Northern Cancer Alliance

Unscheduled Bleed on HRT British Menopause Society guidelines summary for GPs

August 2025

Title:	Unscheduled bleeding on HRT British Menopause Society NCA summary of guidelines for GPs August 2025
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Guidelines Agreed by: NCA pathway board, NTAG guidelines group and NENC CEG June 2025

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Within this document we use the terms woman and women's health. However, it is important to acknowledge that it is not only women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health. Gynaecological services and delivery of care must be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

INTRODUCTION

The BMS guidance published in April 2024 was developed in partnership with the British Society of Gynaecological Endoscopy, British Gynaecological Cancer Society, Faculty of Sexual & Reproductive Healthcare, Getting It Right First Time (GIRFT), Royal College of General Practitioners and the Royal College of Obstetricians & Gynaecologists.

Unscheduled on HRT bleeding is a common problem but referral or investigation is not always required. The BMS guideline is designed to facilitate and standardise the management of women with unscheduled bleeding on HRT. It is designed to utilise resources efficiently to ensure women are not over investigated but also identify people in whom endometrial cancer is a possibility. The full guidance is here:

Management of unscheduled bleeding on HRT joint guidance

Implementation of this guidance has been discussed with the Northern Cancer Alliance (NCA) Gynae-oncology Managed Clinical Network, the NCA GP clinical leads, ICB Imaging Network gynae special interest group and the ICB guideline development group.

DEFINITION OF UNSCHEDULED BLEEDING

For women taking Continuous combined HRT: Irregular bleeding after initiating or changing a preparation which should be bleed free.

Assessment / investigation recommended if bleeding is more than 6 months after initiating HRT or more than 3 months after a change in dose or preparation if already established on HRT or after achieving amenorrhoea on their current HRT.

For women taking sequential HRT: Bleeding in addition to the scheduled monthly withdrawal bleeds or if there is an increase in heaviness, duration of bleeding or irregular bleeding.

Unscheduled bleeding is common: Unscheduled bleeding within the first 6 months of initiating any HRT or within 3 months of change in dose or preparation in those already established on HRT is common.

It can affect 40% of women using HRT. As more women are being prescribed HRT, more are experiencing unscheduled bleeding. Referrals to the urgent suspected cancer pathway have increased by 40% in the last 3 years but the incidence of endometrial cancer has only increased by 2%.

Management depends on history, examination and individual risk assessment. (**Appendix 1**)

Heavy, prolonged or persistent and bleeding in any time scale needs earlier assessment (Appendix 1)

UNDERSTANDING RISKS OF ENDOMETRIAL CANCER

Post menopausal bleeding is not the same as unscheduled bleeding on HRT. It is defined as vaginal bleeding > 12 months after the cessation of menses due to menopause.

Women with post-menopausal bleeding: Risk of endometrial cancer is highest in women with post-menopausal bleeding who are not taking HRT.

Risks of Endometrial Cancer associated with HRT:

<table>
<tr><th>HRT prep</th><th>No unscheduled bleeding</th><th>Unscheduled bleeding</th></tr>
<tr><td>Continuous combined

ccHRT</td><td>Women who are amenorrhoeic and postmenopausal on standard dose oestrogen and proportionate progesterone. Risk of endometrial cancer seems to be lower than in non-HRT users

Greatest effect in women BMI≥ 30</td><td>Low/ standard dose oestrogen, no individual risk factors and thickened endometrium, risk of endometrial hyperplasia and cancer appears less than for women with post menopausal bleeding. Risk increases with duration of use

Moderate/ high dose oestrogen risk is unknown</td></tr>
<tr><td rowspan="2">Sequential/ cyclical

sHRT</td><td>Over 50 and using proportionate progesterone. Risk is the same as in non-HRT users for up to 5 years. Change to ccHRT after that</td><td rowspan="2">Low/ standard dose oestrogen and thickened endometrium risk of endometrial hyperplasia and cancer appears less than for women with post menopausal bleeding.

Moderate/ high dose oestrogen risk unknown</td></tr>
<tr><td>Risk increases by x3 If progesterones are used for <10 days for 6months</td></tr>
<tr><td>Unopposed oestrogen or tricycling daily oestrogen with progesterone every 3 months</td><td>Significant risk factor</td><td>Significant risk factor</td></tr>
</table>

When to assess / Investigate:

Unscheduled bleeding within 6 months of initiating or changing HRT requires history examination and check compliance and offer adjustment to progesterone dose.

If there are no individual risk factors (1 major or 3 minor risk factors) or any indication to do urgent Transvaginal ultrasound scan (TVUS) (**Appendix 1**), offer HRT/ progesterone adjustments for 6 months (follow BMS or NENC guidance) If symptoms persist > 6 months after initiating or changing HRT and compliance is good then assessment and investigation is indicated.

