**Vaginal Bleeding**

\* Must r/o pregnancy in any pt with vaginal bleeding

**CCFP Priority Topics-Pregnant patients with vaginal bleeding**

a) Consider worrisome causes (e.g., ectopic pregnancy, abruption, abortion), and confirm or

exclude the diagnosis through appropriate interpretation of test results.

b) Do not forget blood typing and screening, and offer rH immunoglobulin treatment, if

appropriate.

c) Diagnose (and treat) hemodynamic instability.

|  |  |
| --- | --- |
| First Trimester (20-40% of pregnancies) | Second and Third Trimester |
| 1. Implantation bleeding 2. Abnormal pregnancy (ectopic or molar) 3. Miscarriage (threatened, inevitable, incomplete, complete) 4. Uterine, Cervical, Vaginal pathology | 1. Bloody show 2. Placenta previa 3. Placental Abruption 4. Uterine Rupture 5. Vasa previa |

**1st Trimester bleeding**

**HX:**

**Preg Hx**

GTPAL, Dates/LMP, Ultrasound

Concerns with current or past pregnancies

Blood type/ Partners blood type

**Bleeding Hx-**

Onset and Duration

Quantity – # of pads

Passing tissue or clots

RF: trauma, Intercourse, bleeding disorder, fibroid, pelvic surgery, PID, STD, IUD

**PX:**

ABC’s, Orthostatic Vital

Abdominal Exam- ? FHR

Pelvic Exam- look for source, is cervix **open or closed**, products of conception

**Investigation**

CBCD, lytes, BUN, Cr

Group and Screen

B-HCG

Transvaginal Ultrasound

**Miscarriage Definition and Management**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Definition | Clinical | Management |
| Threatened | Bleeding through a closed os | Cervix closed  Bleeding  +FHR | 1. Watch and wait |
| Inevitable | SA is imminent | Cervix dilated  Increase cramping and bleeding  Tissue visualized in os | 1. Watch and wait 2. Misoprostal |
| Incomplete | Membrane ruptured and fetus passed  Retention of placental tissue | Uterus small but not well contracted  Cervix open  ++ bleeding | 1. Watch and wait 2. Misoprostal 3. D&C |
| Complete | Complete passage of sac/gestational tissue | Uterus small and contracted  Cervix closed  Scant vaginal bleeding | No management needed |
| Missed abortion | Intrauterine death prior to 20 weeks with retention of pregnancy for prolonged period of time |  | 1. watch and wait 2. Misoprostal 3. D&C |

\*\*\* rh immunoglobulin if RH -

**Management of Ectopic Pregnancy**

1. Suspect if abdominal pain, vaginal pain and + b-hCG
2. Surgery if vitals unstable
3. Transvaginal ultrasound if stable (should see gestational sac 5.5-6 wks after LMP)
4. Methotrexate if : <3.5cm, unruptured, absent FHR, b-hCG <5000, no liver/renal/heme dz, willing and able to follow up. HCG is followed until undetectable

**2nd and 3rd Trimester Bleed**

**Differential Diagnosis**

**Cervix/Vagina**- polyps, CA, postcoital, laceration

**Bloody show**

**Uterine Rupture**

**Placental**

1)Abruption - placental separation

Presentation- bleeding plus abdominal/back pain, increased uterine tone, uterine irritability/contractions, +/- fetal distress/demise

RF include HTN, previous abruption, large uterus (macrosomia, polyhydramnios, multiple gestation), smoking, EtOH, cocaine, uterine anomaly, trauma

**2)** Placental Previa • Placenta over OS- Types: Complete or Partial previa. Marginal or Low lying

Presentation -Painless vaginal bleeding, uterus soft non-tender,+/- fetal distress

RF include history of placenta previa, multiple gestation, multiparity, increased maternal age, uterine anomalies including surgical scars

3) Vasa previa - rupture of fetal vessels- Painless vaginal bleeding and fetal distress

**Physical Exam**

Vitals- maternal and fetal

Abdominal exam including measurement of uterine size, Leopolds, increased uterine tone

Doppler for fetal heart NST

Sterile speculum-Amount of bleeding, tissue/clots, cervical dilatation, uterine and adnexal tenderness

**\*\* NO bimanual until previa ruled out with ultrasound**

**Investigations**

CBC, blood type/type and screen, crossmatch- Rh status

Kleihaurer/Apt test- assess fetal blood

Fetal Ultrasound assess for abruption

**Management**

Maternal stabilization - ABC's, monitors, IV fluids, PRBCs if required

Continuous Fetal monitoring

Rhogam Rh negative -300mcg IM

Consider corticosteroids for fetal lung immaturity (24-34 weeks GA)- Betamethasone 12mg IM q24 hr x2

