Royal Berkshire
NHS Foundation Trust

Endometrial hyperplasia

You have been given this leaflet to help explain what endometrial hyperplasia is and how the condition is managed and treated. If you have any further questions please discuss with the nurse at your appointment or contact us on 0118 322 7191.

What is endometrial hyperplasia?

Endometrial hyperplasia is a condition in which the lining of the uterus (endometrium) becomes unusually thick. This occurs due to an imbalance of hormones, specifically when there is excess oestrogen without sufficient progesterone.

Oestrogen and progesterone are hormones secreted by the ovaries that control the growth and shedding of the uterine lining as part of your normal menstrual cycle (period). Oestrogen causes the growth of the uterine lining and progesterone counteracts this growth. If, over a long time, there is an excess of oestrogen without progesterone, this can cause overgrowth of the womb lining and result in endometrial hyperplasia.

Endometrial hyperplasia is not cancer, but certain types may increase the risk of developing uterine cancer.

What are the types of endometrial hyperplasia?

There are two main categories of endometrial hyperplasia.

1. **Hyperplasia without atypia:** Atypia is when the cells in the endometrial lining are abnormal so this is when there is thickening of the endometrial lining with the cells still looking normal.
2. **Atypical hyperplasia (hyperplasia with atypia):** this is when there is thickening of the endometrial lining with abnormal cells.

Can endometrial hyperplasia progress to womb cancer?

In hyperplasia without atypia, the risk of progression to womb cancer over 20 years is uncommon, about less than 5% risk (less than 1 out 20 women).

Endometrial hyperplasia with atypia has a higher risk of developing into cancer. The risk of progression of this type to endometrial cancer is up to 30% (3 out of 10 women). In about 48% of women (almost 5 out of 10 women) with this condition, there is also a risk of cancer being already present that was not detected in the biopsy. Please see below about how you will be closely monitored and treated.

What are the risk factors associated with endometrial hyperplasia?

- **Hormonal imbalance:** When there is excess oestrogen without progesterone, such as taking oestrogen only medication or medications that act like oestrogen, or women who are not ovulating.
- **Obesity:** Fat tissue produces oestrogen, increasing levels in the body.
- **Polycystic Ovary Syndrome (PCOS):** Leads to hormonal imbalances.
- **Hormone Replacement Therapy (HRT):** Long-term use of high doses of oestrogen, especially when oestrogen is given without progesterone in women who still have their womb.
- **Age:** Most common after menopause but can occur in younger women.
- **Family history:** A history of uterine, ovarian, or colorectal cancer may increase risk.
- **Other risk factors include:** Never having been pregnant, older age at menopause (over 55 years old), early age when menstruation started and cigarette smoking.

What symptoms can endometrial hyperplasia present with?

- Unusual or heavy menstrual bleeding.
- Spotting between periods.
- Postmenopausal bleeding, including whilst on HRT.
- Abnormally long menstrual cycles.

If you experience these symptoms, consult your doctor/GP immediately.

How can endometrial hyperplasia be diagnosed?

Diagnosis involves a combination of:

1. **Medical history:** Detailed discussion of symptoms and menstrual patterns.
2. **Pelvic ultrasound:** This scan is usually an internal scan to assess the thickness of the womb lining and to check if there are any concerning features.
3. **Endometrial biopsy:** A small sample of uterine lining is taken for laboratory analysis. This can be done either with a small tube that goes into the womb through the cervix with the help of a speculum to take some scrapings using suction or as part of the hysteroscopy procedure. 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 doctor may discuss repeating the biopsy, usually by hysteroscopy.
4. **Hysteroscopy:** A procedure to view the cavity of the uterus directly and collect tissue samples. This procedure involves looking directly at the lining of the womb using a telescope.

What treatment will I receive with a diagnosis of endometrial hyperplasia?

Your management will depend on the type of hyperplasia and the individual risk factors. Your doctor will discuss this further with you.

A. Hyperplasia without atypia

In most women with this type of endometrial hyperplasia, the cells in the lining of the womb will go back to normal by themselves. Your doctor may recommend some hormone treatment (see below) to help the cells go back to normal. As part of your care, your doctor will advise you on some important lifestyle changes that will be of help to you.

