance of the cervix is suspicious of cancer [4].

In UHL we have developed a PRISM pathway for PCB referrals to streamline their care. This includes exclusion of common and obvious causes of PCB (i.e. infections, polyps and contraceptive use) which enables these women to be seen by clinicians experienced in cervical diseases who are Colposcopy Accredited. Women are assessed within 6 weeks of referral. All women referred via the PRISM pathway must have an in-date cervical smear, a recent infection screen to exclude chlamydia, gonorrhoea, trichomonas and candida infections and a speculum examination must have been performed in primary care. Pregnancy should be considered and excluded as appropriate.

The majority of these women have concomitant symptoms of heavy menstrual bleeding and intermenstrual bleeding; it is beyond the scope of the PCB service to deal with these symptoms. Those with treatable conditions such as polyps, endometritis, cervicitis and ectropion will be offered appropriate treatments within these clinics. Women with no underlying cause for their post-coital bleeding will be referred back to the GP with advice for further referral to Benign Gynaecology if symptoms of HMB and IMB are persistent.

Rationale for the Virtual PCB Clinic

In May 2020, the RCOG published guidance related to the management of unscheduled vaginal bleeding in view of the COVID-19 pandemic [9]. The RCOG recommended that women with PCB can initially be managed in a virtual clinic primarily to reassure women that cervical cancer is extremely unlikely if they have an in-date negative cervical screening test. Risk factors for sexually transmitted disease should be assessed and if identified, ongoing referral to sexual health services should be made for appropriate assessment and treatment of these women. Women with absent or overdue cervical screening require a speculum examination and smear test which can be carried out in primary care [9].

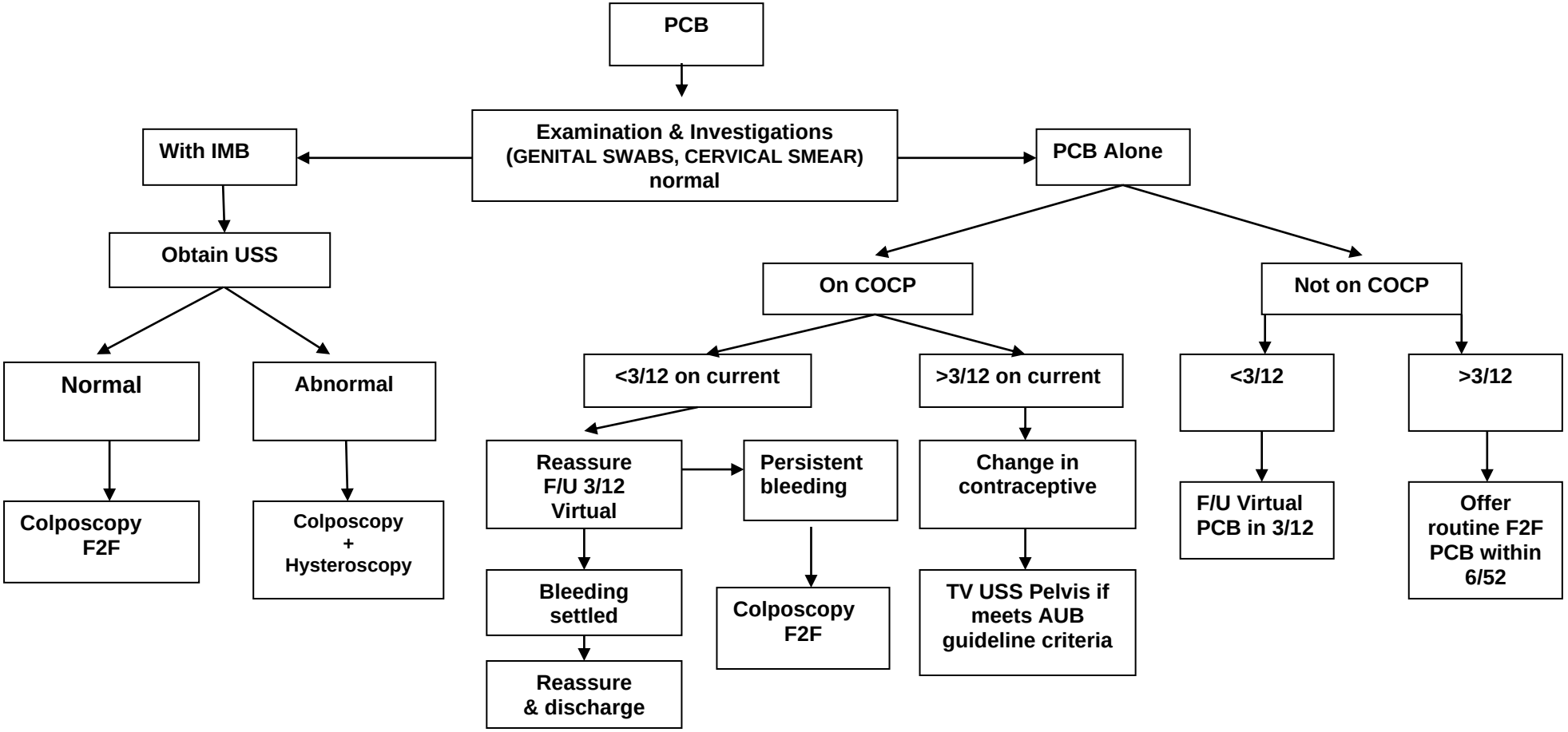
The RCOG recommended that the following women should be seen in secondary care within 14 days if the appearance of the cervix is consistent with cervical cancer, women aged 35 years or under with abnormal, absent or overdue cervical screening or women over 35 years, regardless of smear history. Women with PCB aged under 35 years should have an appointment (virtual or F2F) in secondary care within 42 days if they have a negative in-date cervical smear and investigated according to local protocols and testing resources [9].

