

POSTCOITAL BLEEDING

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Defination

- Spotting or BPV that occurs during or after sexual intercourse and is not related with menses
- Prevalence: 0.7%-9%
- 6% in menstruating women

Course

- For premenopausal
 - Resolution in 51%
 - 30% have AUB also
 - 15% have dyspareunia

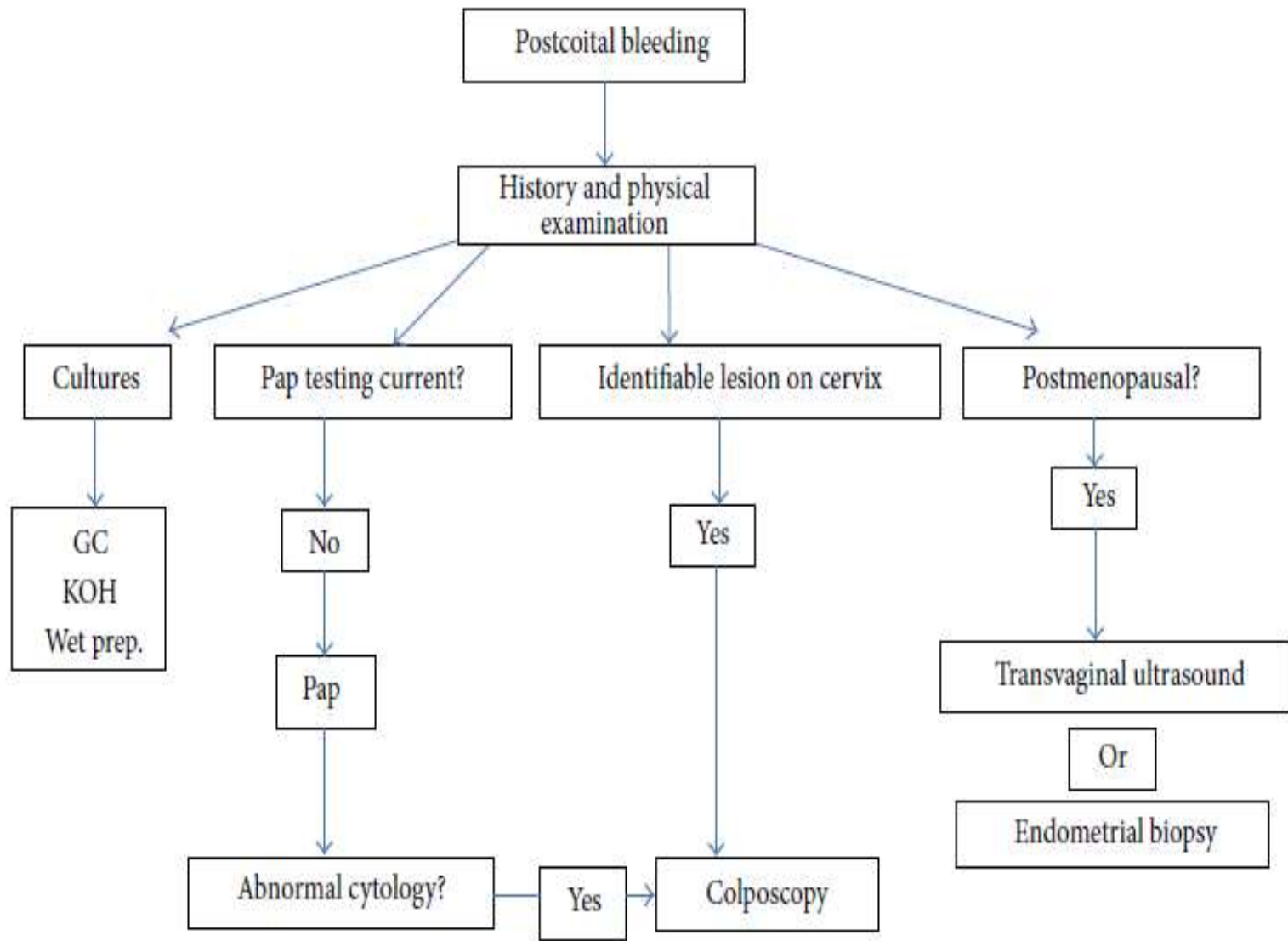
Causes

- **Cervical** : Polyps, Carcinoma, Ectropion, Trauma, Cervicitis, Genital warts
- **Vaginal** : Carcinoma, Vaginitis (Atrophic or Infective)
- **Endometrial**: Polyps, Carcinoma

