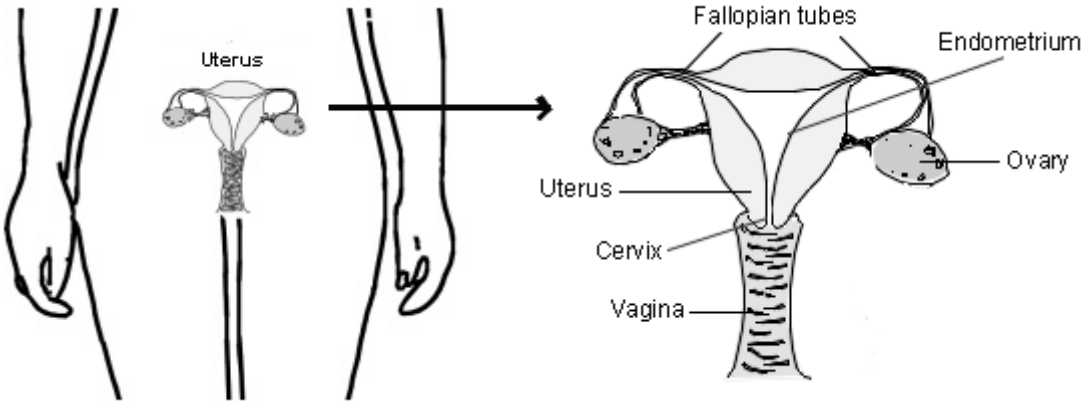
North West Anglia
NHS Foundation Trust

What is Atypical Endometrial Hyperplasia?

The Womb

The uterus or womb is a muscular organ found at the top of the vagina. The lower part of the uterus is called the cervix and the lining of the uterus is called the endometrium.



Endometrial hyperplasia is a thickening of the lining of the womb (uterus). The endometrium is the inner lining of the womb. In women who have not reached their menopause, this lining is shed each month during a menstrual period.

Hyperplasia means excessive growth. In endometrial hyperplasia, the cells that make up the endometrium multiply excessively, so that it becomes thicker.

There are two types of endometrial hyperplasia: **Hyperplasia without atypia and atypical hyperplasia.**

- **Atypical hyperplasia**.
  In this type, the cells are not normal (they are said to be atypical). This type of hyperplasia is more likely to become cancerous over time if not treated.

Who develops endometrial hyperplasia?

Endometrial hyperplasia is more common in women after their menopause, but may occur in younger women before the menopause. Endometrial hyperplasia is caused by an excess of the hormone oestrogen, which is not balanced by the progesterone hormone. Certain conditions make you more likely to have this imbalance, and endometrial hyperplasia is more common if this is the case. However, any woman can develop endometrial hyperplasia. It is more common if the patient -

- Is overweight.
- Takes certain types of hormone replacement therapy (HRT).
- Has not had a child.
- Has polycystic ovary syndrome (PCOS).
- Has an unusual type of tumour of the ovary, such as a granulosa cell tumour.
- Takes a medicine called tamoxifen (for breast cancer).
- Has diabetes.

What are the symptoms of endometrial hyperplasia?

Usually endometrial hyperplasia causes vaginal bleeding which is different to your usual pattern. Some women may have bleeding in between their periods, when it is not expected. In other women, periods may become heavier or more irregular. If you have already stopped your periods and are in your menopause, you may experience unexpected bleeding. If you take HRT, you may get bleeding at a time when you do not usually have a bleed. Some women may have a vaginal discharge. In some women there may be no symptoms, and the hyperplasia may be picked up whilst having tests for other reasons.

Treatment for Atypical endometrial hyperplasia

SURGERY: If you have atypical endometrial hyperplasia, your specialist will probably recommend you have a hysterectomy. This is an operation to remove the womb. This is to prevent you developing a cancer of the lining of the womb. If you are in the menopause, you will be offered removal of your ovaries and Fallopian tubes as well; this is called a hysterectomy and salpingo-oophorectomy.

HORMONE TREATMENT: If you have a high BMI and/or are unfit for surgery the Mirena IUS will be recommended as first line treatment, with oral progestogens as a second-best alternative. You will be followed up at regular intervals and endometrial biopsy obtained every 3 months until two consecutive negative biopsies are obtained. After a minimum of two consecutive negative endometrial biopsies, long-term follow-up with biopsy every 6–12 months will be recommended until a hysterectomy can be performed. This will provide time for you to lose weight or improve your general fitness, if possible.

If you want to be able to get pregnant and you do not want a hysterectomy, you can discuss the options with your specialist. You may be able to have hormone treatment for six months and if a repeat biopsy shows it has worked, you may be able to delay a hysterectomy until after you have completed your family. However, you will still be advised to have a hysterectomy at some point, as there is a high chance that the endometrial hyperplasia will return, and a risk that it may change to cancer. You may be referred to a fertility specialist for further advice regarding fertility sparing.

Multidisciplinary Team Meeting (MDT)

All women diagnosed with a gynaecological cancer or a suspicion of cancer will be discussed by the gynaecology multidisciplinary team, whether they have surgery or not. This is so a consensus agreement can be made in recommending surgical or medical treatment.

This meeting is held on Tuesdays. We will contact you following the meeting to update you on the suggested plan of care. This will be discussed in more detail with you at your outpatient appointment after this MDT. Your GP will also be informed of the MDT outcome.