

Updated Guidance Regarding The Role of Transvaginal Ultrasonography in Evaluating the Endometrium of Individuals With Postmenopausal Bleeding

This Clinical Practice Update was developed by the American College of Obstetricians & Gynecologists in collaboration with David Shalowitz, MD, and Christine Garcia, MD.

This Clinical Practice Update provides revised guidance on the use of transvaginal ultrasonography to triage patients with postmenopausal bleeding. This document is a focused update of related content in Committee Opinion No. 734, *The Role of Transvaginal Ultrasonography in Evaluating the Endometrium of Women With Postmenopausal Bleeding* (Obstet Gynecol 2018;131:e124–9).

BACKGROUND

The American Cancer Society estimates that, in 2025, 69,120 cases of uterine cancer will be diagnosed in the United States and 13,860 individuals will die from the disease (1). Approximately 90% of patients diagnosed with endometrial cancer have *postmenopausal bleeding*, which, for the purposes of this document, is defined as bleeding presumed to be from the uterus 12 or more months after the final menstrual period (2, 3). Previous guidance from the American College of Obstetricians & Gynecologists (ACOG) supported transvaginal ultrasonography without endometrial biopsy during initial evaluation for patients presenting with postmenopausal bleeding and with endometrial thickness of 4 mm or less, based on data suggesting that the negative predictive value for cancer in this population exceeded 99% (4). Endometrial sampling irrespective of endometrial thickness previously was recommended for patients with known risk factors for endometrial malignancy, including but not limited to obesity, unopposed estrogen, and family history of endometrial cancer (see Box 1 for a non-exhaustive list of additional risk factors), and for patients presenting with recurrent bleeding. In this Clinical Practice Update, these recommendations are revised in the context of a rising incidence of endometrial cancer and contemporary data on the behavior of endometrial cancer subtypes, risk factors for malignancy, and challenges in gynecologic care delivery.

See related editorial on page 11.

UPDATED CLINICAL RECOMMENDATION

- **The combination of both transvaginal ultrasonography and endometrial tissue sampling is recommended as part of the initial evaluation in most patients with postmenopausal bleeding. Transvaginal ultrasonography without endometrial biopsy may be used during initial evaluation of select patients with a single episode of postmenopausal bleeding and a sonographically fully visualized endometrium not thicker than 4 mm, without factors strongly associated with increased risk of endometrial cancer, who are counseled that continued or recurrent bleeding requires immediate re-evaluation, and for whom there are no significant barriers to prompt gynecologic evaluation.**

RATIONALE

Several factors have prompted reconsideration of the previously recommended triage strategy. First, the critical parameter allowing triage by ultrasonography is its ability to rule out malignancy by endometrial thickness (ie, its negative predictive value), which is highly dependent on the prevalence of endometrial cancer. Specifically, the negative predictive value of a threshold endometrial thickness is expected to decrease as the population prevalence of cancer increases. In the decades since the data underlying prior recommendations were collected, the incidence of endometrial cancer in the general

Box 1. Factors Strongly Associated With Increased Risk of Endometrial Cancer*

- Exogenous estrogen use (eg, supplements and hormone therapy with or without progestin[†])
- SERM use (eg, tamoxifen)
- BMI higher than 30
- Nulliparity
- Genetic predisposition to endometrial cancer (eg, known or suspected Lynch or Cowden syndromes or family history of endometrial cancer)
- Black race (independent association with high-grade endometrial cancers)[‡]
- Diabetes mellitus

SERM, selective estrogen receptor modulator; BMI, body mass index.

*Nonexhaustive list.

[†]Patients experiencing unscheduled bleeding more than 6 months after initiation of hormone therapy should undergo further evaluation (29).

[‡]See text for discussion of the complexities between self-reported race and endometrial cancer incidence and outcomes.

