Homerton University Hospital NHS
NHS Foundation Trust

City and Hackney GP Women's Health Education Event

19th November 2021

Dr Priyanka Patel MA (Cantab) MRCGP MFSRH
Locum Consultant Gynaecologist
Homerton University Hospital

Community Gynaecology Service

The Ivy Centre
St Leonard's Hospital
Nuttall Street

- Average of 4 weekly sessions
- Consultants: Dr Sue Mann, Dr Priyanka Patel
- Registrar: Dr Madeleine Benns
- Pilot PCN (Hackney Marshes) bimonthly clinic started in April: Sue Mann and Madeleine Benns

Conditions Seen

- HMB
- Intermenstrual /Postcoital bleeding
- Amenorrhoea
- Dysmenorrhoea
- Advice regarding Fibroids or Adenomyosis if patient does not require/desire surgery
- Menopause and HRT
- PMS
- PCOS
- Pelvic pain
- Vulval and vaginal symptoms including patient concern about appearance of external genitalia
- Cervical polyps
- Cervical ectropion
- Abnormal looking cervix
- Difficult cervical smear
- Difficult IUS insertions and removals if for HMB
- Counselling regarding LARC vs. sterilisation
- Fertility advice

Previously:

- Postmenopausal bleeding: HUH (2 WW)
- Utero-vaginal prolapse: HUH vaginal ring pessary service
- Psychosexual problems: HSHS Service

Case CS

- 34 year old
- IMB and PCB. Infrequent periods, irregular spotting
- Para 0+4
- Smears UTD and negative
- PCOS, Hypothyroidism
- Levothyroxine 100mcg, NKDA
- RMP. STI screening negative
- Trying for pregnancy for 3 years, rejected fertility referral in view of BMI
- FH: cousin had endometrial cancer in her 30s
- Smokes <20/day
- BMI = 31.4

Investigations

- Pelvic USS:

- Heterogeneous myometrium
- Appearances may be suggestive of an endometrial polyp
- Bilateral PCO appearance
- ET = 8.2mm

Colposcopy Review

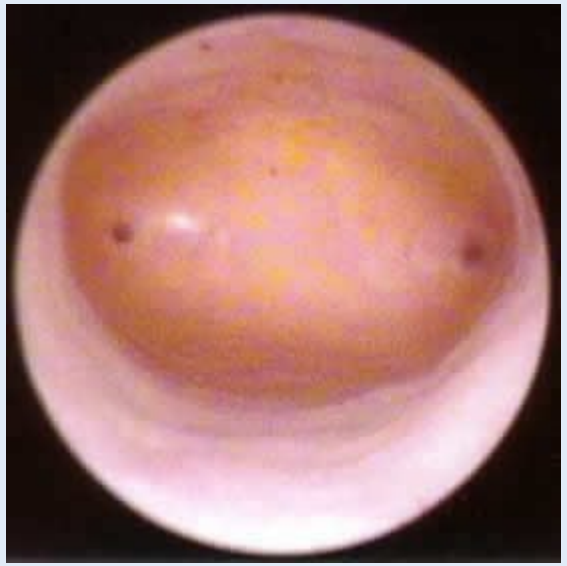
- Colposcopy opinion: HPV
- Multiple punch biopsies taken
- Endometrial pipelle biopsy
- Results:

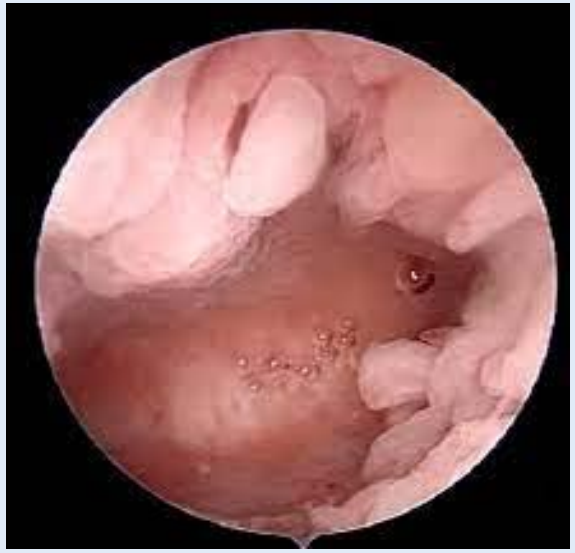
- Cervical biopsies: HPV associated change only
- Endometrial biopsy: atypical hyperplasia

