Information for women

Management of unscheduled bleeding on HRT

Women's Health Concern

A confidential independent service for women and their partners

The British Menopause Society (BMS) has published a joint guideline on the management of unscheduled bleeding on hormone replacement therapy (HRT).

This WHC factsheet provides a summary version of the clinical guideline for those who use HRT and who may have unscheduled bleeding. The full joint guideline is available on the BMS website and it should be used by healthcare professionals for any clinical decision making.

Why is the BMS joint guideline important?

- Unscheduled bleeding is bleeding outside what is considered normal for the type of HRT that you are taking. Different types of HRT have different bleeding patterns. Individuals who start HRT whilst still having natural periods can usually expect a regular and predictable monthly bleed on HRT. Those who start HRT after periods have already stopped will be given continuous HRT, which aims to be bleed free. However there can be a 'settling in' phase of up to six months before all bleeding stops.
- Unscheduled bleeding is a common side effect of HRT and it is unlikely to represent any serious underlying problem.
- Unscheduled bleeding can be of concern to women and it can lead to women stopping HRT, even though HRT has many benefits.
- Unscheduled bleeding may be a warning sign that HRT dosing is not quite right and it should always be reported.
- Investigation of unscheduled bleeding is a common reason for referral to gynaecological services; this guideline helps to ensure that women are correctly referred, only when needed.

What do we mean by unscheduled bleeding?

It is normal to get some bleeding on HRT; you should be advised what bleeding is normal for the type of HRT you are using. You should also have been advised that there may be a settling in phase on some types of HRT when bleeding, although unwanted, may not be a cause for concern (within 6 months of starting HRT or within 3 months of a change in dose or preparation).

When bleeding occurs outside of an expected pattern, it is described as 'unscheduled'.

It is important to report unscheduled (unexpected) bleeding; it will not always need further investigation, but changes to the dose of your HRT may be needed.

What does the guideline recommend?

Assessment: Your healthcare professional will ask you questions about:

- When and how much you're bleeding;
- Your height and weight to calculate body mass index, as endometrial (womb) cancer can be influenced by a higher body mass index;
- What type of HRT you're taking and for how long you've been taking it;
- Your risk factors for endometrial (womb) cancer (things that make you more likely to get it); and
- Whether you have family members who have had endometrial cancer.

They might also do a physical examination and some basic tests, such as a cervical smear test if it is due.

Risk stratification: The guideline helps healthcare professionals to decide how quickly to test for endometrial (womb) cancer if you are on HRT and you have unscheduled bleeding. They should consider different factors to see how likely it is that you have cancer. This helps them to get you the tests you need quickly, and it also helps to avoid unnecessary tests.

Management: The approach to managing unscheduled bleeding depends on your personal risk factors and the type of HRT you are taking. Options include:

- Offering reassurance and monitoring, if bleeding is infrequent and you have a low risk of endometrial cancer;
- Adjusting your dose or type of HRT;
- Performing a transvaginal (internal) ultrasound (TVS) scan to assess the endometrium (womb lining); and
- Referring you to a gynaecologist - this does not mean that you have cancer, it just refers you to the right clinic at the right time.

How might unscheduled bleeding on HRT be assessed and treated?

If you have just started HRT (within the past 6 months) or if you have recently changed your dose or type of HRT and you have unscheduled bleeding, your healthcare professional might adjust your HRT for up to 6 months.

If bleeding continues after adjustments, they may recommend an ultrasound, or stopping HRT altogether if you prefer that.

If you stop HRT and bleeding stops after 4 weeks, you might not need further checks.

If you restart HRT after stopping it, your doctor might adjust it again and recommend an ultrasound if bleeding is heavy/doesn't stop within 6 months.

They might recommend a quicker internal scan (TVS) if bleeding starts more than 6 months after starting/changing HRT, or if it's heavy/prolonged or you have some risk factors for endometrial cancer. This will usually be booked within 6 weeks.

For women with a higher personal risk of endometrial cancer and unscheduled bleeding on HRT, a more urgent referral pathway is recommended, usually within two weeks. This could be combined with changes to progesterone doses or with stopping HRT.

Remember, this is a summary of the clinical guideline only. Always talk to your healthcare professional about any questions or concerns you have regarding HRT and bleeding.

This fact sheet has been prepared by Women's Health Concern and reviewed by the medical advisory council of the British Menopause Society. It is for your information and advice and should be used in consultation with your own medical practitioner.

HRT doses

The guideline makes recommendations for increasing progesterone doses as estrogen doses increase, as shown in these charts:

1. Estrogen doses

	Ultra-low dose	Low-dose	Standard dose	Moderate dose	High dose
Oestrogel	½ pump	1 pump	2 pumps	3 pumps	4 pumps
Sandrena	0.25mg	0.5mg	1.0mg	1.5-2.0mg	3mg*
Lenzetto spray	1 spray	2 sprays	3 sprays	4-5 sprays*	6 sprays*
Patch	12.5µg	25µg	50µg	75µg	100µg
Oral estradiol	0.5mg	1.0mg	2.0mg	3.0mg^	4.0mg^

* Off-license use ^ Off-license use – rarely required to achieve symptom control mg = milligrams µg = micrograms

2. Progesterone/progestogen doses

Estrogen dose	Micronised Progesterone		Medroxyprogesterone		Norethistrone		LNG-IUD (52mg)
	continuous	sequential	continuous	sequential	continuous	sequential	
Ultra/Low	100mg	200mg	2.5mg	10mg	5mg†	5mg†	One – for up to 5 years of use
Standard	100mg	200mg	2.5-5.0mg	10mg	5mg†	5mg†	
Moderate	100mg	200mg	5.0mg	10mg	5mg	5mg	
High	200mg	300mg	10mg‡	20mg‡	5mg	5mg	

† 1mg provides endometrial protection for ultra-low to standard dose estrogen but the lowest stand-alone dose currently available in the UK is 5mg (off-license use of three noriday POP i.e. 1.05mg, could be considered if 5mg is not tolerated).
‡ There is limited evidence in relation to optimal MPA dose with high dose estrogen; the advised dose is based on studies reporting 10mg providing protection with up to moderate dose estrogen.

Remember, HRT prescribing must be individualised - if you are unsure if your progesterone dose is right for you, speak with your healthcare professional.

Key points

- Unscheduled bleeding is common but it should be reported.
- HRT actually lowers your risk of endometrial (womb) cancer compared to not using it at all.
- There are different ways to take HRT and some ways might have a slightly higher risk than others. Generally, taking progesterone every day seems to be best. You will usually switch to this if you stay on HRT for longer (more than 5 years), and certainly by the age of 54 years.
- The dose of progestogen is important. A higher progestogen dose may be needed to protect the endometrium (womb lining) if a higher dose of estrogen is used.
- Other factors such as obesity, diabetes and polycystic ovary syndrome can also increase the risk of endometrial cancer, as can family history; your healthcare professional will discuss these with you if you have unscheduled bleeding on HRT.

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