COMMON CAUSES

- **Benign growths:** endometrial polyps, cervical polyps, ectropion
- **Infection :**
 - cervicitis, PID, Endometriitis, Vaginitis
 - Genital/vulvar lesions: HSV, syphilis, Chancroid, LGV, CA
- **Benign conditions:** vaginal atrophy, POP, Benign vascular neoplasm, endometriosis
- **Malignancy:** cervical , endometrial, vaginal
- **Trauma :** sexual abuse, foreign bodies

- Risk of cervical CA in PCB
 - Age<25 years: 1/4400
 - 25-35 years: 1/5600
 - >35 years: 1/2400-2800



Ca Cervix

- Age
- Pregnancy
- Fertility desire
- Staging
- Size of tumour
- Comorbidities: obesity, nutritional status, diabetes and hypertension

FIGO 2018 Staging

FIGO stage	Definition
I	Cervical carcinoma confined to uterus (extension to corpus should be disregarded)
IA	Invasive carcinoma diagnosed only by microscopy, with maximum depth of invasion < 5 mm
IA1	Stromal invasion < 3.0 mm in depth (measured from the base of the epithelium)
IA2	Stromal invasion \geq 3.0 mm and < 5.0 mm in depth
IB	Clinically visible lesion confined to cervix or microscopic lesion with deepest invasion \geq 5.0 mm (greater than Stage IA)
IB1	Invasive carcinoma \geq 5.0 mm in depth of stromal invasion and < 2.0 cm in greatest dimension
IB2	Invasive carcinoma \geq 2.0 cm and < 4.0 cm in greatest dimension
IB3	Invasive carcinoma \geq 4.0 cm in greatest dimension

