Gloucestershire Hospitals NHS Foundation Trust

Patient Information

Endometrial hyperplasia

Introduction

This leaflet has been written for patients who have been diagnosed with Endometrial Hyperplasia and aims to explain what causes this condition and how it can be treated.

What is endometrial hyperplasia?

Endometrial hyperplasia is when the lining of the uterus/womb (endometrium) becomes excessively thick. This is **not** cancer however, it can lead to cancer of the lining of uterus (endometrial cancer) in some women.

Why is the endometrium important?

The endometrium is the lining of the uterus. This lining gets thicker when you ovulate (release an egg from an ovary) and the top layers shed during your period if you do not become pregnant. Regular menstruation usually prevents too much thickening in women before the menopause.

What causes endometrial hyperplasia?

The endometrium is controlled by 2 hormones, oestrogen and progesterone, which are secreted by the ovaries.

Oestrogen causes the growth of the endometrial lining and progesterone works against it. If there is an imbalance between the two hormones, for example there is an excess of oestrogen and not enough progesterone to counteract it, an overgrowth of the uterus lining can occur. This can lead to endometrial hyperplasia. There are several reasons why you might have an imbalance of hormones.

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Why might I have endometrial hyperplasia?

Women with the following risk factors are more likely to have an imbalance of hormones and develop endometrial hyperplasia:

- Obesity (fat tissue can convert other hormones into oestrogen).
- Use of menopause medication with oestrogen such as Hormone Replacement Therapy (HRT) often with no or too little progesterone. If you have not had a hysterectomy (removal of your uterus), your HRT should contain **both** oestrogen and progesterone.
- Use of medication that can act like oestrogen, for example tamoxifen.
- Polycystic Ovarian Syndrome (PCOS) – a condition that can cause infrequent menstrual periods, infertility and obesity.
- Rarer causes include some types of ovarian tumours which can produce additional oestrogen, for example, granulosa cell tumour.

You are also more likely to develop endometrial hyperplasia with any of the following:

- Never had children.
- You are in transitional time before your menopause (perimenopause).
- You have already reached or gone past the menopause (postmenopause).
- You were 55 years of age or older when you reached the menopause.
- You started your periods at an early age (before 12 years).
- You have Diabetes Mellitus (Type 1 or Type 2).
- You have a family history of womb, bowel, or ovarian cancer.

What are the symptoms of endometrial hyperplasia?

The most common symptom of endometrial hyperplasia is abnormal vaginal bleeding. This can include heavier and longer periods, bleeding between your periods or unexpected vaginal bleeding after the menopause.

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What are the types of endometrial hyperplasia?

- **Endometrial hyperplasia without atypia**
  There are more cells produced within the endometrium, and these are crowded together producing a thicker lining. However, all cells appear normal in structure.
- **Atypical endometrial hyperplasia**
  In this type, the cells within the endometrium appear abnormal (atypical) and there is a higher risk of those cells developing into cancer.

How is endometrial hyperplasia diagnosed?

Endometrial hyperplasia may be suspected if an ultrasound shows a thickened endometrium. However, the only way to diagnose endometrial hyperplasia with certainty is to take a small sample of the lining of the uterus (a biopsy), and to look at the cells under the microscope.

A biopsy is usually be taken during an outpatient clinic appointment. This will involve passing a thin plastic tube through your cervix into the womb to obtain a sample from the lining of the womb.

Alternatively, a biopsy may be taken during a hysteroscopy procedure which is when a slim telescope is used to look inside the womb. Most patients will have their hysteroscopy as an outpatient procedure, but occasionally a general anaesthetic may be required.

The sample taken during the biopsy is then examined under a microscope to check if endometrial hyperplasia is present and if so, what type.

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How is endometrial hyperplasia treated?

1) Endometrial hyperplasia without atypia

In endometrial hyperplasia without atypia, the risk of developing into cancer is less than 5 in every 100 women over 20 years:

In many women with this type of endometrial hyperplasia, the lining of the womb will return to normal without treatment.

A number of treatment options may be discussed with you in clinic, including:

- **Progesterone** – this is the most effective treatment option for endometrial hyperplasia, with an 89 to 96% chance of the endometrial lining going back to normal. Progesterone hormone can be given in a form of tablets or as a hormone-releasing coil (Mirena® IUS) that sits inside the uterus for up to 5 years. The Mirena® coil has the best success rate for treating endometrial hyperplasia and the least side effects. It can be fitted during your clinic appointment.
- **Watch and wait** – observation alone with a follow up biopsy may be suggested if you have risk factors that can be reversed over time. For example, weight loss (if you are overweight) or stopping oestrogen HRT. However, the success rate of the lining of the womb going back to normal with this option is lower (75%), compared with progesterone treatment.

