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Post Coital Bleeding

What is Post Coital Bleeding

Post Coital Bleeding (PCB) is defined as non-menstrual bleeding, which occurs immediately after sexual intercourse.[1]

Epidemiology

- Within General Practice approximately 6% of patients will present with post coital bleeding.
- PCB occurs in 0.7-39% of women with cervical cancer. [2]
- The incidence of finding a woman in the community presenting with PCB who has cervical cancer is 1 in 44,00- of 20-24 year olds and 1 in 2,400 of 45-54 year olds.[2]

What are the main causes of Post Coital Bleeding[1,2,3,4,5]

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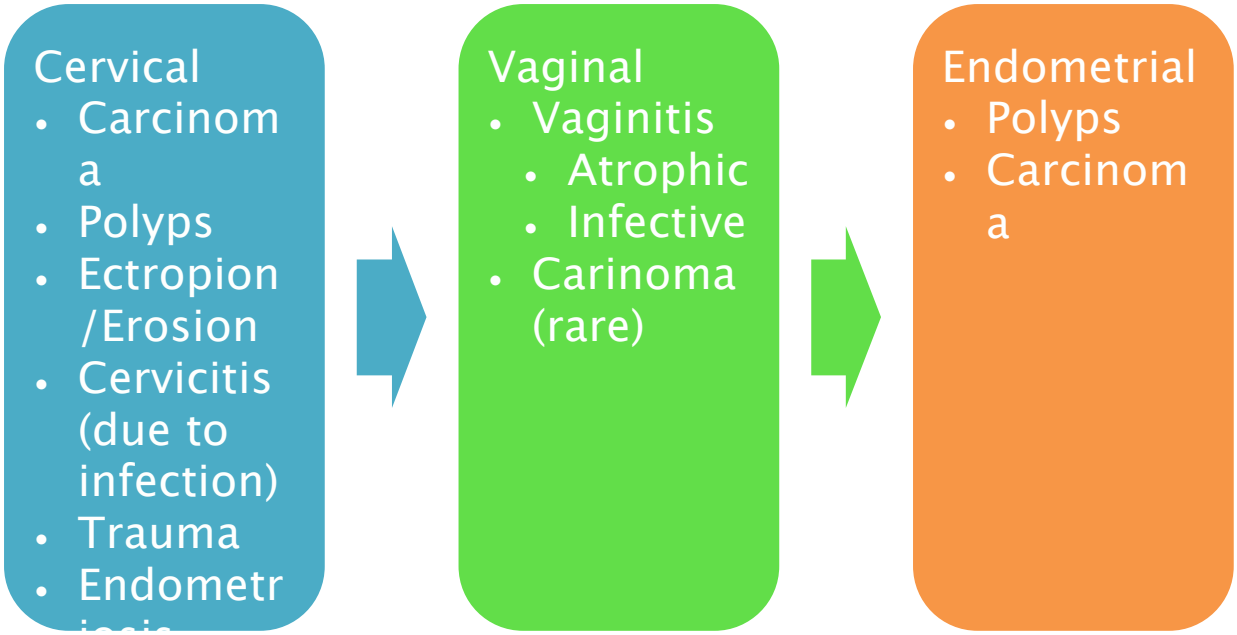

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Important questions to ask in the history

Presenting Complaint

- Post Coital Bleeding

History of Presenting Complaint

-How long has it been going on for?

- When did the bleeding start?

- How heavy is the bleeding?

- Any pain associated with the bleeding? (abdominal pain, dyspareunia [superficial or deep])

- Any urinary symptoms?

- Has this happened before?