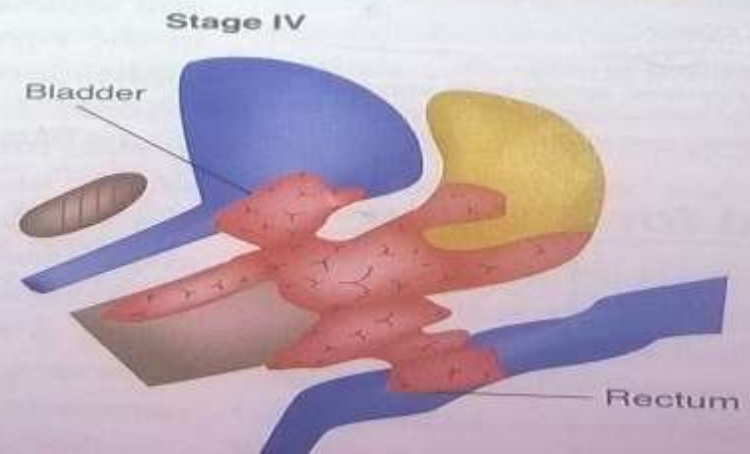
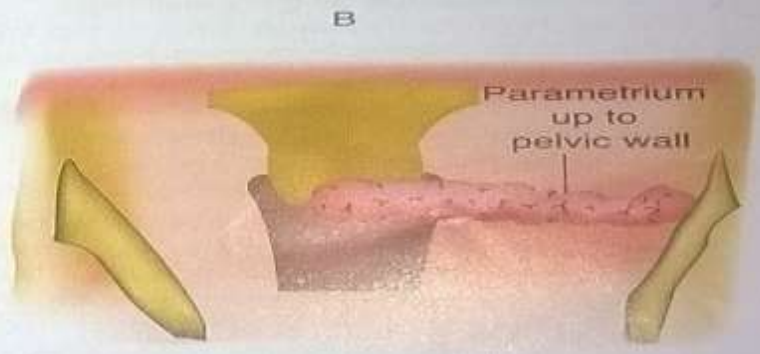
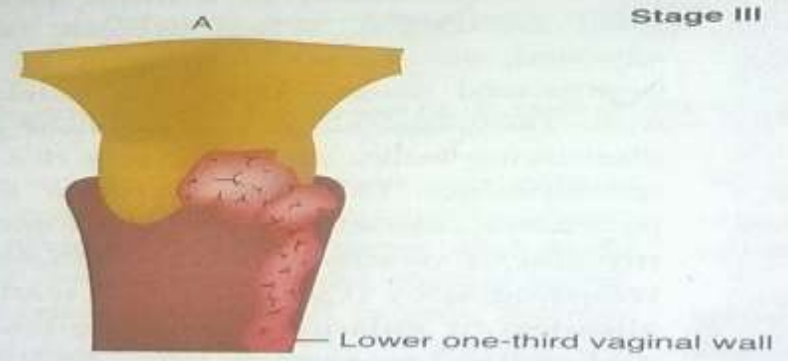
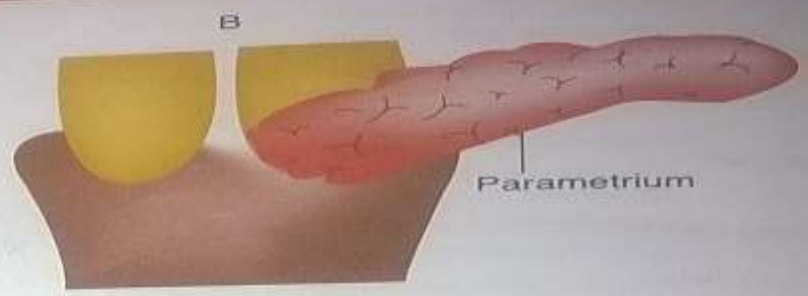
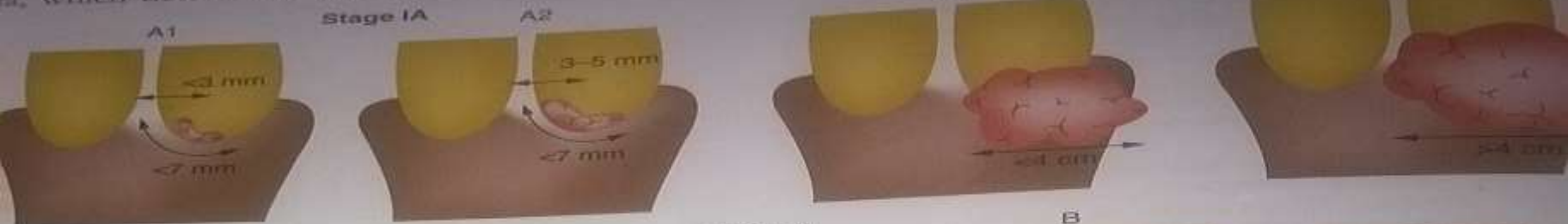
FIGO 2018 Staging

FIGO stage	Definition
II	Cervical carcinoma invades beyond uterus, but has not extended onto the lower third of vagina or to the pelvic wall
IIA	Involvement limited to the upper two-thirds of vagina without parametrial involvement
IIA1	Invasive carcinoma < 4.0 cm in greatest dimension
IIA2	Invasive carcinoma \geq 4.0 cm in greatest dimension
IIB	Tumor with parametrial involvement but not to the pelvic wall
III	The carcinoma involves the lower third of the vagina and/or extends to the pelvic wall and/or causes hydronephrosis or nonfunctioning kidney and/or involves pelvic and/or para-aortic lymph nodes
IIIA	Tumor involves lower third of vagina, no extension to pelvic wall

