

Clinicopathological profile and FIGO staging pattern of cervical cancer in postmenopausal women presenting with bleeding: a cross-sectional study.

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Abstract

Background:

Postmenopausal bleeding (PMB) requires prompt evaluation because it may indicate genital malignancy. This study assessed the etiological profile of PMB and the FIGO staging pattern of cervical cancer among postmenopausal women attending a tertiary care center.

Methods:

This hospital-based cross-sectional study was conducted at the Department of Obstetrics and Gynaecology, Rajendra Institute of Medical Sciences, Ranchi, from April 2021 to August 2022. Seventy-six postmenopausal women presenting with bleeding per vaginum were included. Clinical evaluation, Pap smear, and histopathological examination were performed as clinically indicated. Cervical cancer was staged according to the FIGO 2018 staging system. Data were analyzed using SPSS version 20.0.

Results:

The mean age of participants was 56 ± 7.3 years, with 47.4% aged 51–60 years. Parity ≥ 6 was reported in 30.3%, while 53.9% belonged to the low socioeconomic group. Hypertension was the most common comorbidity (32.9%). Malignant lesions were identified in 51.3% of participants and benign lesions in 48.7%. Squamous cell carcinoma of the cervix was the most frequent malignancy (42.1%). Among 34 cervical carcinoma cases, stage IIB was the most frequently reported stage (44.1%), followed by stages IIIB and IB (11.8% each).

Conclusion:

Cervical cancer was a frequent malignant cause of PMB in this study, with a substantial proportion of cases diagnosed at advanced stages.

Recommendation:

Strengthening awareness, timely evaluation of PMB, cervical cancer screening, and early referral may facilitate earlier diagnosis among postmenopausal women.

Keywords: Postmenopausal bleeding; Cervical cancer; FIGO staging; Squamous cell carcinoma; Histopathology

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Introduction

Cervical cancer continues to be a major health concern for women, particularly in developing nations where preventive and diagnostic facilities remain limited. Globally, it is the fourth most common cancer among women, with a high concentration of cases in low-resource regions[1]. India contributes substantially to this burden, with cervical cancer ranking second only to breast cancer in incidence and mortality [2]. The absence of widespread vaccination programs and limited access to screening services, particularly in rural and semi-urban areas, have meant that many women are still diagnosed at advanced stages. While HPV vaccination and Pap smear screening have reduced disease prevalence in high-income countries, such benefits are not equally distributed in India, where social stigma, financial barriers, and lack of awareness delay health-seeking behavior. Despite being largely preventable, cervical cancer continues to contribute significantly to cancer-related morbidity and mortality in India [3,4]

Postmenopausal bleeding (PMB) is one of the most important clinical symptoms that requires careful evaluation. Defined as vaginal bleeding occurring 12 months after cessation of menstruation, PMB can have both benign and malignant causes [5]. Postmenopausal bleeding should always be regarded as a red-flag symptom, warranting prompt and comprehensive evaluation. Atrophic changes of the endometrium and cervix, polyps, and hyperplasia account for a considerable proportion of cases, yet malignancies such as cervical and endometrial cancer must always be ruled out. Studies suggest that up to 15% of women with PMB may harbor a genital malignancy. The concern becomes greater in postmenopausal women, who often underestimate or dismiss abnormal bleeding as an inconsequential sign of ageing. This, combined with barriers to healthcare access and limited knowledge of preventive services, frequently results in late-stage diagnoses, when treatment becomes more complex, and outcomes are less favorable. Unlike Western populations where endometrial carcinoma predominates, cervical cancer remains a leading malignant cause of postmenopausal bleeding in Indian women [6,7]

The stage of cervical cancer at diagnosis has a direct influence on treatment and prognosis. According to the FIGO system, early stages (I and some cases of II) are potentially curable with surgery or localized radiotherapy, yielding high survival rates. In contrast, women who present with stage IIB or higher require multimodal treatment and face considerably lower survival prospects. Reports from

India consistently highlight that most women are diagnosed beyond stage II, reflecting delays at multiple levels, including recognition of symptoms, access to medical care, and availability of diagnostic facilities. This late presentation not only compromises survival but also increases treatment costs and places a significant burden on families and healthcare systems[3,4].