Data adapted from Raglan O, Kalliala I, Markozannes G, Cividini S, Gunter MJ, Nautiyal J, et al. Risk factors for endometrial cancer: an umbrella review of the literature. *Int J Cancer* 2019;145:1719–30. doi: 10.1002/ijc.31961; Hicks ML, Hicks MM, Mathews RP, Khabele D, Clare CA, Balogun O, et al. Racial disparities in endometrial cancer: where are we after 26 years? *Gynecol Oncol* 2024;184:236–42. doi: 10.1016/j.ygyno.2024.01.054; and National Comprehensive Cancer Network. Genetic/familial high-risk assessment: colorectal, endometrial, and gastric. NCCN Clinical Practice Guidelines in Oncology. Version 1.2025 [after login]. NCCN; 2025. Accessed February 23, 2026. <https://www.nccn.org/guidelines/guidelines-detail?category=2&id=1544>.

population of the United States has increased steadily by approximately 1–2% per year (1, 5). In 2022, the annual incidence of uterine cancer was 28.8 per 100,000 women, increased from 23.5 per 100,000 women in 2000. From 2019 to 2023, the overall death rate was 5.3 per 100,000 women per year, increased from 4.1 per 100,000 women in 2000 (6). Recent meta-analyses of the performance of ultrasound measurement of the endometrium to rule out endometrial cancer have reported a range of sensitivities due to variation in methodology and included studies, with overall estimates lower than those on which existing guidance depends (7, 8). However, these meta-analyses also have limited applicability to the current demographics of the United States. For example, in the 2020 publication by Long et al, of 44 included studies, only two were conducted in the United States, with the most recent published in 2000; of the remainder, 28 were conducted in Europe, four in the Middle East, six in East Asia, and four in other regions. More recent studies not included in the above meta-analyses suggest an unacceptably low sensitivity of 88–95% to detect endometrial cancer using a 4-mm cutoff for endometrial thickness (9–11), with the implication that 5–12% of cancers may be undiagnosed on initial presentation.

Second, endometrial cancer incidence and mortality have risen disproportionately among non-Hispanic Black women. The incidence of endometrial cancer rose 2.7% per year through 2022 in Black women compared with 0.7% for White women (6). Moreover, the risk of death from endometrial cancer from 2019 to 2023 for non-Hispanic

Black women was 9.8 per 100,000 women per year, which is more than twice the risk for non-Hispanic White women (4.8 per 100,000 women per year) (6).

These trends in the rates of endometrial cancer incidence and mortality are associated with care-related and socioeconomic disparities (12–14). Given that race is a social construct rather than a discrete biological characteristic, race by itself does not confer disease risk. Racialized clinical outcomes instead result from a multitude of factors, including the effects of systemic racism (ie, unequal care, access, or treatment; adverse environments influencing genomic changes) and social and structural determinants of health (15).

More research is needed to understand race-associated disparities in endometrial cancer outcomes, such as the significantly higher rate of high-grade histologic subtypes in Black women (16). For example, self-reported Black race is associated with genetic (17) and epigenetic (18) predisposition to TP53-mutated (eg, serous and high-grade endometrioid) endometrial cancers that carry higher disease-specific mortality compared with more common low-grade endometrioid cancers (19) and for which ultrasound-measured endometrial thickness is an insensitive predictor of malignancy in patients with postmenopausal bleeding (20).

Consequently, Black patients in particular may be disadvantaged by over-reliance on ultrasonography as a tool for triage. For example, in a retrospective study, the false-negative probability at the accepted threshold of 4-mm endometrial thickness in a subcohort of Black women with postmenopausal bleeding was 9.5% (21).

Performance was similar in a simulated cohort analysis, with the 4-mm cutoff having a sensitivity of only 47.5% and a negative predictive value of 91.7% for uterine cancer diagnosis in Black women with postmenopausal bleeding (22). If only serous endometrial carcinoma is considered, 25% of cases may be missed if patients with endometrial thickness less than 5 mm do not undergo tissue sampling (20).

Transvaginal ultrasonography also may be technically less effective than is generally recognized. Accurate measurement of endometrial thickness by transvaginal ultrasonography relies on adequate visualization of a distinct endometrial echo complex from cervix to fundus (23). Visualization may be impaired by uterine orientation, adenomyosis, and leiomyomas, the latter associated with higher incidence in Black women (24). As a result, transvaginal ultrasonography may fail to adequately assess the endometrium in 17–38% of women with postmenopausal bleeding, further limiting its utility in the triage of patients to endometrial sampling (25, 26).