Outpatient Hysteroscopy

- Cervix: Healthy
- Endocervical Canal: Polypoidal
- Uterine cavity: Polypoidal endometrium posterior wall, removed with Truclear and endometrial biopsy taken with Truclear
- Ostia: Both seen
- IUS Mirena inserted

Outpatient Hysteroscopy, Images





Results and Management

- Start continuous progestogens orally (medroxyprogesterone 10-20 mg/day)
- Histology: Hyperplasia without atypia
- Review in 6/12 for re-biopsy
- Strongly advised stop smoking and lose weight
- Once BMI <30 re-refer fertility

Endometrial Hyperplasia

- Irregular proliferation of the endometrial glands with an increase in the gland to stroma ratio when compared with proliferative endometrium
- Precursor to endometrial cancer (most common gynaecological malignancy in the Western world)
- Incidence of endometrial hyperplasia is estimated to be at least three times higher than endometrial cancer

Endometrial Hyperplasia

- Most commonly presents with abnormal uterine bleeding:
- HMB
- IMB/ Irregular bleeding
- Unscheduled bleeding on HRT
- PMB
- Risk Factors (contributing to unopposed oestrogen):
- Increased BMI
- Anovulation in perimenopause or PCOS
- Oestrogen secreting tumours e.g. granulosa cell
- Drug induced: systemic oestrogen HRT or tamoxifen
- Immunosuppression and infection

Endometrial Hyperplasia

- Classification (based upon presence of cytological atypia):

- Hyperplasia without atypia
- Atypical hyperplasia

Endometrial Hyperplasia, diagnostic and surveillance methods

- Diagnosis requires histological examination of the endometrial tissue
- Endometrial surveillance should include outpatient endometrial biopsy
- Diagnostic hysteroscopy: considered especially where outpatient sampling fails or is nondiagnostic
- TVUSS may have a role in diagnosing hyperplasia

- PMB: ET cut off <5mm
- Premenopausal: role restricted to identifying structural abnormalities (overlap of ET)
- PCOS and absent or abnormal bleeds (<7mm)

Endometrial Hyperplasia, diagnostic and surveillance methods

- Where endometrial hyperplasia has been diagnosed within a polyp or other discrete focal lesion, direct visualisation and biopsy of the uterine cavity via hysteroscopy

- Insufficient evidence for CT or diffusion-weighted MRI or biomarkers as aids in the management of endometrial hyperplasia. Not routinely recommended

Endometrial Hyperplasia without atypia

- Risk of endometrial hyperplasia without atypia progressing to endometrial cancer is less than 5% over 20 years
- Majority of cases without atypia will regress spontaneously
- Address RFs such as obesity and HRT
- Treatment with progestogens has a higher disease regression rate vs. observation
- Progestogen treatment if fail to regress following observation alone and in symptomatic women

Endometrial Hyperplasia without atypia, Progestogens

- Both continuous oral and local intrauterine (LNG-IUS) progestogens are effective
- LNG-IUS first-line: higher disease regression rate, better bleeding profile and fewer adverse effects
- Continuous progestogens should be used (medroxyprogesterone 10–20 mg/day or norethisterone 10–15 mg/day) if IUS declined
- Cyclical progestogens should not be used

Endometrial Hyperplasia without atypia, Tx and FU

- Treatment for a minimum of 6 months to induce histological regression
- If SEs tolerable and fertility is not desired, encouraged to retain the LNG-IUS for up to 5 years - reduces the risk of relapse, especially if resolves abnormal uterine bleeding symptoms
- Endometrial surveillance via outpatient endometrial biopsy, minimum of 6-monthly intervals – although individualised and responsive

Endometrial Hyperplasia without atypia, Tx and FU

- At least two consecutive 6-monthly negative biopsies to D/C
- Further referral if abnormal vaginal bleeding recurs after completion of Tx ?relapse
- BMI of 35 or greater or those treated with oral progestogens: Once two consecutive negative endometrial biopsies then long-term FU should be considered with annual endometrial biopsies