Examining the staging distribution of cervical cancer among postmenopausal women provides valuable insight into both clinical and public health challenges. Risk factors such as multiparity, low socioeconomic status, poor genital hygiene, early age at marriage, and persistent HPV infection intersect in this group, increasing vulnerability. Unlike in Western populations, where endometrial carcinoma is more frequently associated with PMB, squamous cell carcinoma of the cervix predominates in Indian women [8]. Evaluating the stages at which these women present can shed light on diagnostic delays and underline the need for targeted awareness and screening initiatives. With this background, the present study was designed to assess the causes of postmenopausal bleeding and, in particular, to describe the staging profile of cervical cancer in affected women. By identifying patterns of late presentation, the study emphasizes the importance of early detection strategies and the urgent need to expand preventive care in resource-limited settings.

There is a paucity of region-specific Indian data evaluating the etiological profile of postmenopausal bleeding with particular emphasis on the staging distribution of cervical cancer. The present study was undertaken to assess the causes of postmenopausal bleeding and to analyze the FIGO staging pattern of cervical cancer among postmenopausal women attending a tertiary care center in eastern India.

Materials and Methods

Study Design and Setting

This hospital-based observational cross-sectional study was conducted in the Department of Obstetrics and Gynaecology at Rajendra Institute of Medical Sciences (RIMS), Ranchi, Jharkhand, a tertiary care referral center catering to both urban and rural populations of Jharkhand and neighboring regions. The study was conducted over a period of 17 months, from April 2021 to August 2022. The department provides evaluation and management of women presenting with gynecological complaints, including postmenopausal bleeding, and facilitates appropriate clinical, cytological, and histopathological investigations.

Study Population

All postmenopausal women presenting with bleeding per vaginum during the study period were assessed for eligibility. Postmenopause was defined as the absence of menstruation for a minimum of 12 consecutive months.

Inclusion Criteria

Women were included if they met the following criteria:

Age ≥ 45 years

Postmenopausal status with at least 12 months of amenorrhea

Presentation with vaginal bleeding after menopause

Willingness to participate and provide informed consent

Exclusion Criteria

Women were excluded if they had:

Premature or surgical menopause

Perimenopausal status with irregular menstrual cycles

Current hormone replacement therapy

Bleeding disorders or use of anticoagulant therapy

Study Size

During the study period, 82 postmenopausal women presented with bleeding per vaginum. Six women were excluded because they did not fulfill the inclusion criteria or had incomplete evaluation. Therefore, 76 women who met the eligibility criteria and had adequate evaluation were included in the final analysis. As the study included all eligible women presenting during the predefined study period, the final sample comprised the available eligible study population rather than a separately calculated sample based on a prevalence formula.

Data Collection

A detailed clinical history was obtained from all participants. The information collected included age, parity, socioeconomic status, age at menopause, duration of menopause, and associated comorbidities such as hypertension, diabetes mellitus, and thyroid disorders. A general physical examination and gynecological examination were performed in all participants.

Diagnostic Evaluation

All participants underwent a standardized diagnostic evaluation. A speculum examination was performed to assess the cervix and vagina for any visible pathology. Cervical cytology (Pap smear) was obtained wherever feasible. Women with suspicious cervical lesions or abnormal cytological findings underwent cervical biopsy. Endometrial evaluation was performed using endometrial biopsy in women without obvious cervical pathology or when clinically indicated. All biopsy specimens were subjected to histopathological examination, which was considered the definitive diagnostic modality.

Histopathological Classification

Histopathological findings were categorized into benign and malignant lesions. Malignant lesions were further classified according to their organ of origin and histological subtype. Cervical malignancies were classified according to histological type. Cervical cancer staging was performed according to the International Federation of Gynecology and Obstetrics (FIGO) 2018 staging system.

