

Postmenopausal Bleeding: A Blessing in Disguise

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Abstract

This case report highlights the issue of a clinical need for screening older women beyond the age of 65 years for HPV screening. In view of the emerging evidence of a second peak of cervical cancer in the older population and the fact that there is a reported increase in the prevalence of HPV in this high-risk group, there is room for a consideration of HPV screening in post menopausal women beyond the age of 65 years.

Keywords: Cervical cancer; HPV; Screening; Menopause; Bleeding

Introduction

Postmenopausal bleeding (PMB) is associated with significant anxiety due to risk of malignancy in 5-25% of cases. The other common causes are atrophic vulvovaginitis, endometrial polyp and submucous fibroids. Symptoms of PMB warrant investigations to exclude presence of malignancy.

Case Report

We present an interesting case of PMB which led to the diagnosis of high grade cervical intraepithelial neoplasia.

A 79-year-old multiparous woman was referred with an episode of vaginal spotting 2 weeks ago, which had settled completely. She had long standing uterovaginal prolapse. This was being managed by a ring pessary, replaced every six months. The latest being three months ago. She had no medical disorders. Her cervical smears in the past were unremarkable and she had come off the national cervical screening programme at the age of 65 years.

She had a similar episode of PMB 8 months ago. The endometrial biopsy taken at that time showed atrophic changes

Vaginal Ring pessary was removed for pelvic examination which revealed procidentia with cystocele, rectocele. There was no vaginal ulcer. There was significant cervical elongation and hypertrophy, keeping in with the long standing prolapse

A Pelvic ultrasound scan demonstrated an endometrial thickness of 8 mm and an outpatient Hysteroscopy showed presence of an endometrial polyp. Endometrial curettage and polypectomy was performed. The histopathology of both was subsequently reported to be benign. However, tissue from the endocervical canal, taken inadvertently, was reported as cervical intraepithelial neoplasia-2 (CIN-2).

In view of the unexpected diagnosis, she was invited for a colposcopic assessment of the cervix. The colposcopy was unsatisfactory as the squamocolumnar junction could not be visualised. An Excisional treatment (Large Loop excision of Transformation Zone) was performed with consent. The histopathology of this cervical tissue was subsequently reported as complete excision of CIN 2.

She was advised for a follow-up smear in 6 months and a test of cure, i.e. HPV screening.

Discussion

This case report elucidates the rare occurrence and unusual presentation of unsuspected high grade dyskaryosis in a woman presenting with PMB. The accidental diagnosis of high grade CIN following endometrial and endocervical biopsy makes it unique.

Further to this, as CIN is a cytological diagnosis, the episodic spotting which may be due to the intravaginal ring pessary or the endometrial polyp initiated the investigations and subsequently high grade cervical dyskaryosis was diagnosed.

The recommended age for cervical screening in England, Wales and Northern Ireland, is between 25 and 64 years. The women are invited for three yearly smears from 25 to 49 years, and thereafter five yearly testing until the age of 64 years when presumably if all screening has been normal previously, they are discharged from the national screening programme. There is no routine cervical screening beyond the age of 64 years.

Unlike majority of cancers, cervical cancer is primarily a disease of young women. It accounts for 16% of all cancers in

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the age group of 15 - 34 years [1]. The peak age of diagnosis is between 25 and 29 years. Most high grade abnormalities (CIN-2 and worse) in postmenopausal women are not recognized by a single pap smear [2]. Approximately 60% of cervical cancers occur in women over the age of 45 years, and only 20% in women over the age of 65 years [3].

HPV is isolated in 99.7% of cervical cancers. The peak prevalence of HPV infection occurs in sexually active young women and decreases in middle-aged women. There is evidence that a second spike of increased prevalence of High Risk HPV subtype occurs in postmenopausal women [4]. Certain high-risk HPV subtypes are more likely to persist in older women [5]. A large fraction of pre-invasive cervical cancer cases in postmenopausal women result from infections by HPV types not included in the present vaccine formulas [2].

Cytology screening in postmenopausal women has its limitation due to atrophic changes in the cervix. However, the availability of HPV testing could be a valuable tool for screening older women. Though postmenopausal women do have increased risk of developing cervical cancer, there is very little information available given that there is a secondary peak in prevalence of high-risk HPV subtypes [4].

High-risk HPV which is associated with low grade abnormality has a prevalence of 25% in women over the age of 50. The greatest percentage of high-risk HPV is found within women aged 60 - 70 [5].

In summary, postmenopausal women remain susceptible to HPV-related lower genital tract disease. Despite their age, these women should continue to have HPV testing in appropriate clinical context. HPV remains a useful modality for identifying several treatable lower genital tract diseases in this older population [6].

Unfortunately, these women are not on the national cervical screening programme. In a rapidly growing elderly population, there should be some consideration for continued surveillance for cervical malignancy. There is low efficiency of Pap smear in postmenopausal women; however, HPV testing can

be an important tool for identification and possibly treatment of postmenopausal women as there is a second rise of the HPV DNA detection rates in the postmenopausal years [7].

Without continued surveillance and gynecologic care, many postmenopausal women may suffer from undiagnosed lower genital tract disease.

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