Approaching menopause, the bleeding pattern for many women will perhaps change, with cycles either becoming shorter initially, and then with time the menstrual interval will begin to lengthen, be variable and perhaps some cycles skipped altogether, and then finally the periods stop entirely. A woman is said to be menopausal if more than 6 months have elapsed and she has not had a period.

Not infrequently a patient will present with a history of bleeding episodes that are characterized by prolonged flow, extremely heavy flow, or intermittent and irregular bleeding. This is not the characteristic pattern of menopausal changes, and should be investigated as to the cause of the abnormal perimenopausal bleeding. More importantly, in a woman who is years after the last menstrual cycle, irregular bleeding of any kind ("postmenopausal bleeding or PMB) is decidedly abnormal, and is not a resumption of "periods".

The most common cause of post-menopausal bleeding is hormone replacement therapy. The uterine lining responds to supplemental hormone stimulation just as it did earlier in the woman’s reproductive life. The response for that post-menopausal individual will depend on her own specific endometrial (ie. Uterine lining) sensitivity, as well as the magnitude of the dose of the hormone supplement. Adjustment of the dose of the estrogen, and the synthetic progesterone-like (ie.progestin) compound that should also be administered if the woman had not had a hysterectomy, may alleviate any bleeding. If not, the regimen may be altered so that the patient takes the estrogen and progestin in a cyclic fashion (ie.in sequence), and this may result in regular monthly withdrawal bleeding that is predictable, and not excessive. The combination therapy of estrogen and progestin will reduce the risk of the development of uterine cancer by about half of what would be the case if no hormone supplement were administered. This author has seen two women that had developed uterine malignancy despite being on combination replacement hormone therapy. The risk for the development of uterine cancer in patients on combination therapy is about one chance in a thousand. Fortunately for both of these patients, the cancer was very early, and a hysterectomy was totally curative.

In women who are experiencing post-menopausal bleeding (PMB) and who are NOT on supplemental hormones, the causes are many. For some the total lack of any estrogen can result in the spontaneous breaking down of small blood vessels in the uterine lining (endometrial atrophy), similar to a person developing a small spontaneous nose-bleed without any nasal trauma. Overgrowths of the lining of the uterus may develop that are called "hyperplasias", and some of these are potentially pre-cancerous. Benign uterine growths such as polyps or fibroids may also cause irregular postmenopausal bleeding. Vaginal bleeding can also occur from abnormalities on the cervix or in the vagina itself. Rarely, a problem is due to an abnormality of the fallopian tube or ovary.

Determining the underlying cause of PMB requires a thorough evaluation by a gynecologist. Investigative studies such as a uterine biopsy, ultrasound, or actually looking inside the uterus itself ("Hysteroscopy") may be required. Treatment will obviously depend on what the cause is determined to be. The most important point to be made is that irregular perimenopausal or postmenopausal bleeding not be ignored, or assumed to be a normal phenomenon.