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Case: Intermenstrual Bleeding

Candidate brief

You are a F1 in A&E

Please take a focused history from Sarah Jones, a 45-year-old female who has come in with bleeding.

10 mins	1. Please take a full history (7 mins) 2. Viva with the examiner afterwards (3 mins)

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Patient Brief

(Do not volunteer information unless asked)

Name: Sarah Jones
DOB: 12/09/1975 (45 years old)
Job: English Teacher
Opening statement: "*I've come to A&E because I'm really concerned about the bleeding I'm having"*

HPC:

- You are having **bleeding in between your periods** that is concerning you
- **Going on for 18 months** now but have been too busy at work to get a GP appointment
- When asked – bleeding is heavy, having to use a pad and **change every 2 hours**
- **Clots** in the bleeding size of 50p coin
- Some flooding through your pad
- Bleeding **starts 4 days after your** period ends and lasts for around **7 days**
- Affecting you at work as you can only use the toilet in between classes

Associated symptoms

- Have symptoms of anaemia (**dizziness, tiredness,** less exercise tolerance – used to go to the gym every other day but have started going less as don't feel you can manage as much as before)
- Have some **menstrual "cramp" pain** during IMB and menstrual bleeding for 18 months – SOCRATES
    - Site – general abdominal pain, lower down in stomach but hard to localise
    - Onset – **starts day before bleeding starts** and eases off as bleeding stops, is there constantly
    - Character – a **dull, crampy** pain
    - Radiation - Nil
    - Associated symptoms – sometimes pain can make you feel nauseous but never been sick
    - Timings – there all day when bleeding is there, doesn't come/go or present in waves just in the background, usually eases off at bedtime (due to bath/water bottle)
    - Exacerbation/Relief – nothing makes it worse, hot water bottle and paracetamol help
    - Severity – 5/10
- No post-coital bleeding, nor symptoms of menopause (flushing, irritability, hot sweats)
- No changes to physiological discharge, no changes to vulval skin
- No weight loss or night sweats

Obs Hx

- 3 pregnancies in the past

- 2 children delivered at term via vaginal delivery with no complications antenatally and no conditions in pregnancy (no pre-eclampsia, gestational diabetes, hyperemesis etc), youngest child now 20 and both children are well
- 1 miscarriage as teenager, saw the doctors in A&E and was given medication (you can't remember what)
- No changes to urination/frequency
- Have noticed some gradual changes to bowels – more constipated – less frequency used to be once a day now can be 2x a week with bloating

Gynae Hx
Period: Last menstrual period: 1st October 2020

- Periods regular, 28 day cycle, not usually painful
- Have **become heavier over the last 18 months as IMB has worsened** – during period also having to **change towel every 2 hours** and episodes of **flooding**
- Menarche at 14 years old

Smears: Last smear 2 years ago normal, never been to colposcopy

STIs: History of Chlamydia as a teenager, which was detected early as you always made sure you had STI screening with new partners, you had treatment at the GUM clinic and finished the course

Contraception: Use condoms with husband, tried the COCP in the past but was forgetful so wasn't an effective method for you
Menopause: N/A

PMHx – HTN, Anxiety

DHx - NKDA, Sertraline 50mg OD, Ramipril 5mg OD

FHx – Mother has HTN and T2DM, father has Alzheimer's, brother and sister well

SHx – English teacher, lives at home with long-term partner who also works in a school

- Never smoker, minimum alcohol (7U/week at weekends), never used recreational drugs

Other information:

- Other systems review - normal

Ideas: Thinks that the bleeding could be the start of the menopause, but wants to make sure there is nothing else going on because it's been 18 months now and getting heavier
Concerns: Concerned that the bleeding could be caused by malignancy as this is what she read online

Expectations: Wants to know the cause of the bleeding and know if she needs any treatment or if it is just menopause

Investigations findings

INVESTIGATIONS:
BMI – 25kg/m^2

Urinalysis – Normal and BHCG negative

Bloods – BHCG Negative, FSH and LH normal, Hb 88g/dL

Speculum Examination – Normal multiparous os with no discharge

Bimanual Examination – Irregular firm central pelvic mass easily palpable on pelvic examination as no morbid obesity. Some pelvic pain on palpation of the abdominal mass

TVUSS: - Large pedunculated submucosal mass 6cm in size, hyperechoic
- Endometrial Thickness 4mm

Examiner Brief

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- **Please do not** provide **any verbal or non-verbal feedback** for the candidate. This includes nodding to correct answers and shaking head to wrong answers - particularly during the viva.
- **Please provide positive and negative feedback** (both verbal and written) at the end of the session once the examination is complete.
- The questions below are provided as a guide for discussion only. For viva, please ask questions surrounding the case and challenge the candidate where appropriate

