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British Undergraduate Society of Obstetrics & Gynaecology
*Inspiring the next generation of Obstetricians and Gynaecologists*

# Case: Postcoital bleeding

## Candidate brief

You are an F2 doctor in a GP surgery.

Please take a focused history from Jenny Smith, a 32-year-old female who has been having some irregular bleeding

| | |
|---|---|
| 22 mins | 1. Please take a full history and examine the patient (15 mins)<br>2. Prepare case presentation (2 mins)<br>3. Present case and management plan (5 mins) |
| 15 mins | 4. Please take a full history (7 mins)<br>5. Counsel her with an appropriate management plan (4 mins)<br>6. Viva with the examiner afterwards (4 mins) |

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Reviewers: Dr Sivarajini Inparaj, FY1, Peninsula Deanery
& Jenny Maclachlan, Year 5, University of Aberdeen

# Patient Brief

(Do not volunteer information unless asked)

**Name**: Jenny Smith
**DOB**: 25/07/1988 (32 years old)
**Job:** office clerk
**Opening statement:** "*I've been having some bleeding every time I have sex and I wanted to make sure everything is okay"*

**HPC**:

- Started 2 months ago right after sex
- Small amount of bright red blood spotting which lasts about a day
- Happens every time she has sex, usually once or twice a week

**Associated symptoms**

- No pain, discharge, odour, clots

**Obs Hx**

- 3 pregnancies in the past
- 2 vaginal deliveries at 38 and 40 weeks, no complications during either pregnancy
- 1 miscarriage at 9 weeks when she was 20

**Gynae Hx**
**Period: Last menstrual period**: 2 weeks ago

- Regular 28-day cycle due to contraception
- Started periods at 13
- No abnormal bleeding except for after sex

**Smears:** has never had one
**Contraception**: combined contraceptive pill since the age of 20, stopped when she was planning to get pregnant

**Sexual Hx:**
Started being sexually active at 16 and had several partners since then.
Currently sexually active in a monogamous relationship – has been the only partner for 8 years
**STIs:** has genital herpes, no history of other STIs

**PMHx –** asthma, Hashimoto's thyroiditis

**DHx - NKDA,** salbutamol, levothyroxine

**FHx –** mother had premature ovarian failure

**SHx**

- Does not smoke, has a 10 pack-year history
- Drinks a small glass of wine every night
- Diet variable,
- Lives with her husband and 2 children who are 7 and 5
- Not very active, walks the dog most nights
- No recent travel

**Other information:**

- Other systems review - normal

**Ideas:** not sure what it could be, wonders if it could be early menopause

**Concerns**: her aunt had uterine cancer which started off with similar symptoms so she's particularly worried about cancer

**Expectations**: would like to get some tests done to make sure it's nothing malicious

**INVESTIGATIONS:**
BMI – 26kg/$m^2$

Speculum Examination – cervix appears reddened around the os, contact bleeding, no cervical excitation

Bimanual Examination – uterus is normal sized, non-tender and anteverted

Abdominal Examination – soft and non-tender, nothing of significance

Smear report: high grade dyskaryosis

Colposcopy report: the sample received measures 4 × 2 mm and contains enlarged cells with irregular nuclei consistent with CIN3.

# Examiner Brief

Candidate Brief: You are an F2 doctor in a GP surgery. Please take a focused history from Jenny Smith, a 32-year-old female who has been having some irregular bleeding

| | |
|---|---|
| 22 mins | 1. Please take a full history and examine the patient (15 mins)<br>2. Prepare case presentation (2 mins)<br>3. Case presentation including management plan (5 mins) |
| 15 mins | 1. Please take a full history (7 mins)<br>2. Counsel her with an appropriate management plan (4 mins)<br>3. Viva with the examiner afterwards (4 mins) |

- **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 2 domains: patient-student interaction and examiner-student interaction (22-minute station)

| **Positive descriptors** | | **Marks** |
|---|---|---|
| Student-patient interaction (25) | | |
| Application of effective **communication skills** which allow the student to father sufficiently accurate patient history and develop a supportive rapport with the patient | | 5 |
| **History content** – all areas of patient history covered including presenting complaint, background information and system review | | 5 |
| Explores **patient centred issues** fully by discussing impact of their condition as an integral part of the consultation | | 5 |
| **Health, hygiene and safety** – covers all required areas with fluidity and patient-centred approach | | 5 |
| **Examination** – systematic and fluid approach with good technique and demonstrates patient-centred approach throughout | | 5 |
| Student-examiner interaction (30) | | |
| **Introductory statement** – short, giving context to the subsequent presentation, includes patient name/age/occupation and condition and where they saw them. Succinct and precise | | 5 |
| **Presentation of relevant details from history and examination** – concise and accurate, well structured, clearly links history and physical examination findings | | 5 |
| **Selection of relevant investigations** – clear understanding of the investigations required and their interpretation | | 5 |
| **Identification of key issues** – key issues identified and prioritised as part of the presentation | | 5 |
| **Management plan** – full therapeutic plan detailed including sequential interventions, awareness of benefits, side effects and alternative options, clearly defined strategy to progress and review with timelines | | 5 |
| **Summarising statement** – precise and relevant details of the preceding presentation accurately summarised in a short statement | | 5 |