With this in mind, we have developed local protocols for a virtual PCB clinic to enable triage of patients into rapid access URGENT face-to-face PCB clinics or into routine PCB follow-up protocols with appropriate investigation and management of symptoms based on availability of local resources. The following flow-charts describe the recommended assessment, further investigation and initial management of patients in the virtual PCB clinic. Patients referred to the face-to-face PCB clinic will be assessed and managed by an accredited colposcopist and consultant with experience in the management of cervical disease.

Name ……..

Post……..

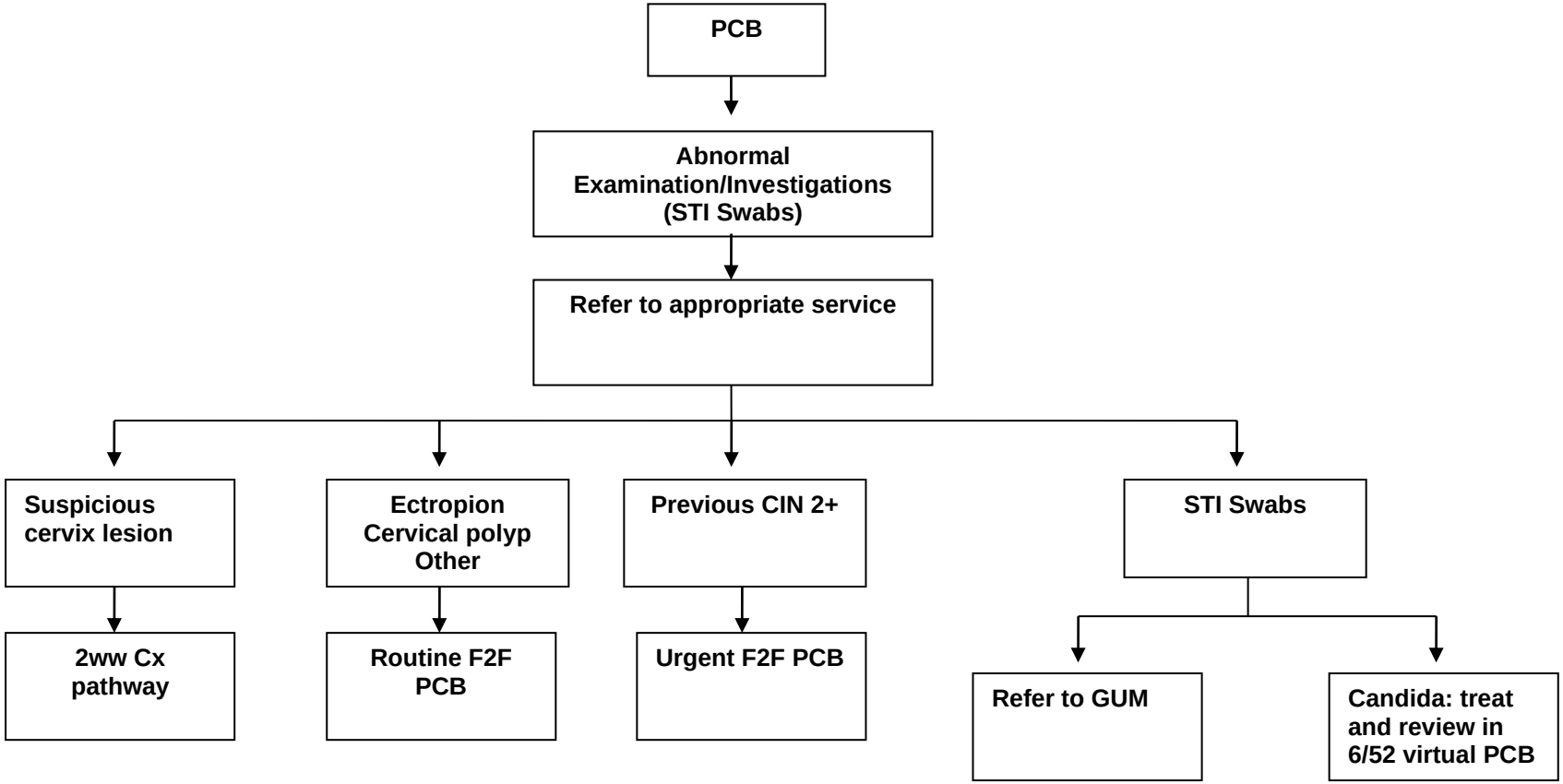
PCB WITH NORMAL EXAMINATION AND INVESTIGATIONS BY GP



PCB	Post coital bleed	**TV**	Trans vaginal
AUB	Abnormal uterine bleeding	**F2F**	Face to face
COCP	Combined oral contraceptive pill	**F/U**	Follow-up
IMB	Intermenstrual bleeding	**USS**	Ultrasound scan

Clinic for F2F Booking. Colp and Hysteroscopy: H.Ball, V Shesha PMB, A.Banerji PMB

PCB AND ABNORMAL EXAMINATION AND INVESTIGATIONS



Colposcopy only: L.Spence, I.Silina, H.Ball Colp Clinics.

3. Education and Training

e-learning for Sexual and Reproductive Healthcare (e-SRH) supports healthcare professionals in acquiring the relevant knowledge needed for delivering sexual and reproductive healthcare. You will need an e-LfH account. You can register on their website here to access the eSRH.

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Number of referrals discharged after virtual consultation	Service evaluation Audit	Dr.V.Shesha	6 monthly	Audit Meeting presentation
Number needed to be seen F2F	Service evaluation Audit	Dr.V.Shesha	6 monthly	Audit Meeting presentation
Number diagnosed with Precancer or cancer.	Service evaluation Audit	Dr.V.Shesha	Yearly	Audit Meeting presentation

