Troubleshooting for Unscheduled Bleeding on HRT

What type of HRT is recommended?

If someone has endogenous ovarian activity, they require SHRT (sequential HRT) because they will bleed erratically on CCHRT (continuous combined HRT).

- Any 52mg LNG-IUD (e.g. Mirena) provides endometrial protection as part of HRT for 5 years after insertion.
- Estrogen only HRT (without a progestogen) can be used after total hysterectomy – with uterus, cervix removed and no history of endometriosis.

What bleeding pattern is expected?

Unscheduled PV bleeding in the first 6 months of starting an HRT regimen is very common, thereafter:

- Sequential HRT: PV bleed once a month only, usually in the estrogen-only phase.
- Continuous combined HRT: No bleeding expected after 6 months of use.

Consider changing to CCHRT when appropriate.

If the LNG-IUD (e.g. Mirena) has expired:

- replacement with a new device,
- or removal without replacement and change to SHRT or CCHRT may stop the bleeding.

The dose of progestogen may not be enough to prevent bleeding. (see RefHelp Sexual and Reproductive Health - Menopause for alternative options)

They are prescribed the correct HRT and there is ongoing unscheduled bleeding after 3-6 months.

Frequently found reasons why patients may not be receiving the intended dose of HRT, and bleeding as a result:

- HRT patches not remaining stuck to skin
- Estrogen gel not drying
- Gastrointestinal malabsorption
- Concurrent use of liver enzyme inducing drugs
- Concurrent use of hormonal contraception
- Incorrect use of correctly prescribed HRT
- Concurrent use of GLP-1 medication

For patches not sticking or gel not drying, consider alternative estrogen and/or oral progestogen.

For GI malabsorption or enzyme-inducing drugs, switch to non-oral options such as using **transdermal combined HRT**, or **transdermal estrogen with LNG-IUD** may stop bleeding.

Amending HRT regimen may be required to align to patient preference and facilitate correct use. For GLP-1 advice see RefHelp Sexual and Reproductive Health.

What are other causes of bleeding I should consider while adjusting HRT?

Speculum examination should be performed and may reveal a local cause of bleeding such as cervical polyp, or vaginal atrophy.

Bimanual examination may suggest fibroids or ovarian cysts, and ultrasound for assessment if so.

Consider if the patient is at risk of an STI as untreated infections may cause erratic bleeding, and less commonly bleeding may be a complication of an unplanned pregnancy.

Please arrange for routine smear testing to be brought up to date if overdue.

An atrophic appearance to the vagina or cervix may cause irregular bleeding and responds well to vaginal estrogen pessaries or cream.

Gynaecology referral for cervical polyp, and colposcopy referral if cervix appears abnormal.

Stop HRT if pregnancy test positive.

Treatment of STI if confirmed on testing.

Unscheduled bleeding on HRT (2026 Update)

GP: Vaginal/speculum examination.
Smear if overdue.

Please see PMB RefHelp for advice for:
- Women who have **post-menopausal bleeding and not using HRT.**
- **Lynch and Cowden syndrome** carry a higher baseline risk of cancer e.g. Lynch lifetime risk = 50%. In this group, a thin endometrium does not provide reassurance about the absence of underlying pathology.

Unscheduled bleeding is common, especially with the introduction of HRT, and if it is introduced in the peri-menopause. Around 80% of women will experience unscheduled bleeding which will settle by 6 months of HRT use.

The development of endometrial cancer is rare with HRT being used at BNF doses and indications.

Vulva/ vagina/ cervix cancer suspected. → **USOC referral Gynaecology**

- Unopposed or inadequately opposed estrogen.
- No changes to HRT in prior 6 months.
- 6 months or more of amenorrhoea or predictable pattern of bleeding, before the onset of unscheduled bleeding.
- Risk factors present for endometrial cancer:
  - BMI > 35 (risk x2)
  - Diabetes
  - PCOS
  - Daily estrogen dose >100mcg
- High risk genetics for endometrial cancer (Lynch & Cowden syndrome) – see info box above.

→ **Unscheduled Bleeding on HRT Ultrasound Scan Request** (not PMB Scan)

→ **Non-reassuring scan report**:
Endometrium thickened:
- Sequential HRT ≥7.0mm
- Continuous HRT ≥ 5.0mm
- Inadequately opposed estrogen HRT ≥ 5.0mm

Or,
Inadequate views of endometrium on scan

Or,
Structural causes for bleeding seen e.g. polyp or fibroid distorting endometrial cavity.

Higher risk: USOC PMB Abnormal Ultrasound Referral

→ **Reassuring scan findings:**
- Sequential HRT < 7.0mm
- Continuous HRT < 5.0mm
- Inadequately opposed estrogen HRT < 5.0mm

Lower risk: Bleeding more likely to be related to HRT.

- Less than 6 months since initiation of HRT.
- Changes to HRT within previous 6 months
- Ongoing unscheduled bleeding with normal scan or biopsy within the prior 6 months

→ **Troubleshoot HRT**

See table attached to this guidance.

Discuss stopping HRT to avoid invasive investigations.

→ Ongoing unscheduled bleeding after a **total of 12 months of HRT despite troubleshooting actions.**

Higher risk: USOC Referral + PMB scan (not unscheduled bleeding on HRT scan)

→ Ongoing bleeding at 6 weeks since stopping HRT

Higher risk: USOC Referral + PMB scan (not unscheduled bleeding on HRT scan)