Atypical Hyperplasia

- First line: total hysterectomy because of the risk of underlying malignancy or progression to cancer (laparoscopic approach preferable)
- Postmenopausal women: offered bilateral salpingo-oophorectomy and individualise in premenopausal women; consider bilateral salpingectomy, may reduce the risk of a future ovarian malignancy
- Endometrial ablation not recommended - complete and persistent endometrial destruction cannot be ensured and risk of intrauterine adhesion formation

Atypical Hyperplasia, preserving fertility or unsuitable for surgery

- Counselled about risks of underlying malignancy and subsequent progression to endometrial cancer
- Pretreatment Ix: aim to rule out invasive endometrial cancer or co-existing ovarian cancer
- Histology, imaging and tumour marker review in MDT: Mx and ongoing endometrial surveillance plan
- First-line treatment with the LNG-IUS
- Oral progestogens second line
- Once fertility is no longer required, hysterectomy offered - high risk of disease relapse

Atypical Hyperplasia, Tx and FU

- Endometrial biopsy: Every 3 months until two consecutive negative biopsies
- Review schedules individualised and responsive to changes in a woman's clinical condition
- Asymptomatic women with a uterus and evidence of histological disease regression: long-term follow-up with endometrial biopsy every 6–12 months until a hysterectomy

Atypical Hyperplasia, Fertility

- Disease regression on at least one endometrial sample before attempting to conceive
- Fertility specialist to discuss the options for attempting conception, further assessment and appropriate treatment
- Assisted reproduction considered as the live birth rate is higher and it may have increased chance of preventing relapse
- Prior to assisted reproduction, should be regression of hyperplasia - associated with higher implantation and clinical pregnancy rates

HRT and Endometrial Hyperplasia

- Systemic estrogen-only HRT should not be used in women with a uterus
- Taking HRT: report any unscheduled vaginal bleeding
- Taking a sequential HRT preparation - advised to change to continuous progestogen (LNG-IUS or a continuous combined HRT preparation)
- Taking a continuous combined preparation - need to continue HRT reviewed. Evidence limited regarding the optimal progestogen regimen– consider LNG-IUS

Thank you

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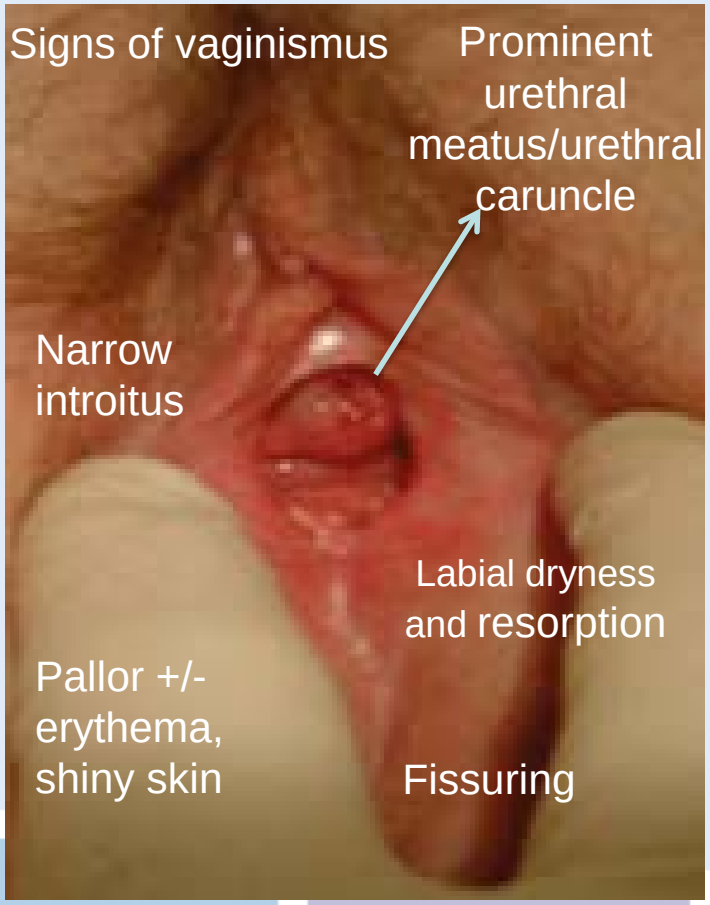
Community Gynaecology Menopause Case Presentation

