

Special Problems In The Management of Postmenopausal Bleeding

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Post-menopausal bleeding (P.M.B.) is a special gynaecological problem in itself. To the women whose cyclical bleeding has apparently stopped for months or years, the recurrence of bleeding however slight must be a shattering experience, particularly if she has been otherwise well.

Most women are aware that P.M.B. is a serious symptom and the majority of these patients come up for examination within two months of the onset of bleeding. From the small series of 26 cases in the second half of 1962, the average duration of symptoms was 2.5 months before the patient came to see her doctor. The shortest period was 2 weeks, and the longest 6 months.

The age of the patients complaining of P.M.B. is interesting. From Table I, it can be seen that 13 cases out of 26 (50 per cent) belong to the age group 50-54, while the average onset of menopause in these 26 cases was between 46-47 years. This suggests that, irrespective of the cause of P.M.B., this symptom occurs most frequently between 3-8 years after the stoppage of cyclical bleeding.

The causes of P.M.B. are well discussed by Jeffcoate and a summary is given here for easy reference. Our own small series is given in Table I for purposes of comparison. It has to be pointed out that the Kandang Kerbau Hospital series excludes the obvious cases of genital cancer, and even the cases that are suspicious of cancer are not included in this series. These two categories are admitted as in-patients to our wards for further investigation and possible treatment, thus leaving the cases that are not suspicious of malignancy to be dealt with in our Outpatient Service.

CAUSES OF POST-MENOPAUSAL BLEEDING (After Jeffcoate)

Oestrogen therapy
? Commonest.

30% Malignant Neoplasms
of Vulva, Vagina, Cx., Corpus, Tubes.

Innocent Neoplasms
of Vulva, Vagina, Cx., Corpus, Tubes.

Ulcerations
usually obvious and do not come under category of Post-Menopausal Bleeding.

Ovarian Tumours
Oestrogen Tumours < Granulosa cell
Thecoma.
Any tumour of sufficient size to affect
vascularity of uterus.

Infections (and treatment).

Vaginitis:

Trichomonas:
Flagyl (also husband).

Monilia:
Nystatin Pessaries.

Senile:
Oestrogen pessaries or Oral Course (3 weeks).

Cervicitis (& Erosion):
After biopsy
——> Caution or Amputation.

Endometritis < Tuberculous
Senile

Pyometra & Haematometra:
Drainage
D. & C.
? Hysterectomy.

10% Dysfunctional Uterine bleeding & Endometrial Hyperplasia.

Curettage usually cures in $\frac{1}{3}$ - $\frac{1}{2}$ cases.

Recurrence may occur—Hormone Therapy. Hysterectomy, if small functioning ovarian tumour cannot be excluded.

Injuries.

1. **Direct trauma:**
2. **Decubitus Ulceration:** (Associated with Prolapse). Posture, (Trendelenburg), packing and when oedema and ulceration healed, definitive surgery carried out for the associated prolapse.
3. **Foreign Bodies:** e.g. supporting pessaries or Grafenberg ring that has been forgotten. Require removal & biopsy of bed!
4. **Post Radiation Ulceration and fistulae:** May tax ingenuity of surgeon to extreme.

Blood Dyscrasias with coagulation Defects:—
Medical or surgical treatment as needed.

Haemorrhage from urethra, bladder and rectum can be mistaken for vaginal bleedin; e.g.

1. Urethral Caruncle
2. Papilloma & Ca. of bladder, Renal Calculi.
3. Haemorrhoids & fissure in Ano.
4. Ca Rectum.

Special Problems.

Premature Menopause.

Premature but permanent cessation of menstruation may be due to some:—

- (a) local lesion
- (b) general condition, or
- (c) some endocrine disorder.

Definite and specific causes are:—

- (1) Hysterectomy
- (2) Bilateral oophorectomy, and
- (3) Tumours or diseases causing destruction of the ovaries; Radiotherapy.
- (4) Severe systemic disease, e.g. blood dyscrasia or respiratory, gastro-intestinal, urinary, endogastro-intestinal, urinary, endocrine or cardiovascular disease may so weaken the patient as to cause permanent cessation of menstruation. Sheehan's syndrome is a good example of this group.

Delayed Menopause.

This term may be applied to menstruation continued beyond the average space of some 30 years; i.e. where the patient has cyclical bleeding till the age of 50 or 55 years.