FIGO 2018 Staging

FIGO stage	Definition
IIIB	Tumor extends to pelvic sidewall and/or causes hydronephrosis or nonfunctioning kidney
IIIC	Involvement of pelvic and/or para-aortic lymph nodes, irrespective of tumor size and extent
IIIC1	Pelvic lymph node metastasis only
IIIC2	Para-aortic lymph node metastasis
IV	The carcinoma has extended beyond the true pelvis or has involved (biopsy proven) the mucosa of the bladder or rectum
IVA	Spread to adjacent organs
IVB	Spread to distant organs

tips in identifying CIN III changes...
a, which determines the size of the vaginal cuff

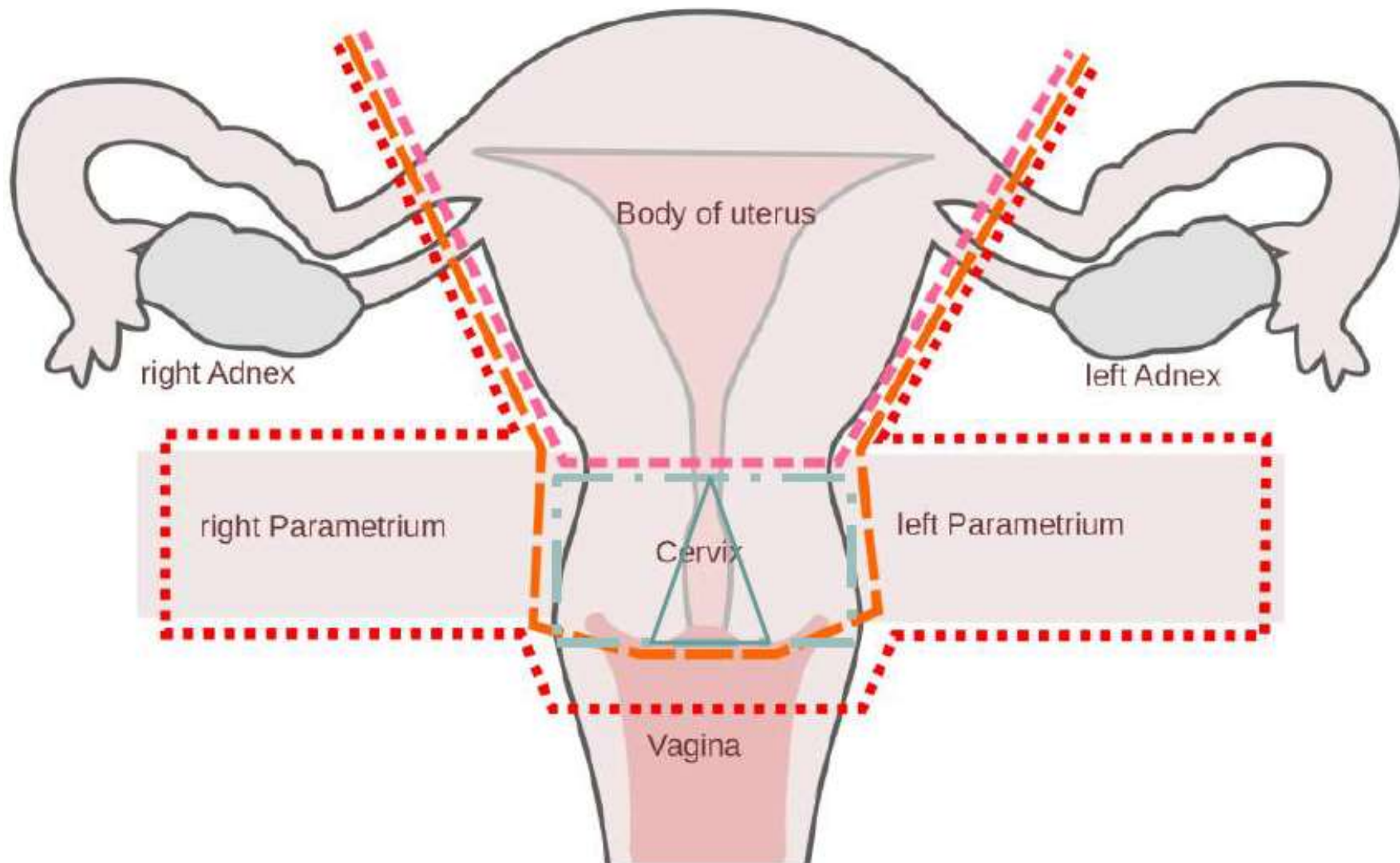


Preop inv

- Routine
- Cystoscopy/ proctoscopy not mandatory
- IVP
- MRI optional
- Final staging cannot be changed once therapy has begun. If in doubt the lower stage s/be chosen

- CIS, Stage 1-2 A– surgical
- Beyond: radiotheapy/ chemoradiotherapy

MICROINVAASIVE DISEASE Stage 1 A1 with no LVS	Conization if fertility is to be spared/ simple hysterectomy
Stage 1 A1 with LVS	Conization with laparoscopic SLN mapping and lymphadenectomy or pelvic lymphadenectomy
Stage 1 A2, 1 B, 2 A	Radical hysterectomy with lymphadenectomy
1 A2, 1 B 1 <2 cm	Radical trachelectomy with lymphadenectomy
2 B & onwards	Radiation / chemoradiation/chemotherapy f/by RH
Recurrent disease	Pelvic exentration



- - - subtotal
 - - - total
 · · · radical

- - - Trachelectomy
 △ Conization

TABLE 73.7 TYPES OF ABDOMINAL HYSTERECTOMY

	Intrafascial	Extrafascial Type I	Modified Radical Type II	Radical Type III-IV ^a
Cervical fascia	Partially removed	Completely removed	_____	_____
Vaginal cuff removal	None	Small rim removed	Proximal 1-2 cm removed	Upper one-third to one-half removed
Bladder	Partially mobilized	_____	_____	Mobilized