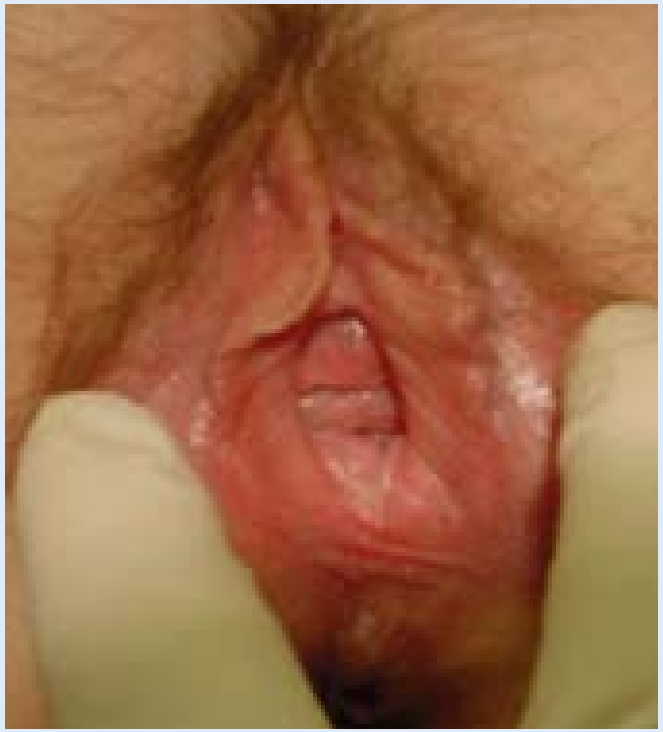
Dr Madeleine Benns MbCHB FSRH
Specialty Doctor in Sexual and Reproductive Health
Homerton Hospital

- 57yr woman
- Referred to Community Gynaecology due to difficult smear
- PMH: T2DM, obesity, asthma, multiple PE’s, HTN, hypercholestrolaemia, OSA, depression, fibroids
- Meds: Metformin, Warfarin, statin, antihypertensives, prednisalone, codeine, gabapentin

- G 4 P 2 (2x NVD 28+30yrs ago, 2x misc)
- RMP 18/12 using condoms, denies dyspaerunia/vaginal dryness/PCB
- LMP 9yrs ago
- HRT/menopause never discussed
- Hot flushes, joint pains, poor sleep, low mood

On examination..





Healthy vulva- patient on HRT

Difficult smear due to body habitus (BMI>45) and signs of GSM

Upon redressing reports that her vaginal has felt dry and itchy and sex has been painful

Genitourinary Syndrome of the Menopause (GSM)

Introduced in 2014 to encompass:

- Vulvovaginal atrophy
- Atrophic vaginitis
- Lower urinary tract symptoms related to low oestrogen levels

How common is it?