This group of patients should be viewed with suspicion and investigation should not be withheld even when the patient does not notice any change in the rhythm or character of her intermittent flow.

A local lesion may be revealed by pelvic examination, e.g. carcinoma of the cervix or body; uterine myoma, ovarian tumour, or a tumour or inflammation of some adjacent structure.

Further investigation may reveal some extra pelvic or general disease causing the bleeding, such, as blood dyscrasia, cardiac or renal hypertension, or some endocrine disorder e.g. thyroid or adrenal disease.

There remains a small group of cases presenting no obvious genital lesion or extra genital disease to account for the bleeding, and in which the bleeding simulates more or less the menstrual rhythm. This very interesting group represents some of the unsolved problems in pelvic physiology and pathology. The patients are past the usual age for normal ovarian function, and yet they present evidence of endometrial activity dependent on ovarian activity.

Are these patients examples of the unusual disparity between the chronological age in years and their biological or "ovarian" age, and consequently have a longer span of menstrual activity? Is there a reactivity or "flare-up" of their ovarian function? Or is there some measure of hyperactivity of the adrenal? Does this prolongation of endometrial stimulation have a harmful effect on the endometrium?

Whatever the answers to the first 3 questions, the answer to the last question is definitely yes. The literature has many series in which endometrial Carcinoma is found more frequently in those with a delayed menopause, than in others with a menopause at the normal age.

Endometrial Hyperplasia.

While it may be difficult to prove that endometrial hyperplasia precedes carcinoma, there were several instances (Crossen & Crossen) where benign endometrial hyperplasia in a previous curettage had been shown to be malignant in subsequent curettages. Also in one case, a benign endometrial hyperplasia was found; subsequent curettage showed endometrial carcinoma; at hysterectomy a double uterus was found—one side benign, the other malignant!

This last case was, of course, a freak, but when one bears in mind that some small functioning tumour, of the ovary may be missed on ordinary pelvic examination, there would appear to be a place for laparotomy and hysterectomy in some cases of endometrial hyperplasia particularly when bleeding recurs.

It must be decided whether it is a simple hyperplasia or an adenocarcinoma of the endometrium. If it is hyperplasia, one must determine the presence or absence of an ovarian tumour capable of stimulating the endometrium. Distinction must also be made between hyperplasia and an endometrial polyp, the latter is a common benign cause of P.M.B. which is cured by curettage.

Hyperplastic Endometrium may macroscopically resemble adenocarcinoma. Even the microscopic differentiation between the two may be difficult at times. Cytology is again less reliable than it is in cases of cervical carcinoma. Because of these difficulties, a second and thorough curettage may be advantageous; the opportunity; of

course, is taken to make a thorough examination under anaesthesia.

When complete microscopic study of the curettings has confirmed the lesion to be endometrial hyperplasia, and oestrogen therapy precluded, the plan of treatment should be as follows:—

- (1) **If no ovarian tumour** is palpated, and if **no bleeding recurs** after D & C, the management consists of monthly bimanual examination, to detect a growing ovarian tumour which may have been missed previously. However, follow-up here may present difficulties.
- (2) **If an ovarian tumour**, even of small size, is palpated, hysterectomy with bilateral Salpingo oophorectomy is carried out.
- (3) If bleeding recurs after curettage, even in the absence of an ovarian tumour, I would be inclined to carry out hysterectomy and bilateral salpingo oophorectomy. In patients who are unfit for surgery, the ovaries may be ablated by radiotherapy.

POST-MENOPAUSAL BLEEDING: JULY-DEC. 1962, (K.K. HOSPITAL)
Series of 26 cases (Malignancies Excluded)

	Age: 40-44	45-49	50-54	55 +
Urethral Caruncle	—	1	1	1
Trichomonas Vaginitis	—	—	1	—
Senile Vaginitis	—	—	—	1
Cervicitis	1	2	6	1
Decubitus Ulceration	—	—	1	—
Cervical Polyp.	—	—	2	1
Endometrial Hyperplasia	1	1 (+ fibroid) 1	(Endometrium 1 Polyp).	—
Oestrogen	—	1	—	—
No Cause	—	1	1	—
TOTAL:	2	7	13	4 = 26

Table I

Average Age = 46-47 years

Agerage Duration of Symptoms = 2.5 months