Abruption <37 weeks - serial hemoglobin, deliver when hemorrhage dictates o

>37 weeks - stabilize and deliver

Placenta previa-Keep pregnancy intrauterine until the risk of delivery < risk of not delivering

Vasa previa- Emergency cesarean section

**CCFP Priority Features-In a postmenopausal women with vaginal bleeding, investigate any new or changed vaginal bleeding in a timely manner.**

**Post- Menopausal Vaginal Bleeding**

\* Most common cause in post-menopausal women is endometrial/vaginal atrophy

**Ddx/Frequency:**

Atrophic Vaginitis 59%

Endometrial polyp 12%

Endometrial hyperplasia 10%

Endometrial CA 10%

Hormonal Effect 7%

Cervical CA 2%

OTHER <1%

**Hx Important Question**

Amount/Frequency of blood loss

Medication: HRT, anticoagulants, ASA, Tamoxifen

**PX**

Vitals- Are they hemodynamically stable?

Pelvic Exam- atrophic/infectious vaginitis, cervical polyps, uterine size and contour

Pap and Swabs

**Investigation**

CBC, ferritin, TSH

Tranvaginal Ultrasound

\* Sensitivity 96% for detecting endometrial CA

\* If endometrial echo (EE) < 5 mm and symptoms resolve- WATCH

\* If endometrial echo (EE) > 5 mm or symptoms persist- NEED ENDOMETRIAL biopsy

**\*** Either endometrial biopsy, transvaginal US or both can be done to initially assess the endometrium- can base choice of first investigation upon patient preference, physician comfort with procedure, US availability

**TX**

**Results of Biopsy**

Normal- Symptoms resolve- watch

Hyperplasia without Atypia- Treat with Provera and repeat biopsy in 3-6 months

Hyperplasia with Atypia/Cancer- Gyne consult for surgery

**TX for Vaginal Atrophy-** Topical estrogen (creams, tablets, vaginal ring)

**CCFP Key Features- In a non-pregnant patient with vaginal bleeding:**

**a) Do an appropriate work–up and testing to diagnose worrisome causes (eg. CA) using an age appropriate approach**

**b) Diagnose (and treat) hemodynamic instability?**

**c) Manage hemodynamic stable but significant vaginal bleeding?**

Abnormal Uterine Bleeding: any persistent change in menstrual period frequency, duration or amount +/- breakthrough bleeding

Dysfunctional Uterine Bleeding: excessively heavy, prolonged or frequent bleeding of uterine origin which is not due to pregnancy or to recognizable pelvic or systemic disease

**Hx: RULE OUT PREGNANCY**

Amt-Def:>80 ml, changing soaked pad >1 hr, changing pad overnight, postural hypotension

Ovulatory vs.Anovulatory

|  |  |
| --- | --- |
| Ovulatory | Anovulatory |
| Cyclical bleeding  Premenstrual symptoms  Midcycle pain  Dysmenorrhea | Irregular bleeding  Minimal pain  Higher risk of endometrial hyperplasia or cancer |

Psychosocial issues-stress

Medication causing bleeding- Anticoagulants, ASA, Phenzothiazines, SSRI, TCA, Tamoxifen. Corticosteroids, Thyroxine, Contraception-OCP, DEPO, IUD

Systemic causes- ie. Thyroid

**PX:**

Pap + swabs

Pelvic/bimanual exam

\*detect genital tract pathology (fibroids. Polyps

\* if abnormal consider transvaginal ultrasound

**Investigations:**

CBC, ferritin, TSH

Coagulation work up- of FH/bleeding dyscrasia

Pelvic ultrasound

Endometrial biopsy

**Endometrial Cancer Risk Factors**

BMI >40

Age >40

DM

Anovulatory cycles/PCOS

Tamoxifen

FH of endometrial CA or colon CA

**Management of Acute Bleeding**

**If stable:** Hormonal contraceptive 2-4 pills per day for 7 days and then 1 pill/d for 2 weeks

**If unstable:** Send to emerg,

Conjugated equine estrogen (premarin) 25mg IV q 6 hr x 4 doses

Once bleeding has subsided oral hormonal therapy is continued for 2-3 weeks with conjugated estrogen 2.5 mg-10 mg daily along with progesterone (provera )10 mg for the last 10 days

Should be followed by cyclic hormonal contraceptive or cyclic progestin for 4-6 months

Gyne consult for surgical options- hysteroscopy, endometrial ablation, hysterectomy