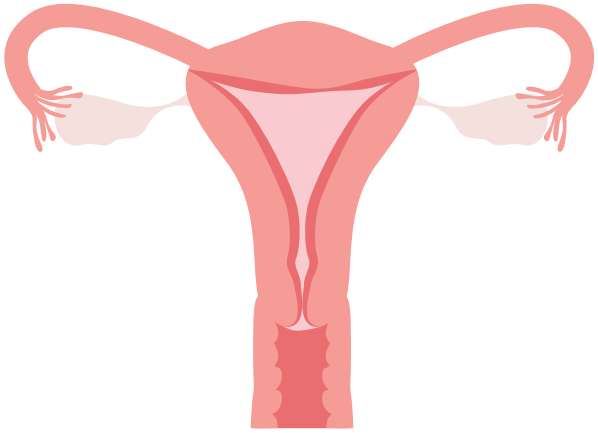
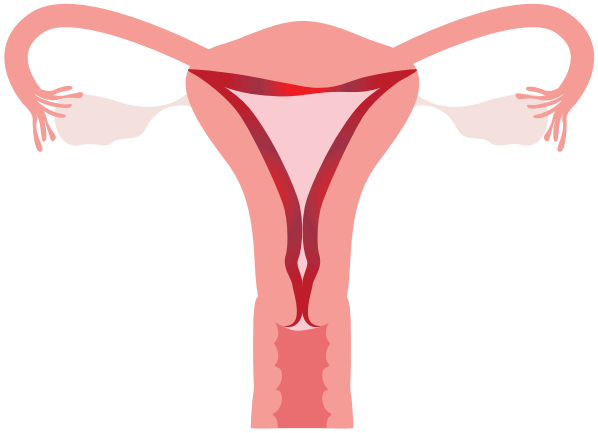
Endometrial Hyperplasia:
General Information, Evaluation, and Treatment

The endometrium is the lining of the uterus that grows and sheds with each menstrual cycle. After menopause, this lining should remain thin and not bleed at all. **Endometrial hyperplasia is where this endometrial lining grows in a crowded, disorganized way**. In some cases, endometrial hyperplasia can be a precursor for cancer of the endometrium if left unchecked.

Normal Endometrium



Endometrial Hyperplasia



TYPES OF ENDOMETRIAL HYPERPLASIA

Endometrial Hyperplasia **with atypia**	**Endometrial hyperplasia "with atypia"** means that the sampled cells are crowded, and look disorganized under a microscope. This suggests a closer resemblance to a cancer. The risk of progressing to endometrial cancer is up to 40% in these cases, and many will have a co-existing endometrial cancer that just wasn't detected during tissue sampling.
Endometrial Hyperplasia **without atypia**	**Endometrial hyperplasia "without atypia"** suggests that while the cells are more crowded, they still look normal under the microscope. The risk of progressing to endometrial cancer is approximately 1% in these cases.

Symptoms of Endometrial Hyperplasia

The **most common symptom of endometrial hyperplasia is abnormal uterine bleeding.** However, other conditions can have these symptoms too. This abnormal bleeding can come in different forms, including:

- Heavy Menstrual Bleeding (HMB)
- Intermenstural Bleeding (IMB, i.e. bleeding in between periods)
- Postmenopausal Bleeding (PMB)
- Longer duration of menstural cycle

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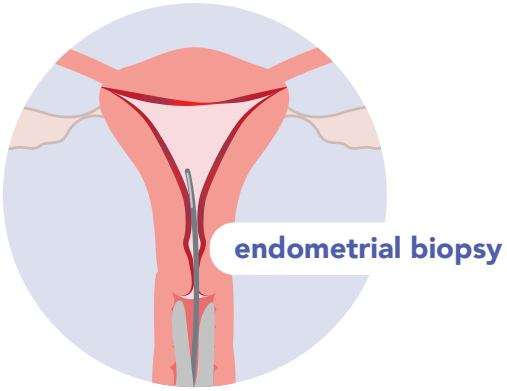
Diagnosis of Endometrial Hyperplasia

Endometrial hyperplasia is most commonly diagnosed by an **endometrial biopsy.** This is an office procedure where a physician passes a narrow straw through the cervix into the uterus and takes a sample of the lining. The setup for this procedure is similar to a Pap test, however the procedure is usually more uncomfortable.

Some people find this procedure uncomfortable and cannot tolerate having it done in the office. Your doctor may recommend a short procedure in the operating room under anesthesia instead.



Treatment of Endometrial Hyperplasia

Endometrial hyperplasia with atypia is treated different than endometrial hyperplasia without atypia because the risk of cancer is different for each.

ENDOMETRIAL HYPERPLASIA **WITH ATYPIA**

For endometrial hyperplasia with atypia, in patients with this diagnosis, there is a higher risk of a concurrent, undiagnosed endometrial cancer.

Surgical Management

For endometrial hyperplasia with atypia, **preferred management is hysterectomy with concomitant bilateral salpingo-oophorectomy** due to the underlying risk of malignancy or progression to endometrial cancer. Leaving the ovaries intact in a premenopausal woman may be considered.

ENDOMETRIAL HYPERPLASIA **WITHOUT ATYPIA**

In endometrial hyperplasia without atypia, there is a lower risk of progressing to cancer.

Medical Management

This lower risk of progression to cancer means that **medical management, with progesterone, can be an option**. This can include a progesterone-containing intrauterine device (IUD) commonly known as *Mirena*, or other formulations such as oral tablets (e.g. *Megace* or *Provera*) or intramuscular injection (*Depo-Provera*). If you choose medical management, your doctor will recommend re-sampling the endometrial lining. It is possible medical management may not work and your doctor may recommend surgical management.

Surgical Management

Some patients who have endometrial hyperplasia without atypia may be offered surgical management with a hysterectomy. According to current guidelines in Canada, postmenopausal women should also be offered removal of the ovaries and fallopian tubes (bilateral salpingo-oophorectomy) at the same time. This decision is individualized for premenopausal women.

References
1. Auclair MH, Yong PJ, Salvador S, Thurston J, Colgan TT, Sebastianelli A. Guideline No. 390-Classification and Management of Endometrial Hyperplasia. Journal of Obstetrics and Gynaecology Canada. 2019 Dec 1;41(12):1789-800.

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