Chief complaint: Vaginal bleeding x 2 days

HPI: R.S is a 66 year old postmenopausal female (since age 45) with past medical history of HTN, type II DM, iron deficiency anemia, uterine fibroids, and indeterminate pre-sacral 7 mm soft tissue nodule found on CTAP in October 2025, who presents with vaginal bleeding for the past two days, associated with mild pelvic discomfort. Pt states the bleeding is similar to her previous menstrual periods, and is bright red in color. She states she has been using approximately 3-4 pads per day but has not been soaking through them and denies passage of blood clots. Pt denies similar episodes since menopause. She is not currently sexually active and denies concerns for sexually transmitted infections. Her last pap smear was in November 2025. Pt follows regularly with her gynecologist in Florida. She denies associated vaginal discharge, dysuria, back pain, abdominal pain, nausea, vomiting, diarrhea, constipation, fever, chills, dizziness, fatigue, unintentional weight loss, or night sweats. She denies a personal or family history of malignancy. Pt is not on any hormone replacement therapy.

Past Medical History
- Hypertension
- Type II diabetes mellitus

Past Surgical History
- Cesarean section in 1994 and 1996
- Exploratory laparotomy for ruptured right ovary in 1990; no complications

OBGYN History
G4P4004
C-section x2; NSVD x 2
Currently postmenopausal; last menses at age 45
Not currently sexually active; last intercourse was approximately 1 year ago with husband
History of uterine fibroids and indeterminate pre-sacral 7 mm soft tissue nodule (2025)

Medications
- Amlodipine 10 mg tablet PO once daily
- Atorvastatin 20 mg tablet PO once daily
- Dapagliflozin propanediol 10 mg tablet PO once daily
- Ferrous sulfate 325 mg tablet PO once daily

Allergies
Allergy to apples- breaks out into hives

Family History
No known significant FHx

Social History
Habits: denies smoking, alcohol or illicit drug use. No caffeine intake.
Occupation: patient is currently unemployed.
Diet: patient endorses healthy eating habits.
Exercise: does not exercise, but is able to walk without a cane.
Travel: recent travel from Florida to NY (visiting family)
Sleep habits: patient endorses healthy sleeping patterns.
Marital status/living situation: married to husband; currently lives in Florida with husband

ROS
General: denies weight loss, loss of appetite, fatigue, weakness, fever, chills, or night sweats
HEENT: denies headache, lightheadedness, visual changes, congestion, sore throat
Neck: denies localized swelling, lumps, stiffness or decreased ROM
Pulmonary: denies cough, SOB, orthopnea, sputum, hemoptysis, or wheezing
Cardiovascular: denies chest pain, palpitations, or swelling of legs or feet
Gastrointestinal: denies nausea, vomiting, diarrhea, or abdominal pain
Genitourinary: (+) vaginal bleeding; denies urinary frequency or urgency, dysuria, hematuria, incontinence, flank pain or vaginal discharge
Neurological: denies weakness, seizures, numbness, tingling, changes in gait or mental status
Musculoskeletal: denies muscle/joint pain, redness, deformity, or trauma
Hematologic: (+) hx of iron deficiency anemia; denies easy bruising, blood transfusions or hx of DVT/PE
Endocrine: denies thyroid gland enlargement, heat or cold intolerance, changes in facial or body hair, change in weight or excessive hair growth
Psychiatric: denies depression, anxiety, mood changes, new difficulty sleeping, difficulty concentrating or suicidal ideations

Physical Exam
General: 66 year old female, well nourished, well developed and well groomed. Pt appears stated age and is in no acute distress; AOx3 to person, place, and time.

Vital Signs:
Blood pressure: 140/65 mmHg
Respiratory rate: 18 breaths per minute, unlabored
Pulse: 67 beats/min, regular rate & rhythm, 2+
Temperature: 36.8 degrees C, oral
SpO2: 99% on RA
Height: 5 feet, 4 inches
Weight: 159 lbs
BMI: 27.3

Skin: warm and moist, good turgor. Nonicteric, no lesions.
HENT: head is normocephalic, atraumatic. Ears are symmetric without lesions or discharge; no conjunctival pallor. Nose is symmetric without deformity; nares are patent. Lips are pink and mucous membranes are moist.
Pulm: symmetrical expansion with respiration. No intercostal retractions, or tenderness. Breath sounds equal bilaterally. No rales, wheezes, or rhonchi auscultated.
CV: regular rate and rhythm. S1 and S2 heard. No murmur, thrills, or clicks.
Abdomen: soft, non distended. No tenderness to palpation, guarding, or rigidity. No palpable masses or organomegaly.

