Endometrial Hyperplasia

About this information

This information is for you if you have been told you have endometrial hyperplasia, or may be at risk of this.

This information may also be helpful if you are a partner, relative or friend of someone who may have endometrial hyperplasia.

The information here aims to help you better understand your health and your options for treatment and care. Your healthcare team is there to support you in making decisions that are right for you. They can help by discussing your situation with you and answering your questions.

Within this leaflet we may use the terms ‘woman’ and ‘women’. However, we know that it is not only people who identify as women who may want to access this leaflet for information. Your care should be appropriate, inclusive and sensitive to your needs whatever your gender identity.

A glossary of all medical terms is available on the RCOG website at: https://www.rcog.org.uk/for-the-public/a-z-of-medical-terms/.

Key points

- Endometrial hyperplasia happens when there is overgrowth of the lining of the uterus (endometrium).
- Some women with endometrial hyperplasia may experience heavy or unexpected vaginal bleeding, including after the menopause. Some women will not have any symptoms.
- It is often suspected from an ultrasound scan, but you will need a biopsy (a sample of endometrium) to confirm the diagnosis.
- In most cases, endometrial hyperplasia resolves with time, even without treatment.
- In some cases, endometrial hyperplasia can progress into cancer of the uterus.
- If endometrial hyperplasia is found, you will usually be offered treatment with the hormone progesterone to lower the risk of progression to cancer. You will also be offered follow-up with a repeat biopsy every few months.
- If there is a high risk of cancer, the option of a hysterectomy (an operation to remove the uterus) will be discussed with you.

What is endometrial hyperplasia?

Endometrial hyperplasia happens when the lining of the uterus (endometrium) grows too thick or in a less regular way, than normal.

Endometrial hyperplasia can lead to cancer of the uterus over time. Follow-up and/or treatment is recommended to prevent cancer or pick it up early.

What are the symptoms of endometrial hyperplasia?

The most common symptom is abnormal vaginal bleeding.
Some women experience:

- heavy bleeding, prolonged periods,
- bleeding between their periods, or,
- unexpected bleeding after the menopause (including while on Hormone Replacement Therapy).

Some women have no symptoms at all, and it is suspected when they have a scan for other reasons.

If you are worried you may have endometrial hyperplasia, you should speak to your GP. Depending on your symptoms, your GP may arrange for you to have an ultrasound scan, or may refer you directly to a Gynaecologist.

Why does endometrial hyperplasia happen?

You are more likely to develop endometrial hyperplasia if you:

- are overweight or obese (have a body mass index above 25)
- are not ovulating regularly, which may happen when you have polycystic ovary syndrome (PCOS), or are approaching the menopause
- take tamoxifen, for example, as treatment for breast cancer.

You can reduce your risk of developing endometrial hyperplasia, or it progressing, by keeping your weight within a healthy range.

What are the different types of endometrial hyperplasia?

Endometrial hyperplasia has two types:

- hyperplasia without atypia
- hyperplasia with atypia.

'Atypia' means that the cells of the endometrium are abnormal.

Endometrial hyperplasia without atypia usually resolves, but it does have a small risk of progressing to cancer over many years. Less than 5 in 100 people with

endometrial hyperplasia without atypia will develop endometrial cancer over 20 years.

Endometrial hyperplasia with atypia has a higher risk of progressing into cancer. The risk is thought to be 8 out of every 100 women by 4 years. There is also a risk of cancer being already present that was not detected in the biopsy.

How is suspected endometrial hyperplasia investigated?

The first investigation is usually a transvaginal ultrasound scan. If the endometrium is thickened, contains polyps, or shows changes in its blood supply, a biopsy (or removal of polyps) will be suggested.

A biopsy is usually taken in an outpatient clinic. This is done by passing a very thin tube through the cervix, with the help of a speculum, with suction used to remove a small sample from the endometrium.

A biopsy can also be taken during a hysteroscopy. This is when a narrow telescope is passed into your uterus through your vagina and cervix. Biopsies can be taken of areas that look thickened, and polyps can be removed. This can be done while you are awake as an outpatient, or when you are asleep (under general anaesthetic).

