Podcast Script

Title: Rethinking the Workup for Postmenopausal Bleeding

Audience: Women's health physicians and advanced practice clinicians (PA-C, CNM, WHNP)

Format: Moderated conversation; Host (women's health clinician) and Subject Matter Expert (Gyn-Onc MD)

Educational objectives: Upon completion, participants will be able to: (1) explain why a thin endometrial stripe no longer reliably excludes cancer in postmenopausal bleeding; (2) differentiate patients eligible for ultrasound-only evaluation from those needing immediate biopsy using ACOG's criteria; and (3) formulate an evaluation plan for postmenopausal bleeding that incorporates risk factors and racial disparities in aggressive disease.

Duration: ~20 minutes

INTRODUCTION

HOST: My name is Dr. Gyn. Welcome back to (name of podcast). As someone who practices women's health, I know that you've triaged postmenopausal bleeding hundreds of times. You send your patient for a transvaginal ultrasound. If the endometrial stripe is thin, you reassure the patient and review precautions. "Call me if it happens again." The reassurance of the thin stripe is a reflex ingrained into how most of us were trained and practice. But in April of this year (2026), the American College of Obstetricians and Gynecologists (ACOG) told us that for most patients, the thin stripe is no longer enough. Today, we're going to talk about endometrial cancer and why a testing threshold we've trusted for two decades is being retired for most patients. This is practice-changing guidance from ACOG. We'll talk about what replaces the previous guidance, and who has been quietly falling through the cracks of the old approach.

[PAUSE]

HOST: Today, I'm joined by Dr. XX. Dr. XX is a Gynecologic Oncologist. Not only does she help care for our patients, but her research also focuses specifically on endometrial cancer — so she's been watching the evidence that guides the new recommendation accumulate for years. Dr. XX, welcome.

DR. XX: Thanks for having me today!

HOST: Before we get going, I want to mention that today's episode is approved for (number) *AMA PRA Category 1 Credit™*. To claim your credits after listening, head over to our show notes, click the link to complete the brief online evaluation and assessment, and your certificate will be generated immediately. And Dr. XX, you have no disclosures.

DR. XX: That's correct. And thanks again for inviting me today. This is a topic I care about a lot, both as a clinician and as a researcher. And to be honest, many of us in the Gyn-Onc community have been anxious to get these new guidelines out. This is not just an issue about making the diagnosis, but an equity problem.

HOST: We are definitely going to get into why this is an equity issue. But first, let's start with the thing we all already know: postmenopausal bleeding is a symptom we don't ignore. Can you talk about that a little bit more?

SEGMENT 1 — THE PROBLEM

DR. XX: We all know postmenopausal bleeding is the sentinel symptom of endometrial cancer. About 90% of patients who turn out to have endometrial cancer present with it. That part hasn't changed. What HAS changed is the denominator. Endometrial cancer incidence has been climbing 1-2% a year, and unlike almost every other cancer, we have not improved outcomes in decades. The American Cancer Society estimated about 68,000 new uterine cancer cases and more than 14,000 deaths in the US in 2026.

HOST: Wow.

DR. XX: Right? I think that, unless you are like me, taking care of patients with endometrial cancer every day, many clinicians don't appreciate how things have changed.

HOST: Yes, many of us think about endometrial cancer not only as the most common gynecologic cancer, but also as a relatively indolent cancer – one that is highly treatable.

DR. XX: Yes, and in many cases, it is highly treatable - as long as we catch it early. Localized endometrial cancer has a five-year survival of 95%. Regionally advanced or metastatic disease drops the five-year survival to somewhere between 20 and 70%. So, the first bleeding episode is the time to identify disease. There are potentially big implications if we miss it on the first go-around.

HOST: Ok, so let's talk about why we've typically started the evaluation with a transvaginal ultrasound.

SEGMENT 2 — THE OLD STANDARD

DR. XX: Sure. The standard came from the ACOG Committee Opinion 734 in 2018, which reaffirmed guidance that goes back to 2009. The rule was simple and easy: for a patient with postmenopausal bleeding and an endometrial thickness of 4 millimeters or less, transvaginal ultrasound without a biopsy was an acceptable initial evaluation. The justification was a negative predictive value for cancer exceeding 99%, based on several large cohort studies. With a thin stripe, cancer was effectively ruled out. No need to biopsy.

HOST: So, what happened?

DR. XX: Well, notably, those studies were done in populations that don't accurately reflect the US. They also excluded cases in which the endometrium wasn't completely visualized. A more recent meta-analysis of 44 studies and more than 17,000 women, which generalizes much better to the US population, found the sensitivity of the 4-millimeter cutoff to be 94.8%. That means the current cutoff misses at least 5% of endometrial cancers.