Examiners will grade the performance across four domains: **(15 minute station)**

1. Clinical skills
2. Formulation of clinical issues
3. Discussion of management
4. Professional behaviours and patient centred approach

Positive descriptors		**Marks**
History/Clinical skills (18)		
Appropriate introduction, elicit patient details and invite consultation		2
Bleeding: Onset, Volume, Colour and Progression		2
Presence of **clots**, **dysuria**, **dyspareunia** or **discharge**		2
Pain – with SOCRATES as appropriate		2
Menstrual history – age at time of menarche, LMP, regularity of periods and characteristics		2
Gynaecological history – **contraception**, menopause, STIs, cervical screening		2
Obstetric history – Gravity, Parity, outcome of pregnancies		2
Enquire about **risk factors**: Establish fibroid and polyp symptoms/history		2
Past medical (surgical) history; drug history, family history, social history		1
Formulation of clinical issue (5)		
Summary and **interpretation** of clinical findings **accurately**		2
Good range of differential diagnoses		1
Viva		2
Discussion of management (4)		
Build patient concerns into plan and justify choice of investigations		2
Demonstrate MDT approach		1
Viva (Management)		1
Professionalism and patient centred approach (3)		
Able to elicit patient ideas, concerns, expectations		1
Use empathic behaviour and language Explain accurately, uses everyday language and check for understanding		1
Professional communication to examiner as colleague		1

Viva Questions: (Please ask questions surrounding the case and challenge the candidate where appropriate); **The questions below are provided as a guide for discussion only.**

1. Differential diagnosis	Most likely diagnosis: Uterine Fibroids. Differential diagnoses: Adenomyosis, Endometrial Polyp, Endometrial Hyperplasia, Uterine sarcoma, Pregnancy, Ovarian cancer,
2. What are the risk factors for fibroids?	Key risk factors include increasing age, black ethnicity, and being overweight.
3. How would you manage a patient with fibroids?	**Medical therapy** Leuprorelin: 3.75 mg intramuscularly once monthly for up to 3 months; or 11.25 mg intramuscularly as a single dose OR Mifepristone: 5-50 mg orally once daily for 3-6 months OR Levonorgestrel intrauterine device: insert 52 mg device into uterine cavity, remove and replace (if necessary) after 5 years +/- Naproxen PRN 500mg PO BD **Surgical therapy** Myomectomy OR Uterine artery embolisation OR Uterine preservation not desired: Hysterectomy
4. What are the different types of uterine fibroids	submucosal, intramural, subserosal +/- being pedunculated
5. What are the prognostic factors	**Medical:** Many currently available medical therapies for the treatment of symptomatic uterine fibroids are effective for shrinking the size of fibroids, thereby significantly ameliorating fibroid-related symptoms. However, long-term use of these agents in premenopausal patients is not recommended because of serious adverse effects with prolonged use. They can, however, be effectively employed preoperatively to reduce fibroid size and reduce menstrual-associated anaemia prior to surgical intervention. - Regrow quickly when medical therapy stopped & symptoms return **Surgical:** Uterine-sparing surgeries such as myomectomy and uterine artery embolisation have been shown to be effective in treating fibroid-related

	symptoms such as menorrhagia and those related to uterine bulk.

Resource: Management of uterine fibroids
NICE CKS Management of uterine fibroids >16 years of age
https://cks.nice.org.uk/topics/fibroids/management/management/

- **If imaging shows the presence of uterine fibroids, appropriate treatment should be planned with the woman, based on the size, number, and location of the fibroids and her symptoms.**
    - **Refer to a specialist, women with:**
        - Complications, such as compressive symptoms from large fibroids (for example dyspareunia, pelvic pain or discomfort, constipation, or urinary symptoms).
        - Fertility or obstetric problems associated with fibroids — for more information, see the CKS topic on Infertility.
        - A clinical or radiological suspicion of malignancy.
        - Fibroids which are palpable abdominally, or intracavity fibroids and/or whose uterine length is measured at ultrasound, or hysteroscopy, greater than 12 cm.
    - **For women with fibroids that are asymptomatic:**
        - The majority of women require no further investigation or treatment once diagnosed unless there is rapid growth or reason to suspect pelvic malignancy.
        - Arrange annual follow up to monitor size and growth.
    - **For women with menorrhagia associated with fibroids,** see the CKS topic on Menorrhagia for management information.