For some women, a speculum examination, biopsy or hysteroscopy causes no or only mild pain, but some women may find these procedures very painful. Your healthcare professional will discuss your options for pain relief, including having the procedure under general anaesthetic.

A specialist then looks at the biopsy under a microscope to make the diagnosis.

Sometimes, the first biopsy is not sufficient to give a diagnosis. This is often reassuring, but if your scan or symptoms suggest that hyperplasia is likely, then your healthcare professional may discuss repeating the biopsy, usually by hysteroscopy.

How is endometrial hyperplasia without atypia treated and monitored?

Endometrial hyperplasia without atypia will resolve over time without treatment in 7-8 out of every 10 women. Treatment with the hormone progesterone has been shown to make it more likely that endometrial hyperplasia will resolve, in 9 out of every 10 women.

If you have troublesome bleeding as a symptom, treatment with progesterone may also make this bleeding better.

Progesterone can be given by tablet – such as norethisterone or medroxyprogesterone. It is usually suggested that you take tablets for six months. It can also be given using a small, T-shaped plastic device, the Mirena ® IUS, which is

placed inside the uterus. Many women prefer the Mirena® as it is more likely that hyperplasia will resolve, it may have fewer side effects and it can offer ongoing treatment for 5 years.

You will usually be recommended to have another biopsy 6 months after diagnosis of endometrial hyperplasia without atypia, and again 6 months after that. Some women may not need any further biopsies.

If you have a BMI of more than 35, or if your treatment was with progesterone tablets, you may have a higher risk of the endometrial hyperplasia coming back. You will usually be offered biopsies every year.

If you have been discharged from follow-up for endometrial hyperplasia, but then experience any unexpected or unusual bleeding in the future, you should tell your GP.

How is endometrial hyperplasia with atypia treated and monitored?

If you have endometrial hyperplasia with atypia and you have completed your family, you will usually be advised to have a hysterectomy (see below).

If you are unable or do not want to have a hysterectomy, then you will be recommended treatment with progesterone tablets or the Mirena® IUS. You will be offered regular biopsies, usually every three months.

Although this may help prevent cancer, or allow cancer to be picked up sooner, you may still develop cancer.

Why might I be recommended to have a hysterectomy?

You may wish to consider a hysterectomy with or without removal of your ovaries, if:

- the hyperplasia without atypia does not resolve
- it comes back after 12 months, or
- your bleeding problems continue.

If you have endometrial hyperplasia with atypia, and have completed your family, this will usually be the recommended treatment.

This can often be performed as a laparoscopic (keyhole) procedure.

You should discuss your options with your doctor. It is your choice whether to decline treatment, even if it has been recommended to you.

If you have decided to have a hysterectomy, you may be advised to have your ovaries removed at the same time. Your gynaecologist will discuss the risks and benefits of this with you.

How is endometrial hyperplasia treated if I want to become pregnant?

You will be advised not to get pregnant until a biopsy has confirmed that the hyperplasia has resolved.

If you are taking progesterone to treat endometrial hyperplasia, your fertility will return once you stop treatment.

You should be offered the opportunity to discuss fertility treatment with a specialist, which may support you to get pregnant sooner.

Can I take Hormone Replacement Therapy (HRT)?

It is not fully known how taking HRT affects endometrial hyperplasia. If you are on HRT and have a diagnosis of endometrial hyperplasia, you should discuss this with your gynaecologist.

You may be advised to stop taking the HRT to see if the hyperplasia resolves. If you wish to continue using HRT, it may be beneficial to take progesterone throughout the month (if you are not doing so already), or to use the Mirena® IUS.

What should I do if I am taking tamoxifen?

If you are on tamoxifen because you have had breast cancer, then your healthcare professional is likely to suggest seeking advice from the doctor who treated your breast cancer (your oncologist). This is so they can discuss, and explain the potential risks and benefits, of stopping or continuing tamoxifen with you.