Staging of Cervical Cancer

Patients diagnosed with cervical carcinoma were staged according to the FIGO 2018 staging system. Clinical examination was supplemented by imaging and/or

pathological findings, where applicable, in accordance with the staging system. The stage at diagnosis was recorded before initiation of treatment.

Measures to Address Potential Bias

Potential selection bias was minimized by assessing all women presenting with postmenopausal bleeding during the study period according to predefined inclusion and exclusion criteria. A standardized clinical and diagnostic evaluation was performed for eligible participants, and histopathological examination was used as the definitive diagnostic modality. Nevertheless, the hospital-based nature of the study may have introduced referral or selection bias, as the study population was derived from a tertiary care referral center.

Statistical Analysis

Data were entered into Microsoft Excel and analyzed using Statistical Package for the Social Sciences (SPSS), version 20.0. Continuous variables were expressed as mean $\pm$ standard deviation, while categorical variables were summarized using frequencies and percentages. Associations between categorical variables were assessed using the chi-square test. A p-value <0.05 was considered statistically significant.

Ethical Considerations

The study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki. Institutional Ethics Committee approval was obtained before initiation of the study. Written informed consent was obtained from all participants before enrollment. Confidentiality of patient information was strictly maintained throughout the study, and participant information was used only for the study.

Results

Demographic Profile

During the study period, 82 postmenopausal women presented with bleeding per vaginum. Six women were excluded due to not fulfilling the inclusion criteria or incomplete evaluation. A total of 76 women were included in the final analysis. A total of 76 postmenopausal women with bleeding per vaginum were studied. The mean age was 56 ± 7.3 years, with most patients (47.4%) in the 51–60-year age group. The majority of women were multiparous, with nearly one-third (30.3%) having six or more children. Socioeconomic status was predominantly low (53.9%), followed by middle (42.1%), while only 3.9% belonged to the high-income group. Hypertension emerged as the most common comorbidity (32.9%), followed by hypothyroidism (10.5%) and diabetes mellitus (7.9%).

Table 1. Demographic and Clinical Characteristics

Variable	Number (n=76)	Percentage (%)
Mean Age (years)	56 ± 7.3	–
Age 51–60 years	36	47.4
Parity ≥ 6	23	30.3
Low Socioeconomic Status	41	53.9
Hypertension	25	32.9
Diabetes Mellitus	6	7.9
Hypothyroidism	8	10.5

Histopathological Findings

Histopathology confirmed malignant lesions in 39 patients (51.3%) and benign lesions in 37 patients (48.7%). Among malignancies, squamous cell carcinoma of the cervix was the most common (42.1%), followed by endometrial

carcinoma (3.9%), adenosquamous carcinoma (2.6%), and carcinosarcoma (2.6%) (Figure 1). Benign causes included chronic cervicitis (14.5%), endometrial hyperplasia (5.3%), endometritis (6.6%), leiomyoma (6.6%), and benign endometrial polyps (6.6%) (Figure 2).

Table 2. Distribution of Histopathological Diagnoses (Grouped by Organ of Origin)

Diagnosis	Number (n)	Percentage (%)
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A. Cervical Malignancies		
- Squamous Cell Carcinoma (Cervix)	32	42.1
- Adenosquamous Carcinoma (Cervix)	2	2.6
Subtotal – Cervical Malignancies	34	44.7
B. Endometrial / Uterine Malignancies		
- Endometrial Carcinoma	3	3.9
- Carcinosarcoma (Uterus)	2	2.6
Subtotal – Endometrial Malignancies	4	5.2
Total Malignant Lesions	39	51.3

Table 3. Distribution of Histopathological Diagnoses

Diagnosis	Number (n)	Percentage (%)
Benign Causes		
Chronic Cervicitis	11	14.5
Endometrial Hyperplasia	4	5.3
Endometritis	5	6.6
Leiomyoma	5	6.6
Endometrial Polyp	5	6.6

Staging of Cervical Cancer

Among the 34 cases of cervical carcinoma, most were diagnosed at stage IIB (44.1%), followed by stage IIIB (11.8%), stage IB (11.8%), stage IIIA (8.8%), and stage IVA (2.9%). This pattern reflects a predominance of advanced-stage presentation.