Assessment includes history/ examination and swabs (**Appendix 2**)

Investigation: Urgent Transvaginal USS (TVUS) within 6 weeks requested in primary care

When to refer after assessment and TVUS investigation in primary care:

(see **Appendix 1**)

Investigation Result	Pathway	Management Recommendation
TVS: Endometrial thickness (ET) ≤ 4 mm if ccHRT and ≤ 7 mm if sHRT	N/A	Offer adjustments to the HRT preparation for 6 months
TVS: ET > 4 mm if ccHRT and > 7 mm if sHRT (thickened endometrium)	USCP	Endometrial assessment (endometrial biopsy and / or hysteroscopy)
TVS: Incomplete assessment of the endometrium (e.g. fibroids/IUD obscuring) but visualised portion within normal ultrasound limits	Urgent (within 6 weeks)	Endometrial assessment (endometrial biopsy and / or hysteroscopy)
TVS: Asymptomatic (no unscheduled bleeding) with incidental ET ≥ 10 mm and *no* risk factors for endometrial cancer.	Urgent	Hysteroscopy + biopsy (preferable) or blind biopsy alone – resources dependent
TVS: Asymptomatic (no unscheduled bleeding) but incidental ET ≥ 10 mm with risk factors for endometrial cancer (x1 major or x2 minor)	USCP	Hysteroscopy + biopsy (preferable) or blind biopsy alone – resources dependent
TVS: Normal ET (≤ 4 mm if ccHRT and ≤ 7 mm if sHRT) but, • Recurrent unscheduled bleeding six months after HRT adjustments or, • Heavy or Persistent (almost daily) bleeding or, • Intracavity fluid and x1 major or x2 minor risk factors for endometrial cancer	Urgent	Endometrial assessment (endometrial biopsy and / or hysteroscopy)

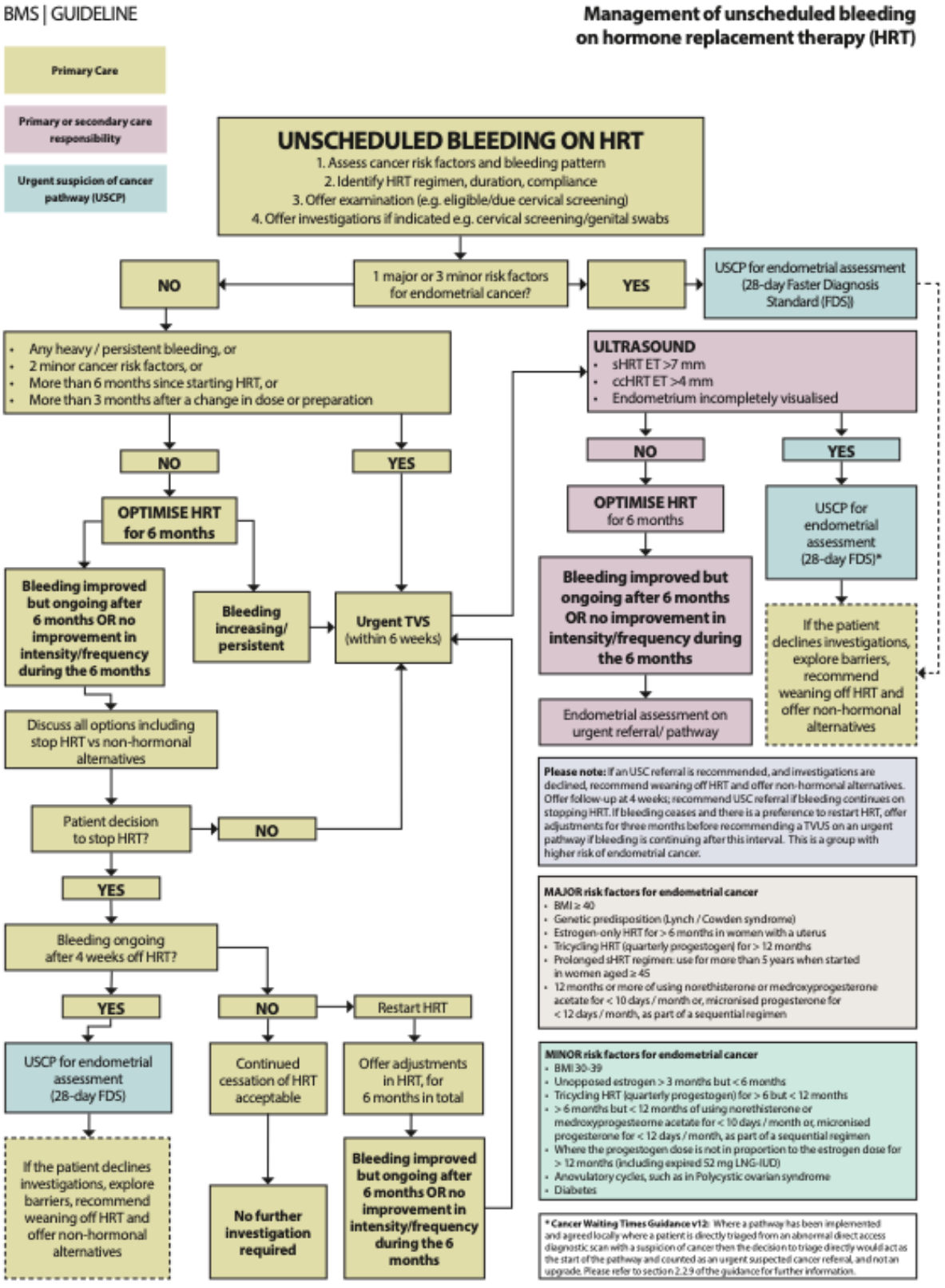
HOW TO MANAGE / ADJUST HRT?