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2) Atypical endometrial hyperplasia

If you have atypical endometrial hyperplasia, you would usually be offered a hysterectomy (removal of your uterus) if you have completed your family, and possible removal of your ovaries at the same time. This is because atypical endometrial hyperplasia has an increased risk of turning into cancer. There is also a higher risk (43%) of cancer cells already being present in another part of the uterus with atypical endometrial hyperplasia. This will be discussed with you at your clinic appointment, as well as alternative treatments available to you if hysterectomy is not possible.

How will my treatment be monitored?

In most women, endometrial hyperplasia can be treated successfully with progesterone and does not progress into cancer. With all medical treatment options, you will need a follow up appointment to check if the uterus lining has gone back to normal. This usually involves a repeat endometrial biopsy in 6 months. Any need for further biopsies will be decided at the time of your repeat biopsy.

You will be discharged if you have biopsy results showing no evidence of endometrial hyperplasia in the samples taken. You may be advised to continue to have yearly biopsies if you have ongoing risk factors.

If you have any further abnormal vaginal bleeding after you have been discharged, you should contact your GP, as you may need a repeat biopsy of the womb lining to be taken.

Contact information

If you have any further questions, please contact your consultant's secretary:

Gloucestershire Hospitals Switchboard
Tel: 0300 422 2222
Ask for the operator when prompted, then for your consultant's secretary.

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Further information

Royal College of Obstetricians and Gynaecologists
Guidelines on the management of endometrial hyperplasia.

Webpage:
www.rcog.org.uk/globalassets/documents/guidelines/green-top-guidelines/gtg_67_endometrial_hyperplasia.pdf

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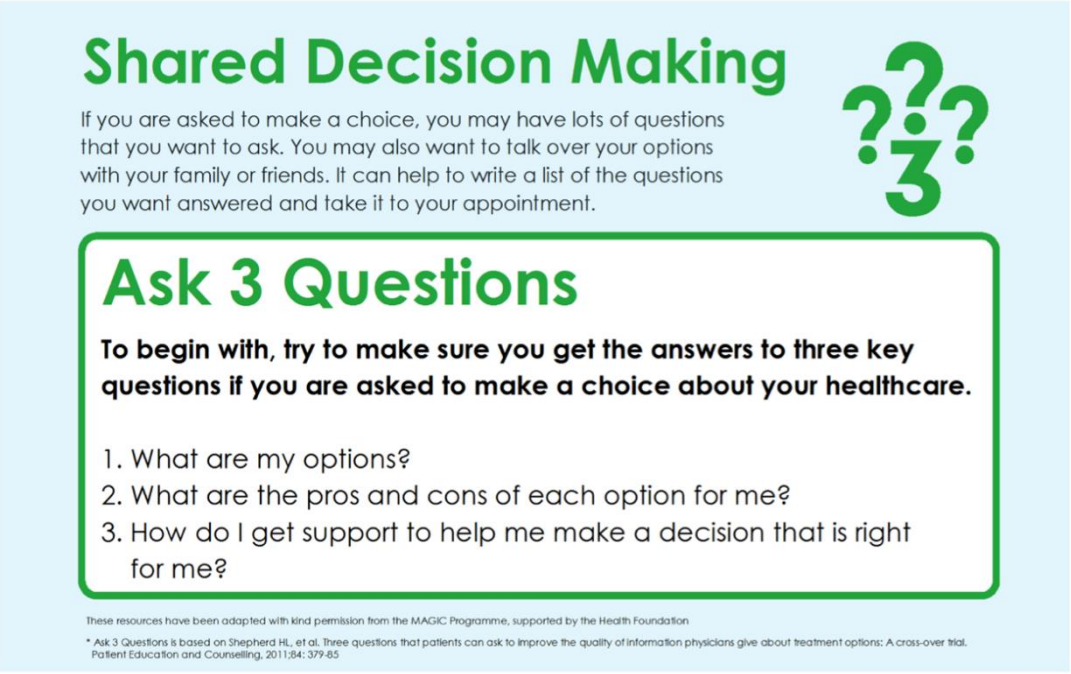
Making a choice



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