These will include weight loss if you are overweight and managing any underlying conditions like PCOS or diabetes.

Treatment options:

1. **Hormonal therapy (progesterone therapy):** This involves the use of progesterone medication to balance oestrogen and can thin the endometrial lining. This is the most effective treatment for endometrial hyperplasia, with around a 90% chance of the cells going back to normal. This can be given either as:
   a) Progesterone containing coil (Levonorgestrel-releasing intrauterine system, LNG-IUS): This is a type of coil that is also sometimes used for contraception. It sits inside the womb and releases progesterone to thin the lining of the womb. It has the best success rate for treating endometrial hyperplasia, fewer side effects and it can offer ongoing treatment for 5 years. It can be fitted in the hospital or at your GP surgery.
   b) Progesterone tablets (e.g. medroxyprogesterone acetate or norethisterone). The tablets must be taken every day as prescribed for at least six months.
2. **Observation:** In certain circumstances, progesterone treatment may not be appropriate and observation without any treatment may be recommended with a further biopsy after 6 months.
3. **Surgery (hysterectomy):** This is an operation to remove the womb (uterus) and can sometimes be recommended based on your risks, recurrent bleeding or when there has been no regression despite progesterone treatment. This operation can be done either laparoscopically (keyhole surgery) or by laparotomy (open surgery).

Monitoring: Women on hormonal therapy or observation will require follow-up with repeat endometrial biopsy every 6 months until regression is confirmed. You may be discharged after two negative biopsies. If you have any abnormal bleeding while you are having follow-up or after you have been discharged, you should inform your GP as they may need to refer you for a repeat biopsy.

B. Atypical hyperplasia

Definitive treatment: Hysterectomy (removal of the womb) will be recommended if you have completed your family or are at high risk of progression. This is often the best treatment for this type of hyperplasia.

Progesterone therapy: Women who have not completed their family size or declined hysterectomy, will be offered progesterone treatment, either as oral or LNG-IUS, with close monitoring. This can also be recommended for those women who are considered not suitable for surgery. Your doctor will discuss this further with you.

Monitoring: Women on hormonal therapy will require follow-up with repeat endometrial biopsy usually every 3 months until regression is confirmed. Although this may help prevent cancer, or allow cancer to be picked up sooner, you may still develop cancer. If you have any abnormal bleeding while you are having follow-up or after you have been discharged, you should inform your GP as you may need a repeat biopsy taking.

Is there anything I can do to prevent endometrial hyperplasia?

- Maintain a healthy weight and lose weight if you are overweight. The risk of endometrial hyperplasia and womb cancer increases with the degree of obesity.
- Discuss hormone therapy options with your doctor if you're undergoing the menopause.
- Tell your doctor if you are taking any over the counter medicines that may act like oestrogen, such as remedies for menopausal symptoms.
- If you are taking medicines such as Tamoxifen, discuss this with your doctor. Do not stop taking any medicines unless advised by your doctor.
- Manage underlying conditions like PCOS or diabetes.
- Consider birth control methods that include both oestrogen and progesterone.

When should I seek medical help?

- Heavy or prolonged bleeding.
- Spotting between periods or postmenopausal bleeding.
- Severe pelvic pain

Frequently asked questions (FAQs)

1. **Can endometrial hyperplasia resolve on its own?** *Mild cases may resolve with lifestyle changes or hormonal adjustments, but others require treatment.*
2. **Is endometrial hyperplasia always a precursor to cancer?** *No, but atypical hyperplasia increases the risk. Regular monitoring and treatment are essential.*
3. **Can I get pregnant if I have endometrial hyperplasia?** *It depends on the type and severity. Consult your doctor about fertility-preserving treatments.*

Contact and further information

If you have questions or need support, please contact:

- Your doctor/GP
- The Royal Berkshire NHS Foundation Trust website: www.royalberkshire.nhs.uk
- The RCOG website: https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/management-of-endometrial-hyperplasia-green-top-guideline-no-67/

Note: This leaflet is for informational purposes only and is not a substitute for professional medical advice.

Feel free to discuss any questions or concerns with your nurse at your appointment or telephone us on **0118 322 7191.**

Please ask if you need this information in another language or format.

C Okoror, Senior Clinical Fellow, January 2025
Next review due: January 2027