- Affects up to 70% of women and only around 7% receive treatment

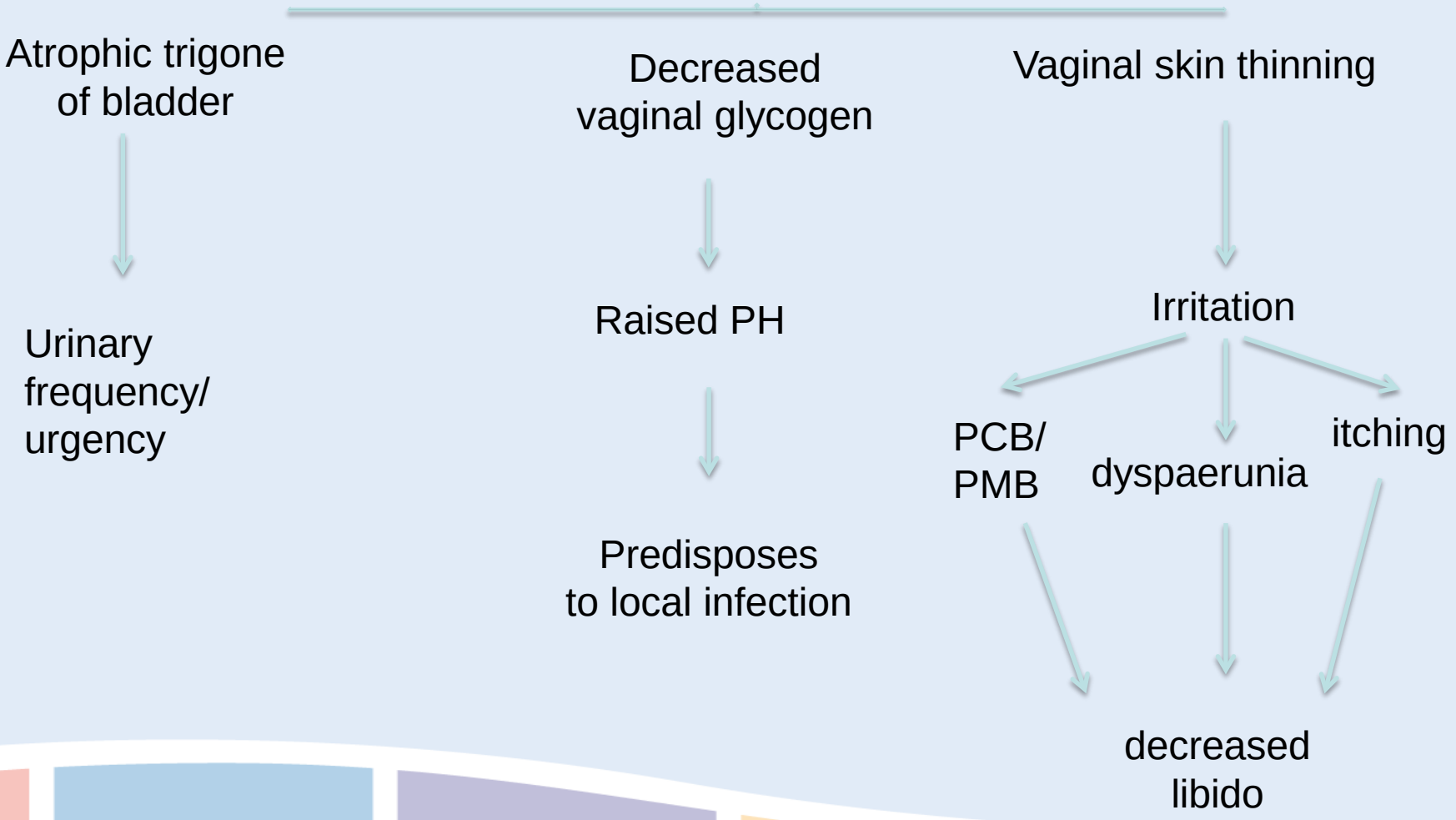
GSM usually improves with time T/F

- False, GSM does not resolve spontaneously

Causes of atrophic vaginitis?

- Natural menopause
- Surgical menopause -post oophorectomy
- Iatrogenic -Tamoxifen and aromatase inhibitors, chemotherapy or radiotherapy
- Post-partum and/or during breast-feeding when oestrogen levels are lower than normal
- PO contraceptives

Decreased systemic oestrogen



Further investigations?

- Consider STI screen and swabs for thrush
- Urinalysis/MSU for urinary symptoms
- 2WW for PMB

How would you manage her GSM?

- Reassurance + Advice
- Avoid irritants
- Counseling/information leaflets on dyspaerunia and consideration of referral to psychosexual clinic
- Vaginal lubricants
- Vaginal moisturisers
- Topical oestrogen

Vaginal Moisturisers

Gynomunal

Dr Wolff's vagisan moisturising cream

Hyalofemme

Feminesse

Sylk

Regell
e

Balance activ
moisture gel

ReplensMD

YES VM

Vagisil internal hydrating gel

Topical Oestrogens

- Creams
- Gel
- Pessaries
- Ring

- Is systemic progesterone needed?

No

Prescribing

- Creams: ESTRIOL CREAM (Ovestin) 0.01% — Daily insertion for 2/52 then twice weekly thereafter. Applicator or fingers can be used inside vagina and externally on vulva
- Gel: ESTRIOL GEL (Blissel gel) Lower dose- 0.005% — ON 3/52 twice a week thereafter
- Pessaries:
- Ring: ESTRADIOL (Vagifem) 10 mcg pessary — Daily insertion for 2/52 then twice weekly thereafter. Comes with applicator

ESTRADIOL (Estring) 7.5 mcg/24 hours vaginal ring
Lasts 3/12

Would you prescribe systemic HRT?