Table 4. Distribution of Cervical Cancer Stages

Stage	Number (n=34)	Percentage (%)
IB	4	11.8%
IIB	15	44.1%
IIIA	3	8.8%
IIIB	4	11.8%
IVA	1	2.9%
Others*	7	20.6%

**Includes repeat sampling and rare histologies.*

Discussion

The present study examined postmenopausal women with vaginal bleeding, focusing on the prevalence and stage distribution of cervical cancer. Out of 76 women, more than half had a malignant cause, with squamous cell carcinoma of the cervix being the most frequent diagnosis. This high proportion of malignancy highlights the importance of treating postmenopausal bleeding as a red-flag symptom that requires thorough evaluation. While in many Western studies benign etiologies dominate, our findings underscore that in India cervical carcinoma remains a major concern. The predominance of malignancy reflects not only biological risk factors but also systemic shortcomings in screening and prevention, which delay diagnosis and worsen outcomes[9].

The majority of women in this study were diagnosed at stage IIB, a point at which parametrial invasion has already occurred, restricting surgical options and shifting the mainstay of treatment toward chemoradiotherapy. Earlier stages, such as stage I or early stage II, where surgery may achieve excellent long-term survival, were much less common in our cohort. This distribution mirrors reports from other parts of India, where women often present with stage II or higher disease. In contrast, high-income countries with robust screening programs frequently report earlier

detection, resulting in better survival rates. The predominance of advanced disease in our study illustrates the consequences of limited awareness, delayed presentation, and insufficient screening coverage among postmenopausal women[10,11].

Socioeconomic factors played an evident role in the disease profile observed. More than half of the participants belonged to low-income groups, consistent with earlier research that identifies poverty as a major determinant of cervical cancer risk. Low socioeconomic status correlates with high parity, early marriage, limited contraceptive use, and poor genital hygiene, all of which increase susceptibility to persistent HPV infection. In our cohort, multiparity was common, with nearly one-third of women having six or more children. Such reproductive patterns may increase cervical trauma and chronic inflammation, facilitating the progression from HPV infection to invasive carcinoma. These findings reinforce the need for targeted interventions in disadvantaged communities, where the combined effects of social and biological risk factors create a high burden of disease[9,12,13].

The comorbid conditions seen in our patients—hypertension, diabetes, and hypothyroidism—deserve attention. While these illnesses are not primary causes of cervical cancer, they complicate treatment and can negatively influence outcomes. Elderly women with

cardiovascular disease may not tolerate aggressive chemoradiotherapy, while diabetes increases the risk of infections and delays recovery. In practice, this means that women diagnosed with advanced-stage cervical cancer often face not only the challenges of the malignancy itself but also the added risks associated with managing multiple chronic diseases. These realities call for a multidisciplinary approach, integrating oncology with internal medicine, endocrinology, and supportive care to optimize outcomes in postmenopausal women [13].

The histopathological findings of this study further illustrate regional differences. Squamous cell carcinoma accounted for the vast majority of cases, while adenocarcinoma and adenosquamous carcinoma were relatively rare. In many high-income countries, the proportion of adenocarcinoma has been increasing, partly due to changes in sexual behavior and contraceptive practices, and also because adenocarcinoma is less reliably detected by Pap smears compared with squamous cell carcinoma [14]. In India, however, squamous histology continues to dominate, most likely due to the persistence of high-risk HPV types 16 and 18. The overwhelming predominance of squamous cell carcinoma in this cohort highlights the urgent need to expand HPV vaccination programs, which have been proven effective in reducing the incidence of HPV-related squamous malignancies [15].