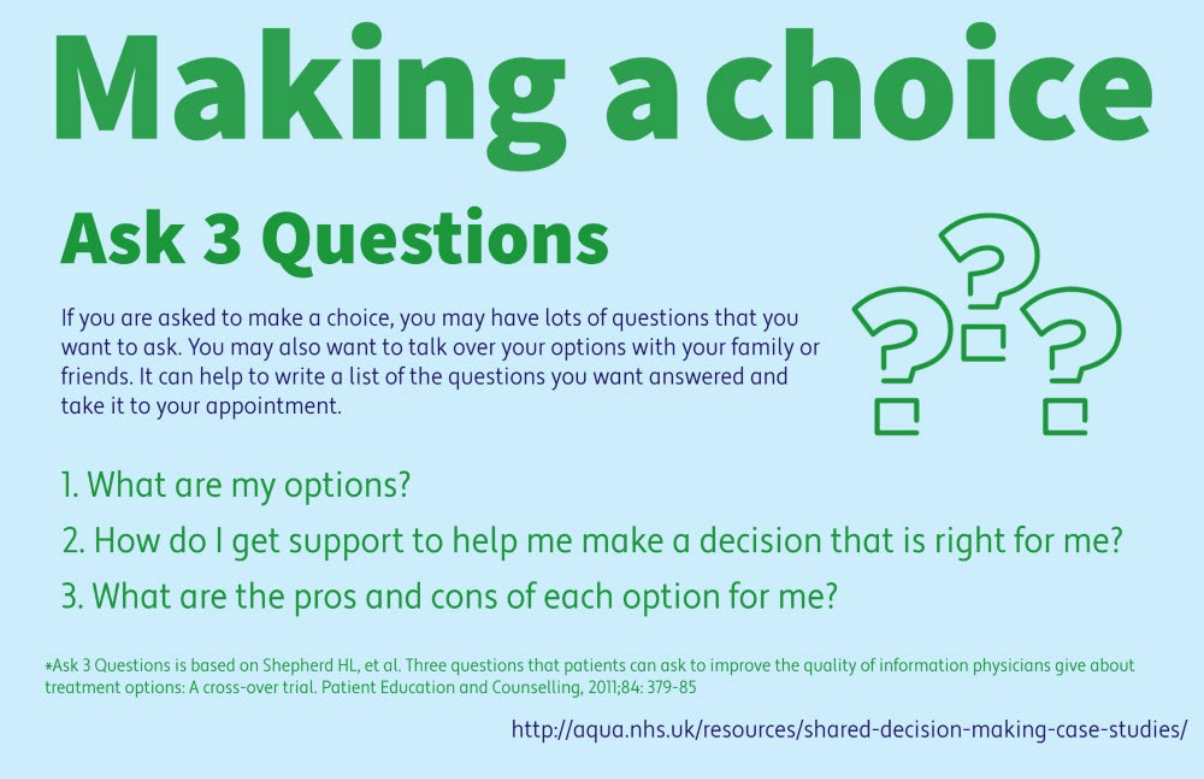
Emotional support

Being told that you may have endometrial hyperplasia can be stressful. If you are feeling anxious or worried in any way, please speak to your healthcare team who can answer your questions and help you get support. The support may come from healthcare professionals, voluntary organisations or other services. Further information and resources are available on the NHS website: https://www.nhs.uk/conditions/stress-anxiety-depression/

Further information

RCOG Patient information: Treatment for the symptoms of the menopause
RCOG Hysterectomy: https://www.rcog.org.uk/for-the-public/menopause-and-later-life/hysterectomy/
RCOG Outpatient hysteroscopy: https://www.rcog.org.uk/for-the-public/browse-all-patient-information-leaflets/outpatient-hysteroscopy/

Making a Choice



Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the RCOG guideline *Management of Endometrial hyperplasia (Green Top No.67)* Published February 2016. The guideline contains a full list of the sources of evidence we have used. You can find it online at: https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/management-of-endometrial-hyperplasia-green-top-guideline-no-67/.