5. Supporting References

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7. Michelle A.L. Godfrey, Manolis Nikolopoulos, Natalia Povolotskaya, Rashna Chenoy, Rekha Wuntakal, Post-coital bleeding: What is the incidence of significant gynaecological pathology in women referred for colposcopy? Sexual & Reproductive Healthcare, Volume 22, 2019, 100462, ISSN 1877-5756, https://doi.org/10.1016/j.srhc.2019.100462.
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9. Morgan S, Datta S. Intermenstrual and post-coital bleeding. Obstetrics, Gynaecology & Reproductive Medicine. 2017;27(12):379-84.
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6. Key Words

Candidiasis, Cervical cancer, Chlamydia, Colposcopy, Ectropion, Gonorrhoea, Hysteroscopy, Polyps, Spotting, Trichomoniasis

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The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

Development and approval record for this document			
Author / Lead Officer:	V Shesha - Consultant	**Executive lead**: Chief Medical Officer	
Reviewed by:	New document		
Approved by:	UHL Gynaecology Governance Committee	**Date Approved:** March 2022	

REVIEW RECORD			
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October 2021	1		New document

Appendix 1 - Post coital bleeding Clinic History sheet

Clinician:
Date
Height **cm**
Weight **kg**
BMI
Age

Addressograph

Telephone ☐ **Face to Face** ☐

Referred by: GP ☐ **Gynae** ☐ **Other** ☐

GP opinion about the cervix: Suspicious ☐ **Polyp** ☐ **Other** ☐

Presenting Complaint(s):

- ☐ **Post Coital bleeding**
- ☐ **Intermenstrual Bleeding**
- ☐ **Heavy Periods – Regular/Irregular**
- ☐ **Unscheduled PVB on HRT**
- ☐ **Peri-menopausal bleeding**
- ☐ **Postmenopausal PVB**

Parity + {___vaginal; ___CS}

LMP
Last Smear *(Date)* _____

Result _____

Previous Colposcopy/LLETZ

Histology

Duration:

Previous episodes:

Contraception:

History to exclude STI: ***(previous STI, partners, trauma etc)***

PGHx (specify if)

PMHx ***DHx***

PSHx **Allergies**

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SHx–

Smoking: Never / Ex ___ yrs. ago / current _____per day

Alcohol: _____ units/week

HVS swab: *result/date*

Signature……..

Chlamydia/GC swab: *result /date*

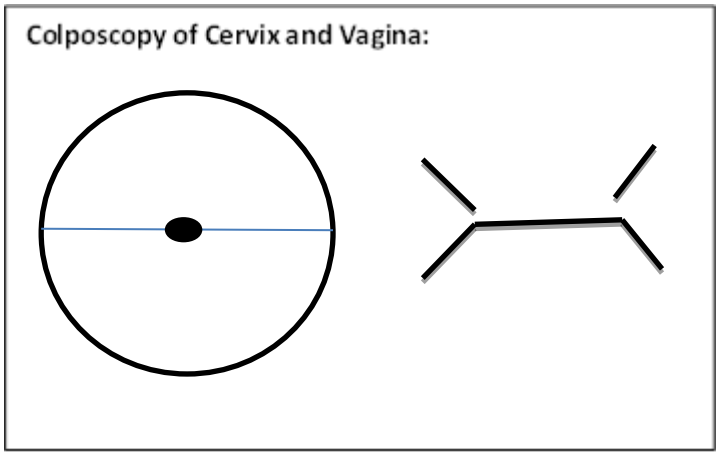
Name…….

Examination: Date:

Clinician:

<u>Findings:</u> **O/E PA:** **PS: V&V -** **PV: Uterus- *(if appropriate)***

Adnexae



<u>Investigations</u>

USS: *result/date*

Cervical punch biopsy: *single /multiple*

Pipelle:

<u>Clinical impression:</u>

Follow up:

☐ **Return for treatment: (Cautery / Ablation / LLETZ)**

☐ **Booked for Hysteroscopy: Urgent / Routine**

☐ **Telephone consultation in _____weeks**

☐ **Write with results**

☐ **Advised change of contraceptive to _____**

☐ **Refer to general Gynae for _____**

☐ **Discharge to GP**

Additional Information:

Signature……

Name ……..

Post……..