

Is post-menopausal bleeding (PMB) being over investigated in secondary care?

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OBJECTIVES

PMB is a common gynaecological presentation caused by a range of pathologies from benign to sinister. In secondary care, National guidance advises patients with PMB and an endometrial thickness (ET) of $\geq 4\text{mm}$ should receive hysteroscopy only if there is ‘a focal lesion or polyp, the patient is on tamoxifen or if bleeding is recurrent after a negative Pipelle’. Otherwise, an endometrial biopsy alone is adequate. Patients assessed in PMB clinic were reviewed to assess concordance with this national standard.

RESULTS

Of the 290 new patients, 188 had an ET $\geq 4\text{mm}$ (Figure 1). Ten women (5.3%) had no biopsy completed; 12 (6.4%) had an endometrial biopsy only. Outpatient hysteroscopy (OPH) and biopsy was performed in 131 (69.7%) and 35 (18.6%) had an inpatient hysteroscopy (IPH) and biopsy (Figure 2). Overall, 166 patients (88.3%) underwent hysteroscopy despite only 43 (25.9%) having one or more documented criterion that warranted hysteroscopy (Figure 3). All investigative outcomes are summarised in Figure 4. There were eight cases (2.8%) with abnormal endometrial histology (six endometrial cancers, one atypical endometrial hyperplasia and one minimal atypia). All six endometrial cancer cases had either a focal lesion or polyp on the TVUS or were unable to tolerate a TVUS so had an IPH completed.

CONCLUSION

A hysteroscopy was completed in three quarters of patients where, according to the current guidelines, a less invasive endometrial biopsy would have been appropriate. No cases of endometrial carcinoma would have been missed if this approach had been adopted. As an estimate of the cost, the tariff for an OPH was £428 with an IPH costing organisations significantly more due to additional theatre and bed costs. Not only is a hysteroscopy associated with significant costs but it also requires a skilled operator and team in a dedicated, specialist, clinic. A wider range of healthcare professionals can perform an endometrial biopsy, often in a less resource hungry setting. Pipelle biopsy offers a high diagnostic accuracy when an adequate specimen is obtained with a post-test probability of endometrial cancer of 81.7% (95% CI 59.7%-92.9%) for a positive test and 0.9% (95% CI 0.4%-2.4%) for a negative test. From the patient’s perspective, a hysteroscopy is more time consuming and may be associated with more discomfort than endometrial biopsy alone.

METHODS

The records of all patients who attended PMB clinic were analysed over a one-year study period of 1st May 2021 to 30th April 2022. The handwritten notes, letter to the General Practitioner (GP), transvaginal ultrasound scan (TVUS) and histology reports were reviewed. Data regarding investigation modality, setting, endometrial thickness and outcome were extracted and compared against NICE guidelines to assess investigative appropriateness.