PMH:

- T2DM
- obesity
- asthma
- multiple PE’s
- HTN
- hypercholestrolaemia
- OSA
- depression

Would you prescribe systemic HRT?

PMH:

- T2DM
- Obesity (increased risk breast cancer)
- Asthma
- Multiple PE's
- HTN
- Hypercholestrolaemia
- OSA
- Depression

- The risk VTE is increased by oral HRT compared with baseline population risk
- However, the risk associated with *transdermal* HRT is no greater than baseline population risk.
- Consider transdermal rather than oral HRT for menopausal women who are at increased risk of VTE
- Consider referring menopausal women at high risk of VTE to a haematologist for assessment before considering HRT

Non-hormonal treatment options

- Lifestyle
- Antidepressants
- Phytoestrogens
- Herbs and vitamins
- Acupuncture
- CBT

Antidepressants for VMS

SSRIs/SNRIs (off label)

- Citalopram 20mg
- Venlafaxine MR 37.5mg
- Fluoxetine 20mg
- Paroxetine 10mg

} Not if taking Tamoxifen (inhibit its action)

Low doses can help to alleviate hot flushes and night sweats

Clonidine

- Alpha-2 adrenergic receptor agonist
- The only non-estrogen based preparation licensed for flushing
- Limited evidence for efficacy but may be helpful for hot flushes
- Initially 50 micrograms twice daily for 2 weeks, then increased to 75 micrograms twice daily, if needed.

N.B

- Do not routinely offer SSRI/NSRI/Clonidine as first line management for vasomotor symptoms in women with no contradindications to HRT
- There is no evidence that SSRI/NSRI alleviate low mood in menopausal women who have not been diagnosed with depression

Gabapentin

- Off-label depending on local prescribing guidelines
- At 900mg OD can reduce hot flushes by 50%
- Up to 300 mg TDS, start low and titrate up over 3 days
- SE: dry mouth/dizzyness/drowsyness may improve with continued use

Phytoestrogens

- Naturally occurring compounds found in plant foods eg Soy
- Structurally similar to 17 a estradiol but1000 fold weaker potency
- 7/15 RCT showed no significant benefit over placebo (MD 6.4 p =0.110)
- 10/15 RCT showed reduced hot flushes compared to placebo (MD = 0.89 p<0.005)
- 5/15 studies show no significant difference in side effects
- NICE suggests: advise that isoflavones may help VMS but products are not standardised for content or quality

Herbs

Black Cohosh

- Partial agonist at 5-HT1A and opiate receptors, afinity to Dopamine D2 receptors
- *Nice guidance:* Some evidence it may relieve hot flushes but quality, purity and safety is unknown-some case reports of hepatotoxicity requiring liver transplant

Don Quai

- May interact with Warfarin
- NOT superior to placebo VMS but may help with hot flushes in combination with other herbs

St Johns wort

- Some improvement in mild-mod menopausal low mood
- NO improvement in hot flushes

There is uncertainty about:

- appropriate doses
- persistence of effect
- variation in the nature and potency of preparations
- potential serious interactions with other drugs (including tamoxifen, anticoagulants and anticonvulsants).

Acupuncture

- Reduces calcitonin gene related peptide- a vasodilator and stimulator of the cholinergic sweat glands
- 12 studies 869 participants
- Showed significant reduction in frequency and severity of hot flushes
- Improved VSM in Menopause Specific QOL score