SEGMENT 3 — HIGH-RISK CANCERS

HOST: And isn't it true that some of the endometrial cancers don't tend to cause thickening of the endometrial stripe?

DR. XX: Non-endometrioid type II cancers, such as papillary serous, mucinous, and clear cell, sometimes don't cause thickening of the endometrial lining. High-grade endometrioid cancers also fall into this category. These are aggressive cancers. So, for these tumors, a 3-millimeter stripe isn't reassurance; it's a blind spot. And that is exactly where the disparity comes in.

SEGMENT 4 — RACIAL DISPARITY

HOST: Tell me more about that.

DR. XX: The disparities here are stark. Endometrial cancer incidence is rising faster among Black women than White women. And Black women are more than twice as likely to die of the disease.

HOST: Why?

DR. XX: Well, we know that self-reported Black race is associated with genetic and epigenetic predisposition to the TP53-mutated cancers, which confer a higher risk. In fact, about 30% of Black women with endometrial cancer have type II, non-endometrioid disease. The TP53-mutated cancers are included in this type. That's roughly three times the rate in other groups. As we talked about, these are the very cancers that don't tend to thicken the stripe. So, the population carrying the most aggressive disease is disproportionately disadvantaged when we rely on an ultrasound-only strategy. But we also know that there are effects of systemic racism. Unequal care, access, and treatment as well as other social determinants of health contribute.

HOST: So, can you be more specific about that? And before you go on, I want to take this opportunity to encourage our listeners to also review the ACOG Committee Statement #10, which discusses racial and ethnic inequities in Obstetrics and Gynecology as a whole. We will link to that in the show notes.

DR. XX: Compared with White women, Black women are more likely to be diagnosed with advanced endometrial cancer. Black women experience more barriers to care and have a lower likelihood of receiving guideline-concordant care.

HOST: Fibroids are a good way to illustrate some of these issues, right?

DR. XX: Yes, fibroids are a good example. They're more common in Black women and distort the uterus, often obscuring the endometrial stripe. This makes ultrasound technically more challenging and often inadequate. The endometrial stripe is often incompletely visualized in this scenario.

HOST: Wasn't there some very recent data about this?

DR. XX: That's right. In a retrospective cohort of more than 3,000 women who underwent transvaginal ultrasound for postmenopausal bleeding, non-Hispanic Black women were shown to have a higher rate of inadequate ultrasound examination, a finding attributable to fibroids.

HOST: And is there some element of *mis*attribution that contributes here, too?

DR. XX: The data show that, too. Because fibroids are so common in this group, both patients and clinicians may chalk the bleeding up to "just the fibroids" instead of treating it as a cancer alarm. So the biology and the behavior compound each other — the tumor is harder to see, and it's easier to dismiss.

HOST: So, is this an equity issue? Or is it a quality issue?

DR. XX: It's both, and that's really the whole point. We now realize that the 4-millimeter threshold underperforms as a test. That's a quality failure that touches **every** patient. But it underperforms **disproportionately** for Black women, at a clinically meaningful rate, and that's an equity failure. Unfortunately, a lot of the evidence about disparity predated the ACOG guidance change by four or five years. We had the data and now the official guidance is finally catching up.

HOST: Well, I'm glad we're here. Let's talk about the new guidance.

SEGMENT 5 — THE NEW GUIDANCE

DR. XX: The core recommendation is this: for most patients with postmenopausal bleeding, the initial evaluation should now include BOTH transvaginal ultrasound and endometrial tissue sampling. **BOTH**. Up front, with the first episode of bleeding. Not an ultrasound to decide whether or not to biopsy.

HOST: Doesn't ACOG say that there are some women for whom ultrasound alone is acceptable?

DR. XX: It does. But this group is small. And the criteria are strict. Here's the deal: You can defer the biopsy only when ALL of these are true: One: a single episode of

bleeding, not recurrent. Two: a fully visualized endometrium at 4 millimeters or less. Three: no factors strongly associated with increased risk of endometrial cancer. And four: the patient is counseled that continued or recurrent bleeding means immediate re-evaluation. Included in the last criterion is the caveat that the patient has no significant barriers to prompt follow-up. If any of these don't apply, you can't rely on ultrasound alone.

HOST: For our listeners, could you review the risk factors strongly associated with endometrial cancer?

DR. XX: Absolutely. ACOG names exogenous estrogen use, with or without a progestin; SERM use, tamoxifen being the most common one; a BMI over 30; nulliparity; genetic predisposition such as Lynch or Cowden or a family history of endometrial cancer; diabetes; and Black race. Many of our patients have one or more of these risk factors and, therefore, would not be candidates for ultrasound only.

HOST: Here's a question I suspect many of our listeners will have. If we're biopsying most of these patients anyway, why do the ultrasound at all?