Figure 1: Endometrial Thickness of PMB Clinic Attendees

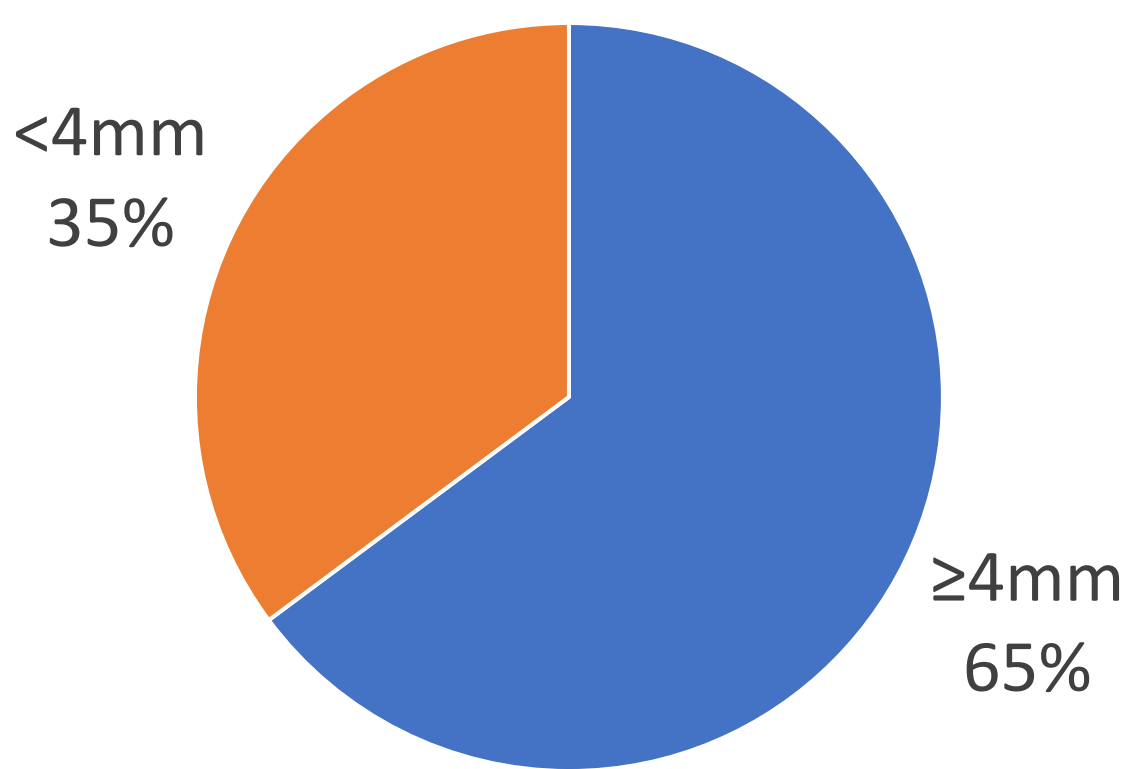


Figure 2: Hysteroscopy Setting