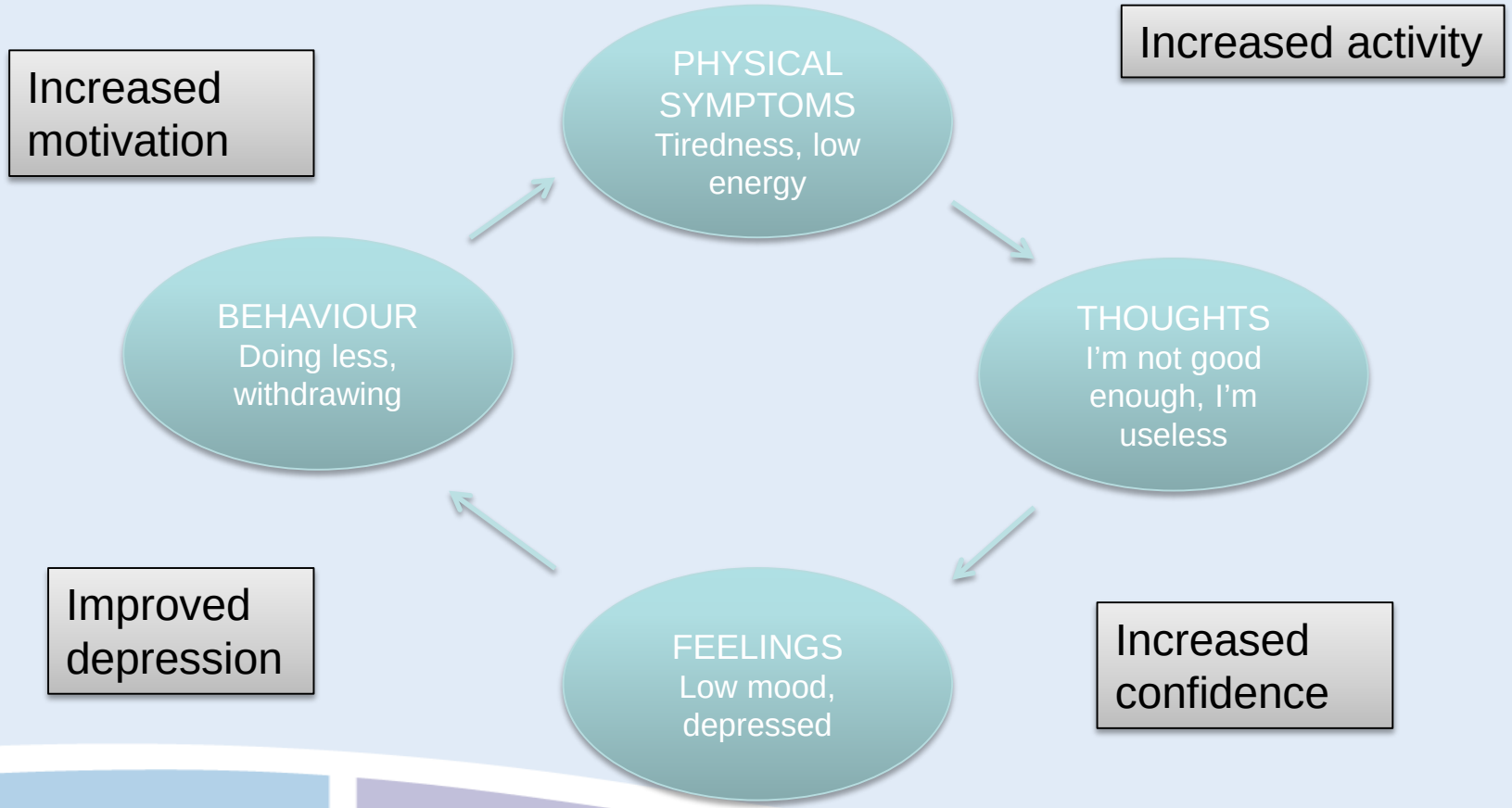
*No studies included SHAM control

Yoga

- 13 RCT showed reduction in menopausal symptoms
- Beneficial compared to aerobic exercise
- Safe and effective
- Aerobic exercise also helps to improve psychological health, mood, difficulty sleeping in those with VMS

