CLINICAL GUIDELINE

Endometrial Hyperplasia, Gynaecology

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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GG&C Gynaecology Guidelines

Endometrial Hyperplasia – management

Endometrial cancer is the most common gynaecological malignancy in the Western world and endometrial hyperplasia is its precursor. The most common presentation of endometrial hyperplasia is abnormal uterine bleeding (this includes HMB, IMB, PMB and bleeding on HRT)

Classification

The 2014 WHO classification separates endometrial hyperplasia into two groups: hyperplasia with atypia and hyperplasia without atypia.

Note: This replaces the 1994 classification of simple or complex hyperplasia with or without atypia.

Diagnosis

This requires histological examination of endometrial tissue obtained by endometrial biopsy or formal curettage.

Management

Endometrial Hyperplasia without atypia

Treatment with progestogens has a higher disease regression rate than observation alone even when identifiable risk factors e.g obesity have been addressed. First line treatment is the levonorgestrel-releasing intrauterine system (IUS) e.g Mirena™. For those who decline the IUS, continuous oral progestogens can be used – medroxyprogesterone acetate 10-20mg/day or norethisterone 10-15mg/day. The IUS has a higher disease regression rate and fewer side effects than oral progestogens.

Treatment should be for a minimum of 6 months in order to induce cytological regression. At least 2 consecutive normal biopsies at 6 month intervals should be obtained prior to discharge.

Hysterectomy is indicated when:

- there is evidence of disease progression (i.e. the development of atypia) during follow up
- there is no histological regression of hyperplasia despite 12 months of treatment
- there is relapse of hyperplasia after completing progestogen treatment
- there is persistence of symptoms despite progestogen treatment
- women are unwilling to undergo endometrial surveillance/repeat biopsy

Endometrial Hyperplasia with atypia

Women with atypical hyperplasia should be offered hysterectomy because of the risk of pre-existing malignancy or progression to malignancy. The laparoscopic approach should be considered where appropriate. Post-menopausal women should also be offered BSO. For pre-menopausal women, the decision to remove the ovaries should be considered on an individual basis and bilateral salpingectomy should also be discussed as this may reduce the risk of ovarian malignancy.

Women with atypical hyperplasia who wish to preserve their fertility should be counseled regarding the risks of underlying malignancy and progression. Treatment using IUS as first line can be offered provided hysteroscopic evaluation and endometrial biopsy has excluded endometrial cancer. Oral progestogens may be offered as second line treatment. Patient review and re-biopsy should take place at 3 month intervals until regression and then 6 monthly. Once fertility is no longer desired, hysterectomy should be offered in view of the high risk of disease relapse.

There is insufficient evidence regarding continued long term surveillance in women with atypical hyperplasia who do not undergo hysterectomy.

Endometrial hyperplasia in women who wish to conceive

Disease regression should be achieved on at least one endometrial sample before women attempt to conceive. The RCOG recommends that women with hyperplasia who wish to conceive should be referred to a fertility specialist as assisted reproduction may be considered since the live birth rate is higher and it may prevent relapse compared with women who attempt natural conception.

Endometrial hyperplasia in women on adjuvant treatment for breast cancer

Women taking tamoxifen are at increased risk of developing endometrial hyperplasia and cancer. Those who take aromatase inhibitors e.g anastrozole, exemestane and letrozole are not at increased risk. Management should be according to the histological type of hyperplasia. Discussion with the breast oncology team is advised.

Endometrial hyperplasia confined to a polyp

Complete removal of the polyp is recommended and an endometrial biopsy obtained to sample the background endometrium. Management is dictated by the histological type of hyperplasia and is the same for those with hyperplasia of the endometrium.

References

Endometrial Hyperplasia, Management of (Green-top Guideline No. 67)

Key words.

Endometrium, hyperplasia, atypical, Tamoxifen

Links

Heavy Menstrual Bleeding
Post Menopausal Bleeding

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