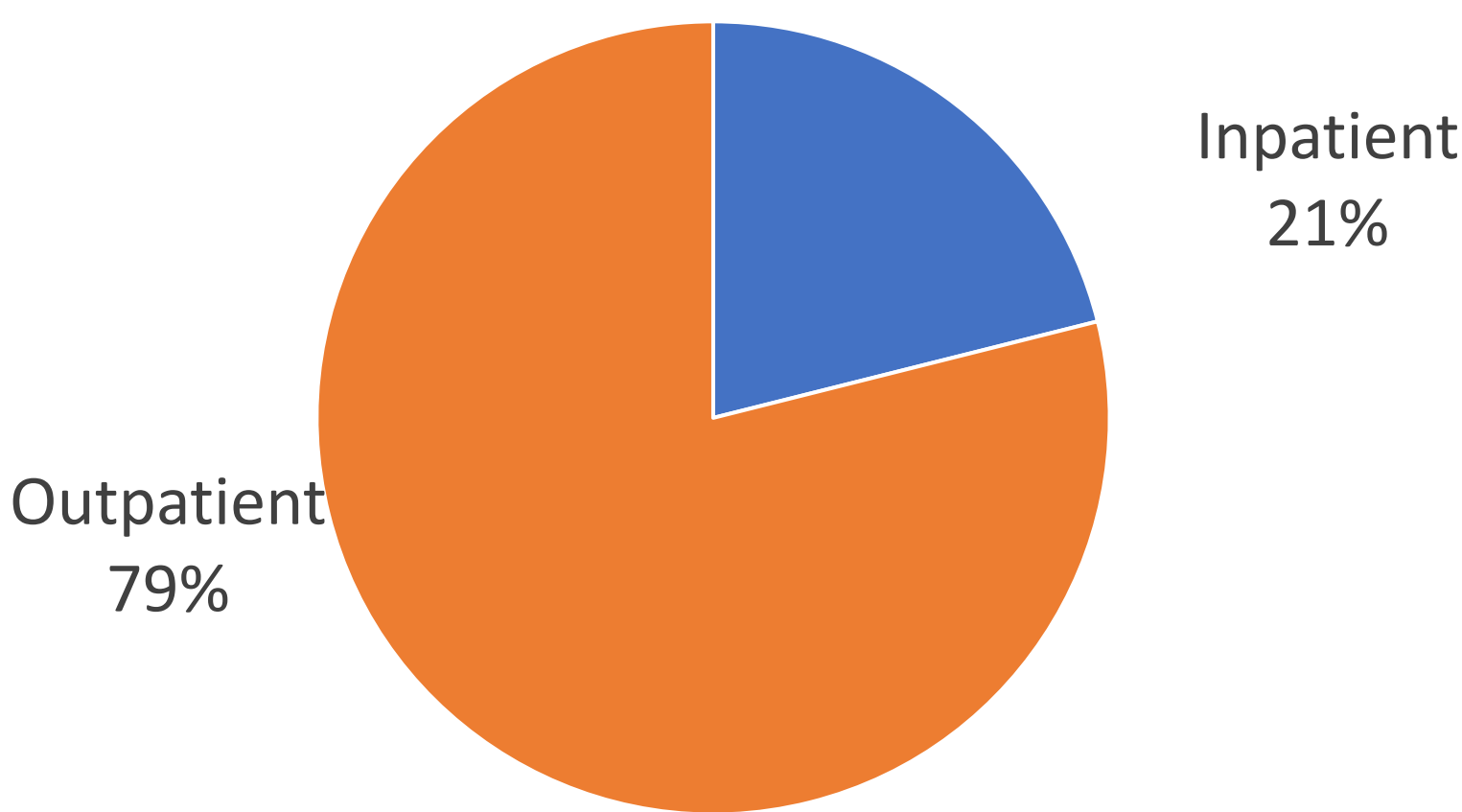


Figure 3: Criteria fulfilment of PMB Patients undergoing Hysteroscopy

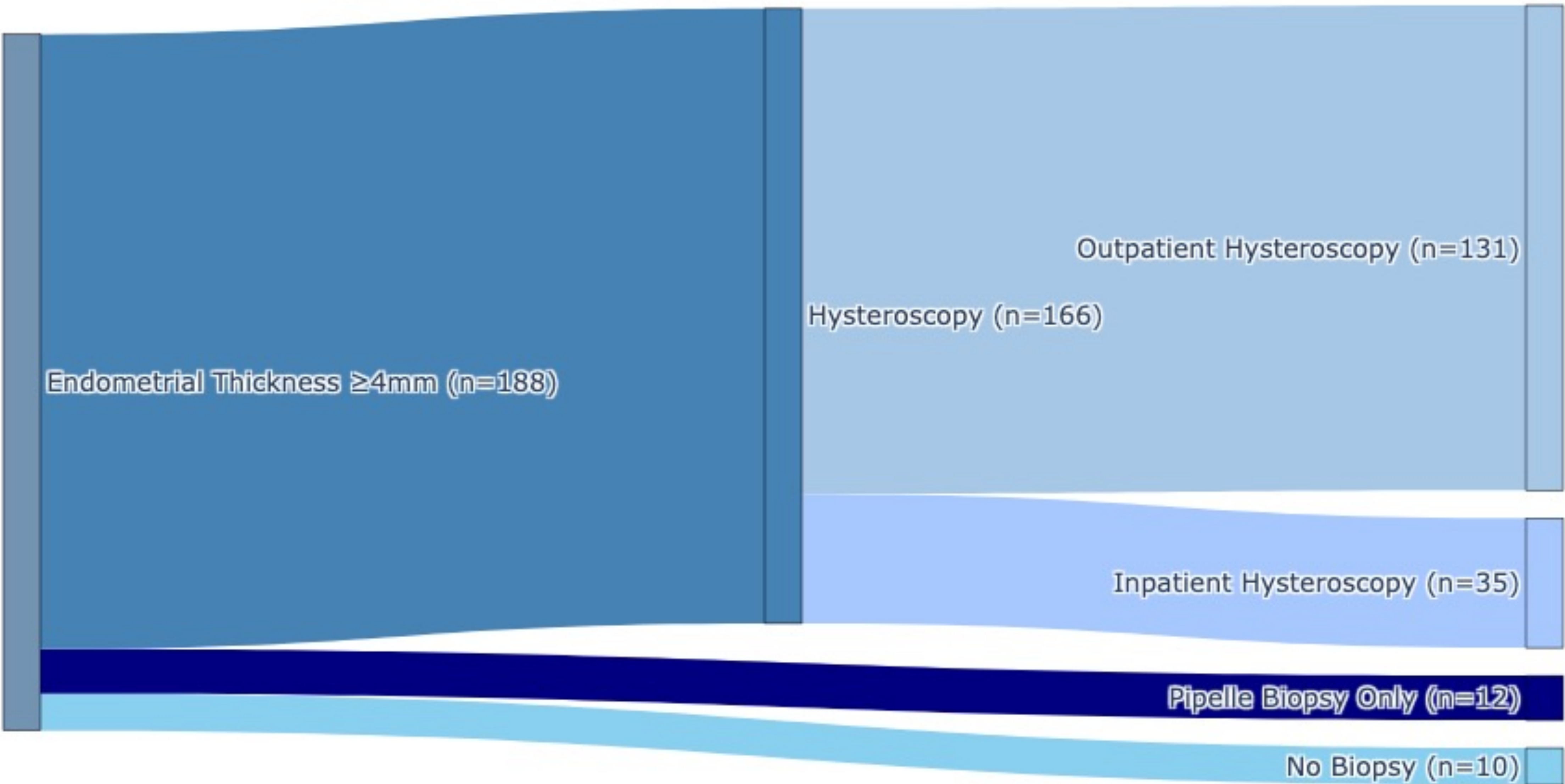
