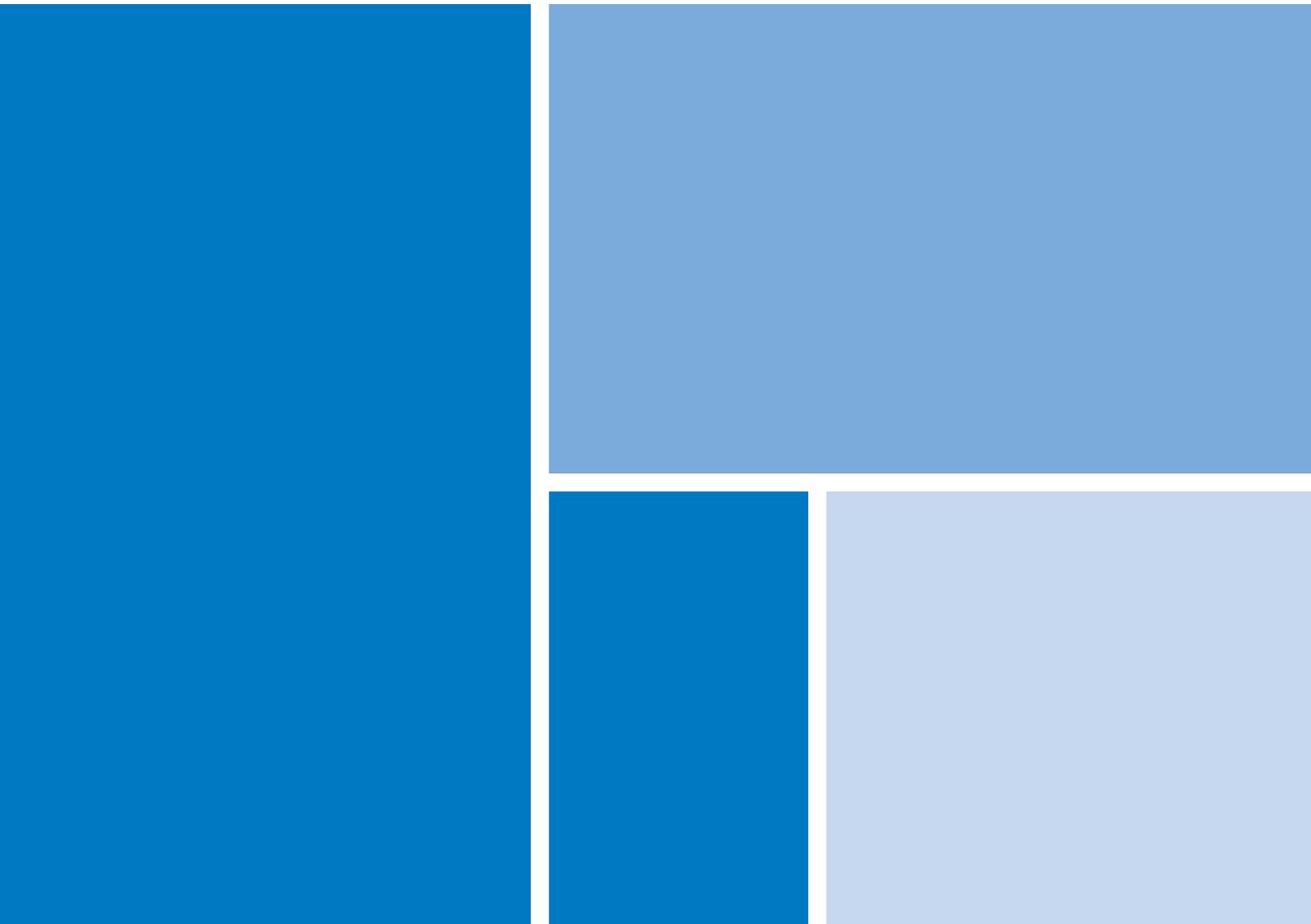


# Clinical Practice Guidance for the Assessment of Young Women aged 20-24 with Abnormal Vaginal Bleeding





## Background

A recent review by the Advisory Committee for Cervical Screening recommended no change to the age of commencing cervical screening and that the screening range would remain at 25-64 years.

This decision was based on the potential for more harm, through morbidity consequent to screening, than benefit achieved by preventing cervical cancer. It was recognised, however, that in the rare cases of cervical cancer which do occur in women younger than 25 years (around 50 per year, with 0-5 deaths). There is a delay in diagnosis in a significant proportion because of delayed pelvic examination following self-referral with abnormal bleeding. The explanation for these delays, which have been documented at 4-6 months in some cases, is that relatively common symptoms of abnormal vaginal bleeding may be attributed initially to dysfunctional bleeding, or related to oral contraceptive use. The ACCS recommended the development of clinical practice guidance, which would reduce the risk of a delayed diagnosis of cervical cancer, by identifying those women most at risk of cervical cancer.

## The Size of the Problem

The number of women aged 20-24 years who develop cervical cancer is generally fewer than 50 cases per year and this will fall over the next 10 years as a consequence of the national HPV vaccination programme. By contrast abnormal vaginal bleeding is relatively common in this age group. It has been estimated from a general practice dataset in Scotland (unpublished) that postcoital bleeding is reported by around 1 in 600 women aged 20-24 per year. Intermenstrual bleeding is more common than this and it may be that 0.5-1% of women in this age present with abnormal vaginal bleeding each year. There are around 1.5m women aged 20-24 in England and it could, therefore, be estimated that 7,500 – 15,000 women per year will report abnormal vaginal bleeding. In practice the number could be larger than this.