The contrast between our findings and data from Western countries also highlights the success of organized screening programs in reducing cervical cancer burden. In nations with widespread Pap smear or HPV DNA testing, women presenting with postmenopausal bleeding are more likely to have benign pathology, with endometrial carcinoma emerging as a leading malignancy rather than cervical carcinoma. In our context, the lack of nationwide screening, combined with poor healthcare access in rural areas, results in a different pattern. Postmenopausal women, in particular, are neglected in prevention campaigns, which tend to focus on women of reproductive age. As a result, older women remain at risk and often present late, when therapeutic options are limited. Our findings therefore emphasize the need to include postmenopausal women in cervical cancer screening initiatives, ensuring that preventive efforts span the full spectrum of women's lives [15].

Generalizability

The findings of this study may apply to postmenopausal women presenting with bleeding who receive care in tertiary healthcare settings, particularly in regions with similar

demographic and healthcare characteristics. The study provides information on the clinicopathological profile and FIGO staging pattern of cervical cancer in a tertiary referral population from eastern India. However, because the study was conducted at a single tertiary care center and included a relatively small number of participants, the findings may not be directly generalizable to the wider population of postmenopausal women, including those attending primary or secondary healthcare facilities. Differences in socioeconomic characteristics, healthcare accessibility, screening practices, referral patterns, and disease awareness may influence the presentation and staging patterns in other populations. Therefore, the findings should be interpreted within the context of the study setting.

Conclusion

Cervical cancer constitutes the leading cause of postmenopausal bleeding in the studied population, with squamous cell carcinoma being the most common histological variant. Most cases were detected at stage IIB, indicating delayed presentation. Regular screening and early referral are critical to shift the diagnostic trend toward earlier stages, thereby improving survival outcomes in postmenopausal women.

Limitations

This study has several limitations. First, it was conducted at a single tertiary care center with a relatively small sample size, which may limit the generalizability of the findings to other healthcare settings and populations. Second, as a hospital-based cross-sectional study, the findings may be influenced by referral and selection patterns and may not represent the distribution of postmenopausal bleeding causes in the community. Third, the study focused on the clinical and histopathological profile and stage distribution at diagnosis; long-term treatment outcomes and survival were not assessed. Finally, potential differences in access to screening and healthcare services among the study participants could have influenced the observed stage distribution.

Recommendation

Postmenopausal bleeding should prompt timely clinical evaluation and appropriate diagnostic investigation to facilitate early identification of cervical and other genital malignancies. Strengthening awareness regarding postmenopausal bleeding, improving access to cervical

cancer screening and diagnostic services, and ensuring timely referral from primary and secondary healthcare facilities to appropriate centers may help reduce delays in diagnosis. Further multicenter studies involving larger and more diverse populations are recommended to evaluate the etiological profile and stage distribution of cervical cancer among postmenopausal women and to assess long-term clinical outcomes.

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HPE – Histopathological Examination

HPV – Human Papillomavirus

PMB – Postmenopausal Bleeding

RIMS – Rajendra Institute of Medical Sciences

SPSS – Statistical Package for the Social Sciences

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Author Contributions

Dr. Amrapali Kumari contributed to the conception and design of the study, patient recruitment, clinical data collection, interpretation of findings, and drafting of the manuscript.

Dr. Atima Bharti contributed to study supervision, clinical evaluation, interpretation of the findings, and critical revision of the manuscript.

Dr. Sonu Kumar contributed to data management, statistical analysis, interpretation of the results, and critical revision of the manuscript.

Dr. Rimjhim Kumari contributed to histopathological evaluation, interpretation of pathological findings, manuscript preparation, and critical revision of the manuscript.

All authors reviewed and approved the final version of the manuscript and agreed to be accountable for the work.

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List of Abbreviations

FIGO – International Federation of Gynecology and Obstetrics

academic and research interests include pathology and diagnostic histopathology.

Data Availability

The data generated and/or analyzed during the present study are not publicly available because they contain participant-related information. De-identified data may be made available from the corresponding author on reasonable request, subject to institutional policies and applicable ethical and confidentiality requirements.

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