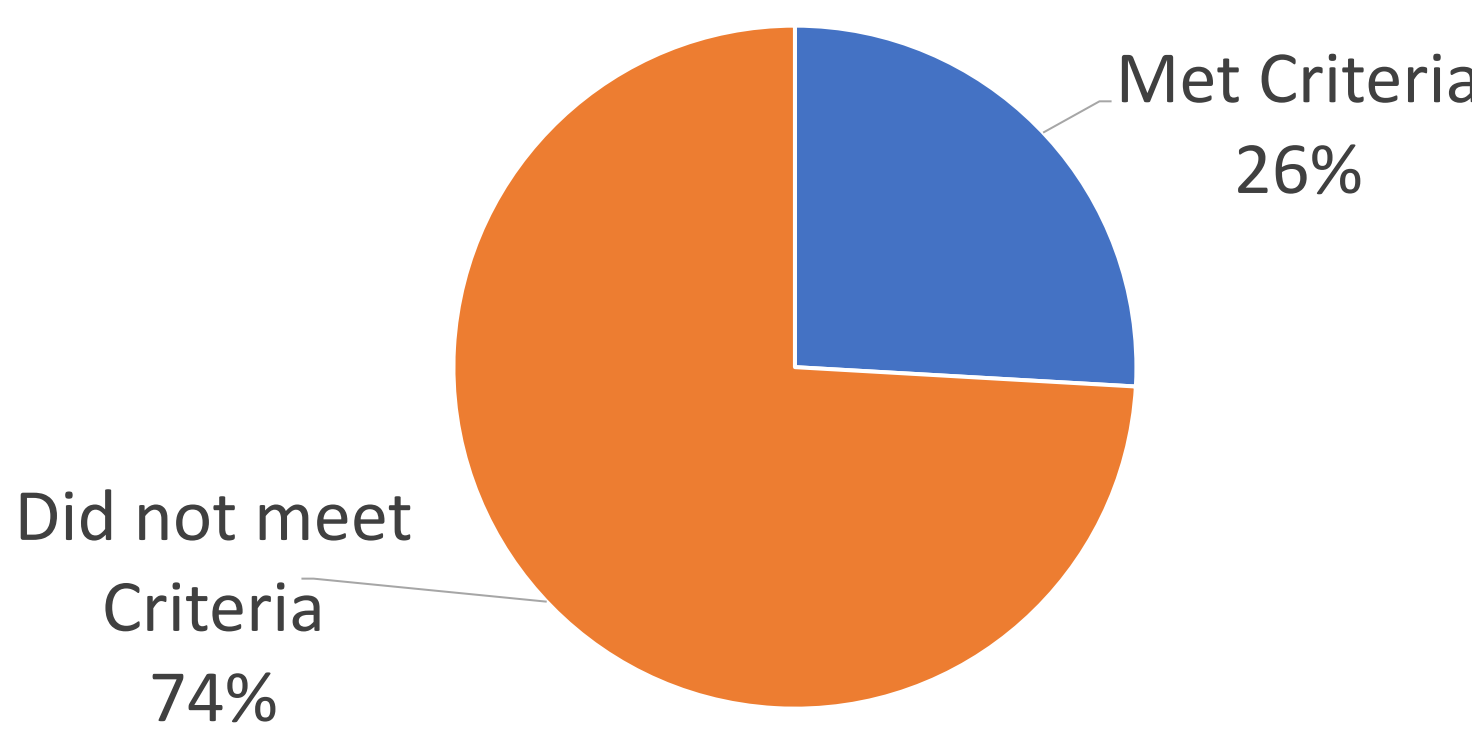


Figure 4: Sankey Diagram depicting outcomes of PMB Clinic Patients with TVUS showing ET $\geq 4\text{mm}$