GU: external genitalia without erythema, lesions, or masses. Speculum exam: vaginal mucosa pink, scant amount of bright red bleeding present in vaginal vault; no clots, erythema, vaginal discharge, or tenderness; cervix is parous and pink, no discharge, friability, erythema, or cervical bleeding

MSK: no swelling, erythema, ecchymosis, atrophy, or deformities in bilateral upper and lower extremities. FROM of all upper and lower extremities bilaterally.
Mental status/neuro exam: Patient is well appearing, good hygiene and neatly groomed. Patient is alert and oriented to person, place, and time. Speech and language ability intact, with normal quantity, fluency, and articulation. Conversation progresses logically. Strength and sensation intact.

Labs/Imaging:

UA:
- Large amount of blood
- Trace protein
- 68 RBCs
- 3-5 casts

CBC:
- RBC 3.85
- HCT 36.9
- MCHC 32.8

BMP within normal limits

Assessment
Patient is a 66 year old post menopausal female with PMHx of HTN, type II DM, iron deficiency anemia, uterine fibroids, and a pre-sacral soft tissue nodule who presents for vaginal bleeding associated with mild pelvic discomfort x 2 days. Pt is hemodynamically stable and well appearing. Pelvic exam demonstrated scant bright red blood within the vaginal vault. Labs are notable for mild anemia. Given vaginal bleeding in a post menopausal female, endometrial carcinoma is most concerning.

Differential Diagnoses
1. Endometrial carcinoma
    A. Any episode of postmenopausal bleeding raises concern for endometrial cancer. Risk factors in this patient include age >65, type II DM, and postmenopausal status. Although she denies constitutional symptoms and has no family or personal history of malignancy, approximately 90% of women with endometrial cancer present with vaginal bleeding.
2. Atrophic vaginitis
    A. This is one of the most common benign causes of postmenopausal bleeding. Decreased estrogen levels lead to thinning and friability of the vaginal mucosa, resulting in spotting or light bleeding. The patient's bleeding is relatively mild, and she has been postmenopausal for more than 20 years. The absence of significant pelvic pain, masses or systemic symptoms makes this a reasonable consideration, although she denies vaginal dryness, burning, or itchiness and on exam, her vaginal mucosa was pink without any obvious atrophy.
3. Uterine fibroids
    A. Patient has a known history of uterine fibroids, which are a common cause of abnormal uterine bleeding in premenopausal women but are less likely after menopause due to decreased estrogen stimulation. However, fibroids may occasionally continue to cause bleeding or become symptomatic, particularly if they have not regressed.
4. Urinary tract infection
    A. Although patient denies classic symptoms of a UTI such as dysuria, urgency, frequency, suprapubic pain, or fever, UTIs can occasionally present atypically in order adults.

Plan/Workup
- CBC to assess hemoglobin and hematocrit and monitor for worsening anemia
- BMP to assess for electrolyte abnormalities
- UA to evaluate for hematuria or possible urinary source of bleeding
- Obtain transvaginal US to evaluate endometrial stripe thickness, uterine fibroids, and other pelvic pathology
    - Pt refused- she states she prefers to follow up with her OBGYN outpatient

Patient education:
Pt was informed that any vaginal bleeding after menopause is considered abnormal and requires further evaluation. While many causes are benign, it is important to rule out endometrial cancer. The

patient verbalized understanding and agrees to follow up with her gynecologist for further evaluation, including a transvaginal US and possible endometrial biopsy is indicated. She was advised to continue taking her iron supplementation as prescribed. Strict return precautions were given, including soaking >1 pad per hour, passage of large clots, dizziness, syncope, or worsening fatigue, severe abdominal or pelvic pain, or fever/new symptoms. She expressed understanding.