## Developing a Guidance for Clinical Practice

The cardinal symptom of cervical cancer in this age group is postcoital bleeding, but persistent intermenstrual bleeding, which is more common, also requires attention. The critical intervention in the diagnosis of cervical cancer is an immediate speculum examination as recommended by SIGN2 and NICE3 Guidance, to enable a clear view of the cervix. Following a relevant history, it is, therefore, necessary for women who present with postcoital bleeding or persistent intermenstrual bleeding to be offered a speculum examination either in primary care or at a GUM clinic. This could be performed by a practice nurse experienced in cervical screening.

If the cervix looks abnormal and suspicious, which will be the case in a very small proportion, the correct action is urgent referral to colposcopy under the 'two week wait' rule. If there is a benign lesion, such as cervical polyp, a routine gynaecological referral will suffice. If the cervix looks normal, the recommended action will be a pregnancy test and testing for cervical infection (e.g. Chlamydia, N Gonorrhoea, Herpes), which could be performed in general practice, family planning clinics or GUM clinics. Any positive tests for sexually transmitted infections would need to be appropriately treated.

This pathway is illustrated below.

The impact of this guidance will be monitored by the Advisory Committee for Cervical Screening.

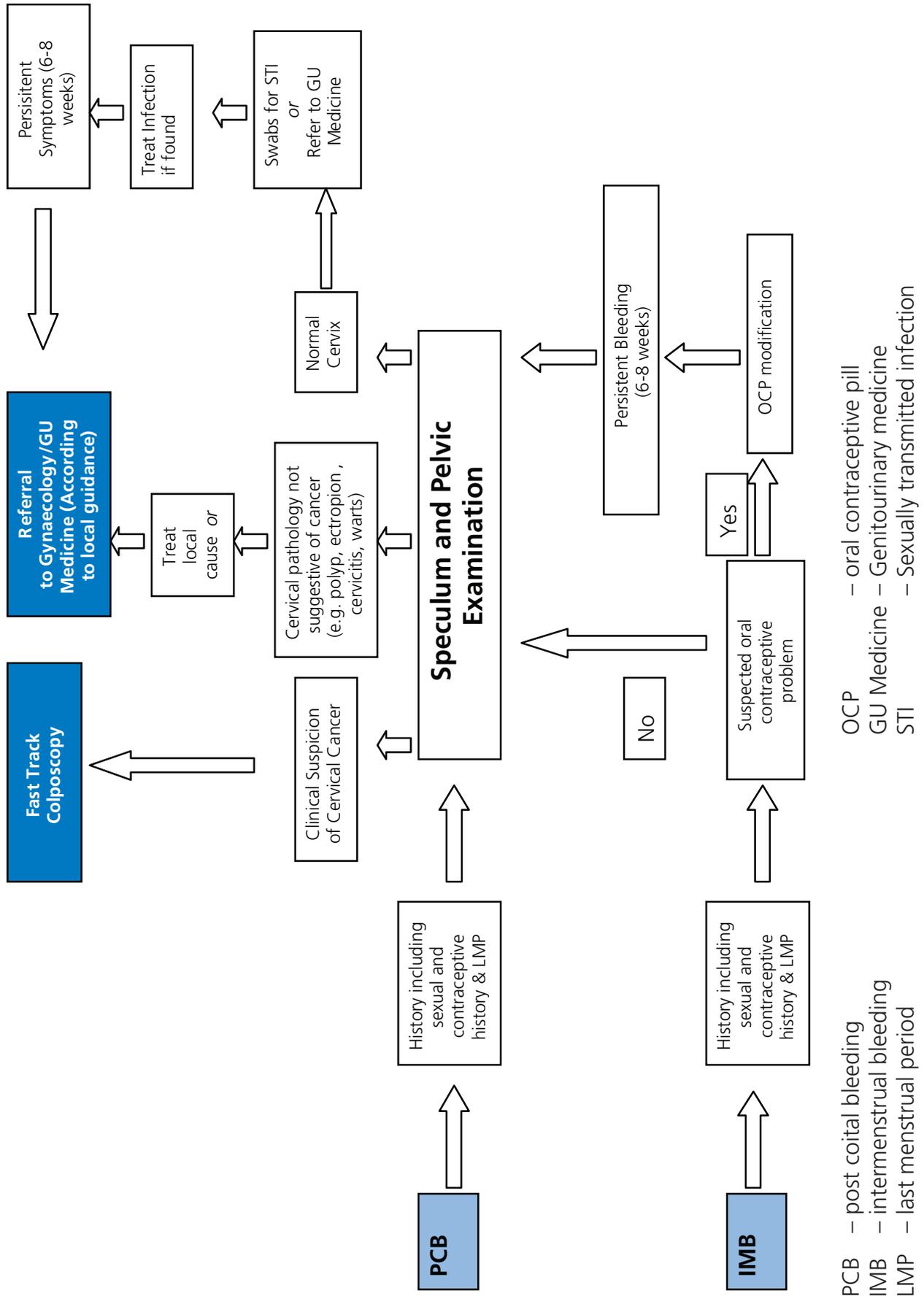
NHS Cancer Screening Programmes produce *Cervix chart for sample takers in primary care*, with pictures of the cervix showing various abnormalities. Copies of the chart can be ordered from [www.orderline.dh.gov.uk](http://www.orderline.dh.gov.uk), quoting NHSCSP publication No 25.

## References

1. Cancer Research UK Cancer Stats, Cervical cancer mortality by age  
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2. Scottish Intercollegiate Guidelines Network (SIGN). Guideline 99, page 4, Management of Cervical Cancer, January 2008, Edinburgh, <http://www.sign.ac.uk/pdf/sign99.pdf>  
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Accessed 25th January 2010.

This guidance was developed by a working Subgroup of the Advisory Committee on Cervical Screening:

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302095 Mar 10  
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Gateway ref: 13767