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postcoital bleeding, colposcopy, cervical cancer Introduction of postcoital bleeding (PCB) refers to spotting or bleeding that occurs after intercourse and is not associated with menstruation. The prevalence of the point ranges from 0.7 to 9.0% with one report indicating that the annual cumulative incidence is 6% among menstruating women. Chlamydia infection is the most important reason for exclusion in women under the age of 35, while in women over 35 it is cervical cancer. Postcoital bleeding is usually caused by cervical or endometrial polyps, cervicitis as a result of chlamydia or gonorrhea and vaginitis associated with trichomoniasis or candidiasis. Endometritis in the presence of intrauterine devices (IUCN) can sometimes cause postcoic bleeding. This symptom is rarely caused by intrapical cervical neoplasia. The debate is there are wide differences in the management of postcotal bleeding women in the UK. Probably due to gynecology, oncology, colposcopy and cervical pathology services are not necessarily integrated in most medical institutions. The National Institute for Health and Care Excellence (NICE) guidelines will state that women with postcotal bleeding should have a full pelvis examination, including speculum examination, primary care and those patients who have clinical features with suspected cervical cancer should be referred for secondary care as a matter of urgency. A cervical smear test is not required before referral, and the previous negative smear result is not a reason for delaying referral to the gynecological department. Similarly, the National Cervical Screening Service in the UK recommends that women with symptoms of cervical cancer - such as postcoic bleeding (especially in women over 40) - should be referred for gynaecological examination and further referral for colposcopy if cancer is suspected. The examination should be carried out by a gynecologist who has experienced cervical diseases (e.g., a leading gynecologist). Equivalent Scottish guidelines recommend the urgent referral of women as 35 years old with persistent (4 weeks) postcoital bleeding and early referral for women with repeated unexplained postcoital bleeding. The guidelines for the treatment of suspected cancer, published by the United Kingdom Department of Health, define referral criteria only: Urgent referral (within 2 weeks) for PCC over 4 weeks in women of zgt:35 years and early direction (within 4-6 weeks) in all other cases of repeated unexplained PCD. Postcoital bleeding mainly comes from superficial lesions pathways, including cervical polyps, cervicitis, ectology, intraepithelial cervical lesions (CINS) or carcinoma. Most women who complain about bleeding will be found to have no obvious underlying cause for their bleeding based on history, examination, or laboratory research. However, the encouraging aspect is that 60% of naturally menstruating women with postcotal bleeding will have a spontaneous resolution of symptoms within six months. Half of these women will support the permit for two years. A retrospective study of Rosenthal et al from 314 women with PCD showed 12 cases of invasive cancer (3.8%): ten had cervical or vaginal cancers and two endometrial cancers. Eight out of ten cases of cervical/vaginal cancer were clinically obvious. Two of them were only visible with the help of colposcope. with cancer /CIN was a normal or inflammatory smear of the cervix. 15 women (5%) 18 had HPV, 49 inflammatory or metaplasia, and no explanation was found in 155 women. Anorlu et al. reports on a series of 885 women at a clinic in Lagos, Nigeria from 1998 to 1999. Discariosis was significantly higher in symptomatic cases compared to asymptomatic cases (6.1% vs. 3.4% of patients with postcoital bleeding, showing discariosis. A series of cases, a study of 248 women referred with PCBs over a five-year period to the Gynaecology Unit at Southend Prittlewell Chase Hospital, Westcliff-on-Sea, Essex, UK; no cases of lower genital cancer have been reported after PCA. Twelve women (4.8%) CIN, 24 women (9.6%) polyps (endometrium and cervix), and 61 (24.6%) was an ectopia of the cervix. Another retrospective study of 142 women with postcotal bleeding reported a total of 27 (19%) of post-genital bleeding. intraepital neoplasia of the cervix (CIN), of which 15 (10.6%) high-end cases (CIN2 and CIN3). Of the 102 women who had a negative smear in the three years prior to referral, 20 were CIN (19.6%) and CIN (19.6%) had a negative smear. and ten of them were high-end CIN (eight with CIN 2 and two with CIN3) (9.8%). In another retrospective study, the prevalence of CIN was 9%, but the high CIN class was only 2.2% and mostly it was CIN2. The prevalence of invasive cancer was zero. no cases of cancer have been detected. Similarly, another retrospective study of 87 women with postcotal bleeding who had negative cervical smears found CIN in 6.9% and there were no cases of invasive cancer (table 1). . 1. Causes of postcoital bleeding. Benign Pathology Malignant Infection Injury Endometrial polyp Cervical Polyp Vaginal Pelvic Atrophy prolapse Benign vascular neoplasm Endometriosis Cervical Ectropion Cervical Cancer Vaginal Cancer Cervical Cancer Cervicite Taz inflammatory disease Endometritis Vaginitis Genital/vulvar herpes simplex syphilis Syphilis Syphilis Chancroid Lymphogranuloma venereum condyloma accuymilinata Sexual violence Foreign body Conclusion of postcoital bleeding remains a cardinal warning sign of cancer of the lower genital tract and it is important to remember that it can also occur in the absence of cancer. In the vast majority of cases there will be no ominous pathological anomalies. Common causes are usually benign conditions such as cervical ectopia and benign cervical polyps. Only a small number of women with PCD will have invasive diseases of the lower genital tract. Based on current data, if women present with symptoms of cervical cancer (e.g. postcoital bleeding, permanent vaginal discharge, which cannot be explained by infection or other causes), then common causes should be excluded in general practice, such as infection, the type of contraceptive use. They should be referred for examination to a gynecologist who is experienced in the treatment of cervical diseases (e.g., leading gynecologists leading to cancer). Gynaecologists can refer these women for symptomatic colposcopic examination outside of NHSCSP if cancer is suspected. Within two weeks of referral is urgently needed, within two weeks of referral, to see women with symptoms of cervical cancer. Links Shapley M, Jordan K, Croft PR (2004) Epidemiological examination of symptoms of menstrual loss in society. Br J Gen Pract 54: 359-363. 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