Finally, although previous recommendations supported biopsy in patients with endometrial thickness 4 mm or less with recurrent bleeding, there is no consensus definition of “recurrent” or “persistent” bleeding that should prompt patients to return to their gynecologists. Re-presentation also may be challenging for patients due to barriers to accessing gynecologic, radiologic, and oncologic care. Patients who are evaluated for postmenopausal bleeding may not return or report continued or recurrent bleeding, and, if they do, repeat evaluation, referral, and biopsy may not be available promptly. These systemic factors may easily result in substantial diagnostic delay, progression of disease, and worsened cancer-related outcomes, especially in patients with limited resources (26). Histologic and known socioeconomic factors also do not appear to entirely explain racial disparities in endometrial cancer outcomes, emphasizing the importance of prompt evaluation and diagnosis of patients with concerning symptoms (14).

For these reasons, ultrasound measurement of endometrial thickness is, by itself, generally insufficient evaluation for patients with postmenopausal bleeding. **The combination of both transvaginal ultrasonography and endometrial tissue sampling is recommended as part of the initial evaluation in most patients with postmenopausal bleeding. Transvaginal ultrasonography may be used without endometrial biopsy during initial evaluation of select patients with a single episode of postmenopausal bleeding and a sonographically fully visualized endometrium not thicker than 4 mm, without factors strongly associated with**

increased risk of endometrial cancer, who are counseled that continued or recurrent bleeding requires immediate re-evaluation, and for whom there are no significant barriers to prompt gynecologic evaluation. This approach encourages prompt diagnosis and treatment of patients with endometrial cancer who otherwise might be falsely reassured by ultrasound results, especially patients with nonendometrioid cancers associated with a thin endometrium. In addition, this dual approach may reduce health care--associated burdens for patients who may have limited access to clinicians capable of sampling endometrial tissue. Conditions under which endometrial sampling may be deferred are listed in Box 2.

IMPLEMENTATION CONSIDERATIONS

This evidence-based Clinical Practice Update may represent a change in practice for some clinicians. The shift in recommendations toward ultrasonography plus biopsy may increase the proportion of patients for whom endometrial sampling is recommended. Prior recommendations for use of endometrial thickness by ultrasonography as triage for patients with postmenopausal bleeding are associated with an unacceptably low sensitivity for malignant and premalignant endometrial pathology and systematically underperform for patients at elevated risk for high-grade cancers. Reassessment of the evaluation of postmenopausal bleeding is an essential part of the response to rising incidence and death rates from endometrial cancer, particularly among Black women. Subsequent implementation research will be critical to quantify the extent to which updated recommendations decrease endometrial cancer-specific morbidity and mortality and to assess measures to decrease clinicians' and patients' burdens related to evidence-based evaluation of postmenopausal bleeding.

Future investigations should include implementation outcomes such as factors supporting adherence to updated guidelines, cost-effectiveness analyses, effect of routine endometrial sampling on existing outcomes disparities, and patient-reported outcomes. Preliminary data suggest that routine biopsy as part of the initial workup for postmenopausal bleeding is likely to be acceptable to patients when accompanied by appropriate counseling (27). Potential technical challenges to sampling, such as nulliparity and cervical stenosis, should be acknowledged and may be the subject of future research on the implementation of updated guidelines. As with any procedure, the decision to proceed with endometrial sampling should be the result of shared decision making and reflect patients' values and preferences (28).

Box 2. Endometrial Biopsy May Be Omitted From Initial Evaluation of a Patient With Postmenopausal Bleeding When All of the Following are Present

1. A single episode of postmenopausal bleeding **and**
2. A sonographically fully visualized endometrium with thickness of 4 mm or less **and**
3. No risk factors strongly associated with malignancy* **and**
4. Access to prompt gynecologic care and follow-up

*See Box 1 for list of risk factors strongly associated with malignancy.

USE OF LANGUAGE

ACOG recognizes and supports the gender diversity of all patients who seek obstetric and gynecologic care. In original portions of this document, authors seek to use gender-inclusive language or gender-neutral language. When describing research findings, this document uses gender terminology reported by investigators. To review ACOG's policy on inclusive language, see <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language>.

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