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\(^1,2,3,4,5\)
Cervical
- Carcinoma
- Polyps
- Ectropion/Erosion
- Cervicitis (due to infection)
- Trauma
- Endometriosis

Vaginal
- Vaginitis
- Atrophic
- Infective
- Carinoma (rare)

Endometrial
- Polyps
- Carcinoma
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
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- 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.\textsuperscript{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.\textsuperscript{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).\textsuperscript{1}

**Management**

**KEY POINTS** for urgent referral:\textsuperscript{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.\textsuperscript{4,12}

**Cervical Ectropion/Erosion**

These are commonly seen in teenagers and patients taking the OCP. Treatment can be with cryocautery.\textsuperscript{4}

**Cervicitis**

Treatment should be tailored towards the results of the swab taken.
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- Chlamydia (1g Azithromycin as a single dose or 100mg doxycycline twice daily for seven days)\textsuperscript{13}
- Gonorrhoea (500mg ceftriaxone 500mg IM stat plus azithromycin 1g orally)\textsuperscript{14}
- Bacterial vaginosis (Metronidazole 400mg BD for 7 days)

VAGINAL

Atrophic vaginitis\textsuperscript{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 perfume
- Topical oestrogen for the vaginal wall

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

Infected vaginitis\textsuperscript{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\textsuperscript{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.\textsuperscript{1}
References