Gynaecological History

- Menstrual
    - Last menstrual period (LMP) – when was it
    - Length and duration of normal cycle
    - Age of menarche/menopause
    - Any menorrhagia and/or dysmenorrhoea
- Sexual
    - Currently sexually active?
    - Frequency
    - Libido
    - Regular partner or multiple partners?
    - Use of contraception? If yes what kind and is it always used?
    - Any vaginal discharge? If yes colour/odour/character, vulval irritation
    - Previous history of sexually transmitted infections

- Cervical Smear history

  - Date of last smear?
  - Any previous abnormal smear result
  - Any previous treatment for abnormal result

- Any previous gynaecological history
- Any previous gynaecological surgery

Obstetric History

- Parity ...+....
- Chronological order: year, gestation, mode of delivery (SVD,caesarean)
- Any problems antenatal/intrapartum/postnatal

Systemic Enquiry

Past Medical and Surgical History

Drug History

- Use of oral contraception pill (OCP)

Family History

Social History

- Smoking – quantity per day
- Alcohol – units per week
- Occupation

Investigations

- **ALWAYS** exclude the possibility of the patient being pregnant. If this is positive then the patient requires urgent referral to early pregnancy clinic for an ultrasound +/- serial serum β-HCG. This will help to exclude an ectopic pregnancy. [1,4,5]
- **Screening for STIs** – This can be performed by a self-obtained low vaginal swab. This swab will allow for you the patient to be tested for Chlamydia and Gonorrhoea.[1,4,5]
- **Cervical Smear** – A speculum examination will allow for you to have a look at the vaginal wall for any evidence of vaginitis, an abnormal cervix, an ectropion or any obvious mass. A smear is not routinely performed

unless the patient is due for a smear. A negative smear, with persistent post coital bleeding should be referred.[5,6,7,8]

- **Bimanual examination** – Feeling for a palpable mass consistent with a polyp or carcinoma, or cervical excitation/tenderness, which would indicate pelvic inflammatory disease. [1]
- **Bloods** – may not be routinely performed but you can perform FBCs (looking for infection and anaemia), Clotting, Thyroid function and FSH/LH levels (if you suspect the onset of menopause). [1]

Management

KEY POINTS for urgent referral:[8,9,10,11]

- >35 years with persistent PCB for more than 4 weeks require URGENT referral to be seen within 2 weeks
- Any features suggestive of cervical cancer must be referred urgently
- A patient with persistent intermenstrual bleeding with a negative pelvic exam should be referred urgently
- Unexplained vulval lump
- Vulval bleeding due to ulceration
- **POST MENOPAUSAL BLEEDING IS ENDOMETRIAL CANCER UNTIL PROVEN OTHERWISE!**

Management of certain causes of Post Coital Bleeding

CERVICAL

Cervical Carcinoma

Cervical Polyps: treatment is removal, which can be done in the GP surgery or gynaecology clinic simply by twisting the polyp. This can only be done if the patient has a small cervical polyp. Larger more persistent polyps should be removed by the Gynaecologist.[4,12]

Cervical Ectropion/Erosion

These are commonly seen in teenagers and patients taking the OCP. Treatment can be with cryocautery.[4]

Cervicitis

Treatment should be tailored towards the results of the swab taken.

- Chlamydia (1g Azithromycin as a single dose or 100mg doxycycline twice daily for seven days)[13]
- Gonorrhoea (500mg ceftriaxone 500mg IM stat plus azithromycin 1g orally)[14]
- Bacterial vaginosis (Metronidazole 400mg BD for 7 days)

VAGINAL

Atrophic vaginitis[1]

This is often due to low levels of oestrogen resulting in thinning of the vaginal wall and decreased lubrication. There are multiple management options for this including:

- Encouraging the patient to use a water-soluble lubricant during intercourse
- Vaginal moisturising cream
- Avoidance of scented soaps, lotions and perfuse
- Topical oestrogen for the vaginal wall

Be aware that this can cause psychosexual problems in the patients' relationship.

Infective vaginitis[1,4]

Management is against the organism. The common causes of infective vaginitis include:

- Candida Albicans (thrush) – Topical clotrimazole 500mg pessary plus vulval cream or 150mg oral Fluconazole once only dose.
- Bacterial Vaginosis – Metronidazole 2g orally once only dose
- Trichomoniasis Vaginalis –Metronidazole 2g orally once only dose

ENDOMETRIUM

Endometrial Polyps[4]

These will require referral to the gynaecologist for surgical removal during a hysteroscopy or with curettage.

Endometrial Carcinoma

Management is dependent upon staging and surgical excision is the main stay management.[1]

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