Please use the guidance in the BMS document or the NENC guidance

and the guidance from BMS on optimum use of progesterone (**Appendix 3**)

APPENDIX

Appendix 1



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Appendix 2

Section 1: Assessment of women presenting with unscheduled bleeding on HRT

When women present with unscheduled bleeding on HRT, clinical assessment should start with a comprehensive review detailing bleeding patterns, HRT preparations and individual risk factors for cancer. Offer an examination (abdominal, pelvic) and, where relevant, initial investigations such as cervical screening, lower genital tract swabs and body-mass index (BMI).

History

- Last menstrual period or withdrawal bleed (before and during HRT)
- Bleeding pattern before starting HRT
- Pelvic pain and / or deep dyspareunia
- Discharge
- Vulvovaginal and / or urinary symptoms
- Bleeding pattern:
  - Number of episodes per month
  - Type; spotting, period-like, flooding
  - Duration of bleeding; if prolonged, is it days or weeks
  - Regularity; such as mid-cycle or before a withdrawal bleed
  - Precipitating factors; such as wiping after urinating or post-coital
- HRT use:
  - Duration since initiation or change in HRT preparation
  - Current preparation, including dose of estrogen and progestogen
  - Type of progestogen, total days in the month it is taken and route (oral / vaginal)
  - Levonorgestrel intrauterine device (52 mg LNG IUD) – type, dose, insertion date, thread checks and whether correctly sited
  - Adherence to estrogen and progestogen regimen
  - Prior preparations and interval of use (including adverse effects that led to cessation)
- Application:
  - Where is it applied
  - If a patch is used, is it sticking well and is there any irritation
  - Awareness of taking the correct order of patches or pills if a sequential preparation
  - Other sources of estrogen (such as herbal/bioidentical)
  - Contraceptive usage, if any[9]
  - Pregnancy risk; compliance with progestogen-only pill (POP), date of last medroxyprogesterone injection, insertion date of implant
  - Cervical screening history: do not delay ongoing assessment if the bleeding pattern prevents smear taking
  - Sexual history
  - Drug interactions; such as anti-epileptics, anti-fungals, COVID vaccinations, St John's Wort
- Malabsorption syndromes
- Endometrial cancer risk factors; such as genetic predisposition to endometrial cancer (Lynch / Cowden Syndrome), BMI ≥ 30, polycystic ovary syndrome (PCOS) and diabetes.

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Appendix 3

Unbalanced estrogen to progestogen dose

British Menopause Society (BMS) guidance[25] recommends a progestogen dose in proportion to the estrogen dose in people who have a uterus, to reduce unscheduled bleeding and endometrial cancer risk.[20, 24, 25, 41]. Table 3 summarises this section and outlines the progestogen dose that appears to provide adequate endometrial protection for different strengths of licensed estrogen dosages (ultra-low, low, standard, moderate and high). Table 2 clarifies the definition of low, medium and high dose estrogen in different preparations.

Table 2: Prescribed estrogen dose for ultra-low, low, standard, moderate and high dose regimens

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

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

Table 3: Progestogen dose per licensed estrogen dose in the baseline population

Estrogen dose	Micronised Progesterone		Medroxy progesterone		Norethisterone		LNG-IUD (52mg)
	continuous	sequential	continuous	sequential	continuous	sequential	
Ultra/Low	100 mg	200 mg	2.5 mg	10 mg	5 mg*	5 mg*	One – for up to 5 years of use
Standard	100 mg	200 mg	2.5-5 mg	10 mg	5 mg*	5 mg*	
Moderate	100 mg	200 mg	5 mg	10 mg	5 mg	5 mg	
High	200 mg	300 mg	10 mg^	20 mg^	5 mg	5 mg	

* 1 mg provides endometrial protection for ultra-low to standard dose estrogen but the lowest stand-alone dose currently available in the UK is 5 mg (off-license use of three noriday POP i.e 1.05 mg, could be considered if 5 mg 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 10 mg providing protection with up to moderate dose estrogen.

References

All the references in this document are from the joint guideline produced on behalf of the British Menopause Society, in partnership with the British Society of Gynaecological Endoscopy, British Gynaecological Cancer Society, Faculty of Sexual & Reproductive Healthcare, Getting It Right First Time (GIRFT), Royal College of General Practitioners and the Royal College of Obstetricians & Gynaecologists.

https://thebms.org.uk/publications/bms-joint-guidelines/management-of-unscheduled-bleeding-on-hormone-replacement-therapy-hrt/

BMS Unscheduled bleeding on HRT FAQ document