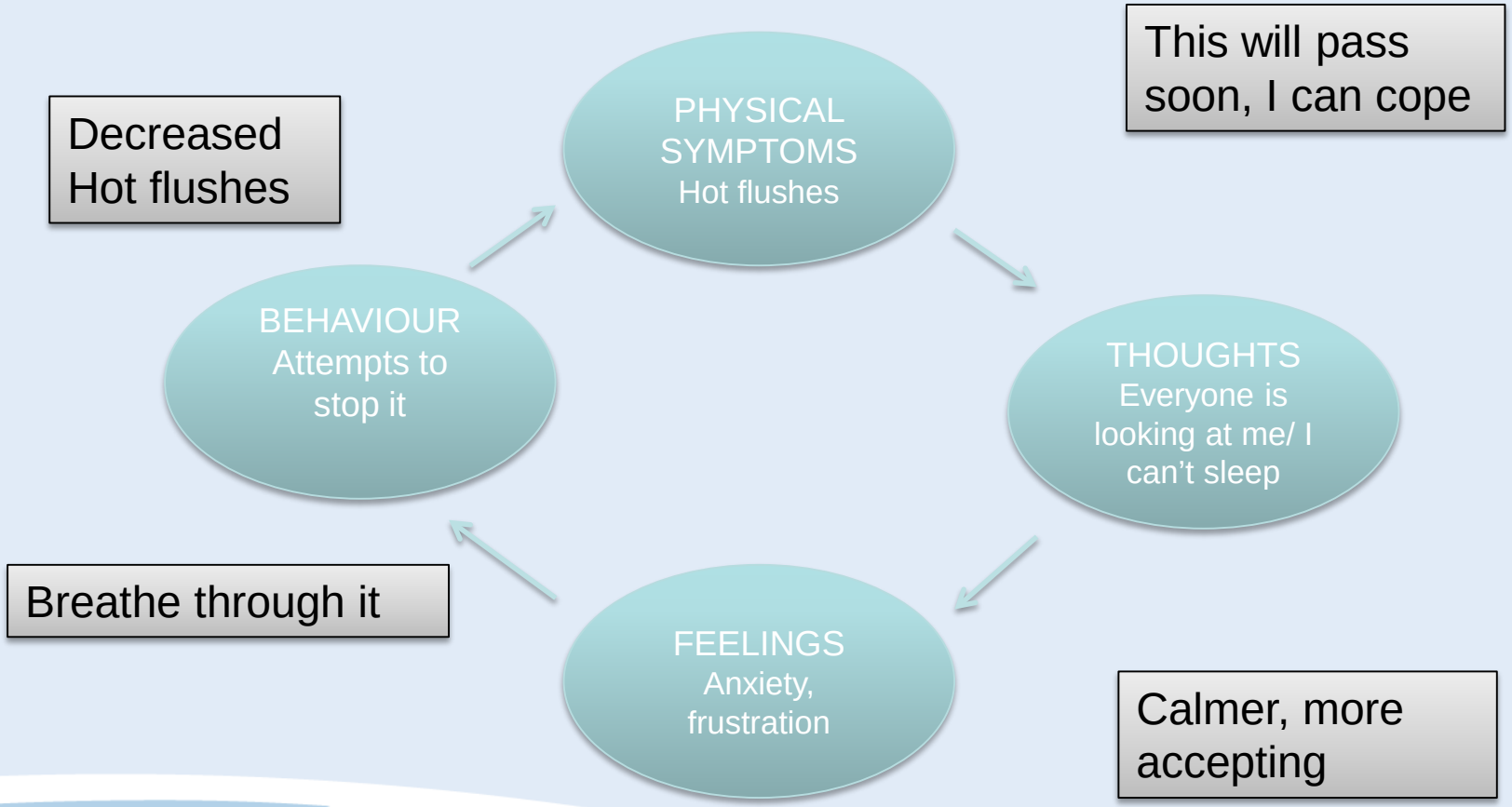
CBT

LOW MOOD


PHYSICAL SYMPTOMS
Tiredness, low energy
THOUGHTS
I'm not good enough, I'm useless
FEELINGS
Low mood, depressed
BEHAVIOUR
Doing less, withdrawing
Increased activity
Increased confidence
Improved depression
Increased motivation

CBT

HOT FLUSHES



Key Points

- Ask about vaginal symptoms
- CBT should be offered to those with low mood/anxiety associated with the menopause
- Women who choose alternative therapies are sometime happy to accept less effective treatment over HRT but should be advised that complementary therapies may lack evidence for efficacy and may not be regulated

References

- https://cks.nice.org.uk/topics/menopause/
- https://www.menopausedoctor.co.uk/
- https://www.imsociety.org/
- https://www.medicines.org.uk/emc/product/5719/smpc

Thank you