DR. XX: Great question. Ultrasound still tells us things biopsy can't: polyps, submucosal fibroids, focal lesions, adnexal findings — structural information that may change management and be helpful for surgical planning, if you're going down that road.

HOST: Can we talk a little bit more about the endometrial biopsy, especially for clinicians listening who aren't proceduralists?

DR. XX: Absolutely. An endometrial biopsy is a brief procedure that is performed in the office. There is no anesthesia required and really no downtime. It's normal to have some cramping, but that resolves pretty quickly, and we try to pretreat with NSAIDs before the procedure. So, for those of you who have ordered the ultrasound and are sending the patient to an OB/GYN or other clinician who performs biopsies, this is good, basic counseling for the patient. I think it's also worth telling patients that we now understand that ultrasound alone will fail to diagnose 5-12% of cancers, so they understand the "why" of the biopsy. We're obviously not trying to scare patients, but we want to share the facts.

HOST: As you know, many of our patients look to social media to get information. Unfortunately, what is out there is largely negative. Appropriate counseling up front might help to mitigate some of that.

DR. XX: Agree.

SEGMENT 6 — IMPLEMENTATION & SHARED DECISION-MAKING

HOST: This is really a change in practice for a lot of us. What is this going to look like for our day-to-day?

DR. XX: We should expect it to increase the number of patients we sample, so the clinicians who perform procedures will be seeing more patients in the office for a biopsy. And we know that, for about 10% of patients, we will not be able to perform the biopsy in the office. As a result, more patients will need dilation and curettage with hysteroscopy.

HOST: I'm assuming this is something that we will be following as these new guidelines are put into action.

DR. XX: Absolutely, this will be part of the outcomes research moving forward.

HOST: Maybe this is a good time to talk about follow-up. And where shared decision-making falls into this.

DR. XX: One of the weaknesses of the prior (2018) guidance was in regard to follow-up. Patients didn't necessarily know when they should come back. With the new guidelines, for that small group of women who meet criteria for ultrasound only, patients need to know to come back right away with any further bleeding. And access to care is of utmost importance – both from the patient side as well as from the clinician side. There is some equity logic built into these recommendations: if there are barriers to care, the patient is no longer a candidate for ultrasound-only.

HOST: As often happens in medicine, we really need to have that discussion with our patient to identify barriers and make the decision together. And there may be some patients who technically meet the ultrasound-only criteria but want to proceed with biopsy. This, too, can be part of our shared decision-making process, right?

DR. XX: Agree, absolutely.

HOST: Let's walk through a patient case.

SEGMENT 7 — PATIENT VIGNETTE

HOST: A 59-year-old Black woman reports that her last period was about 8 years ago. She had a single episode of light spotting last week. No bleeding since that time. Her BMI is 31 and she has type 2 diabetes. You send her for a transvaginal ultrasound. The endometrium is fully visualized, homogeneous, and measures 3 millimeters. Let's pause here for our listeners to think about next steps. [PAUSE]

DR. XX: This is a great case to discuss. A few years ago, we likely would have reassured this patient. A single episode of bleeding with a fully visualized stripe under 4 millimeters. Under the 2018 guidance, most clinicians would have stopped here and said "come back if it recurs." But we now have data showing that she also needs a biopsy – with the very first episode of bleeding. To defer the biopsy and meet the ultrasound-only criteria, she needs no strong risk factors. But this patient is obese, with a BMI of 31, and has type 2 diabetes. She is also Black, and we know that Black race

itself is an independent risk factor for high-grade disease. So, again, I'll emphasize that it is important to proceed with a biopsy.

HOST: So, the pathology report returns showing type II, non-endometrioid carcinoma.

DR. XX: That's right. Thank goodness we biopsied. Catching it with the first sign of disease gives this patient the best chance at a good outcome.

SEGMENT 8 — CLOSE & KEY TAKEAWAYS

HOST: Dr. XX, leave our audience with the pearls.

DR. XX: For sure. First: for most patients with postmenopausal bleeding, initial evaluation is now ultrasound and biopsy — NOT ultrasound as the gatekeeper. Second: a thin stripe is not a clean bill of health. This is often how type II cancers show up, and Black patients are disproportionately at risk for this aggressive subset of endometrial cancer. Third: the ultrasound-only lane still exists but it's narrow: a single episode of bleeding, a fully visualized stripe at 4 millimeters or less, no strong risk factors, **and** reliable follow-up. Any doubt in *any* category, you sample right away.

HOST: And where does this go from here?

DR. XX: Implementation research is the next chapter, assessing whether this strategy actually reduces missed diagnoses and, specifically, whether it narrows the mortality gap for Black women. These are the outcomes that really matter.

HOST: Dr. XX, thank you so much for being here today. This has been a great review of this practice-changing guidance from ACOG. Thanks for listening. We'll be back next week!

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