Rectum	Not mobilized	Rectovaginal septum partially mobilized	_____	Mobilized
Ureters	Not mobilized	_____	Unroofed in the ureteral tunnel	Completely dissected to the bladder entry
Cardinal ligaments	Resected medial to the ureters	_____	Resected at level of the ureter	Resected at pelvic the sidewall
Uterosacral ligaments	Resected at level of the cervix	_____	Partially resected	Resected at postpelvic insertion
Uterus	Removed	_____	_____	_____
Cervix	Partially removed	Completely removed	_____	_____

^aType IV, extended radical hysterectomy (partial removal of the bladder and/or ureter), in addition to type III.

Radiation

- Chemotherapy
Cisplatin 40 mg/M² weekly for 4 weeks
- External radiation
Start along with chemotherapy
Daily for 5 day/week, total 5 weeks (25 fractions)
- Intracavitary radiation
Low dose rate (LDR)
Radioactive source: Caesium-137
Duration: 36–48 hours
High dose rate (HDR)
Radioactive source: Iridium-192
Once a week for 2–3 weeks
- Total dose
Point A: 80–85 Gy
Point B: 55–65 Gy

Complications

Radical surgery

- Preservation of ovaries
- No vaginal narrowing
- Sexual function preserved
- More immediate complication
- Less late complications
- difficult in obese women
- Has to be followed by radiotherapy

Radiotherapy

- Ovaries affected
- Vaginal narrowing
- More late complications than immediate

Post treatment surveillance

- History and examination every 3-6 months for 2 years
- Every 6-12 months thereafter for 3-5 years
- Annual cytology recommended
- Patient education regarding symptoms
- Healthy life style, obesity , nutrition, and exercise, smoking cessation

Prognostic factors

- Stage
- Type
- Grading
- Size/bulk
- Lymph node metastasis
- LVSI
- Molecular markers
- Age
- Functional status
- comorbidities