**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 diagnoses | • STIs<br>• Cervical cancer/neoplasia<br>• Vaginal cancer<br>• Endometrial cancer<br>• Cervical polyps<br>• Endometrial polyps<br>• Atrophic vaginitis<br>• Cervical ectropion<br>• Infection<br>• Trauma<br><br>Source: GP online, Postcoital bleeding – red flag symptoms (2018) |
| 2. Red flags | • Age >35 and symptoms >4 weeks<br>• History of abnormal smears<br>• Systemic symptoms suggesting invasive malignancy - weight loss, night sweats<br>• A recent change in sexual partners<br>• History of lower abdominal pain and fever<br>• Abnormal looking cervix or vaginal walls on examination<br>• Presence of an unexplained cervical or vulval mass<br><br>Source: GP online, Postcoital bleeding – red flag symptoms (2018) |
| 3. Risk factors for cervical cancer and CIN (cervical intraepithelial neoplasia) | • HPV infection<br>• Age group<br>• Immunocompromised state/HIV infection<br>• Multiple sexual partners and early onset sexual activity (<18)<br>• Smoking<br>• History of STI<br>• Oral contraceptive pill use<br>• High parity<br>• Uncircumcised male partner<br>• Micronutrient malnutrition<br>• Low serum folate, vitamin C and E<br>• Alcohol abuse<br>• Low socioeconomic status<br><br>Source: BMJ Best practice, Cervical cancer (2020) |
| 4. How would you manage a patient with postcoital bleeding | • STI testing<br>• Cervical smear test<br>• Urinalysis<br>• Urinary pregnancy test<br>• Transvaginal USS<br>• FBC if the bleeding is very heavy<br><br>Source: GP Online, Postcoital bleeding – red flag symptoms (2018) |

| | |
|---|---|
| | Women with PCB should be referred to secondary care and seen within 14 days if:<br>● The appearance of the cervix is consistent with cervical cancer<br>● They are aged 35 years or under with abnormal, absent or overdue cervical screening<br>● They are aged >35 years, regardless of smear history<br><br>Women with PCB aged <35 years, should be referred to secondary care and seen within 42 days<br><br>Source: Joint RCOG, BSGE and BGCS guidance for the management of abnormal uterine bleeding in the evolving Coronavirus (COVID-19) pandemic (2020) |
| 5. What are the management options for CIN 3 | Excision options:<br>● knife cone biopsy<br>● laser colonisation<br>● large loop excision of the transformation zone (LLETZ)<br>● laser ablation<br>● cryocautery<br>● cold coagulation<br>● radical diathermy<br><br>Source: Public Health England, NHSCSP publication number 20 (2016) |
| 6. How is CIN staged | Graded by how deep the cell changes go into the surface of the cervix<br>● CIN 1 – abnormal cells occupy basal 1/3 of the epithelium<br>● CIN 2 – abnormal cells occupy 1/3-2/3 of the epithelium<br>● CIN 3 – abnormal cells occupy >2/3 of the epithelium<br><br>Source: World Health Organisation, Chapter 2: An Introduction to Cervical Intraepithelial Neoplasia (CIN) (2004) |

**Algorithm for management of post coital bleeding (Joint RCOG, BSGE and BGCS guidance for the management of abnormal uterine bleeding in the evolving Coronavirus (COVID-19) pandemic)**

- Women with PCB should initially be managed by remote communication to:
  - Reassure them that a cervical cancer is extremely unlikely if they have an in-date negative cervical screening test.
  - Elucidate whether they have any risk factors for a sexually transmitted disease. If such risk factors exist, they should be seen in primary care or a Sexual Health Clinic for further investigation and management.
  - Women who do not have an in-date negative cervical screening test need to be seen for a speculum examination to exclude cervical cancer and for a smear to be taken; depending on local circumstances, this could be in primary or secondary care.

- Women with PCB should be referred to secondary care and seen within 14 days if:
  - The appearance of the cervix is consistent with cervical cancer
  - They are aged 35 years or under with abnormal, absent or overdue cervical screening
  - They are aged >35 years, regardless of smear history

- Women with PCB aged <35 years, should be referred to secondary care and seen within 42 days
- Women referred to secondary care should be investigated according to local protocols and testing resources