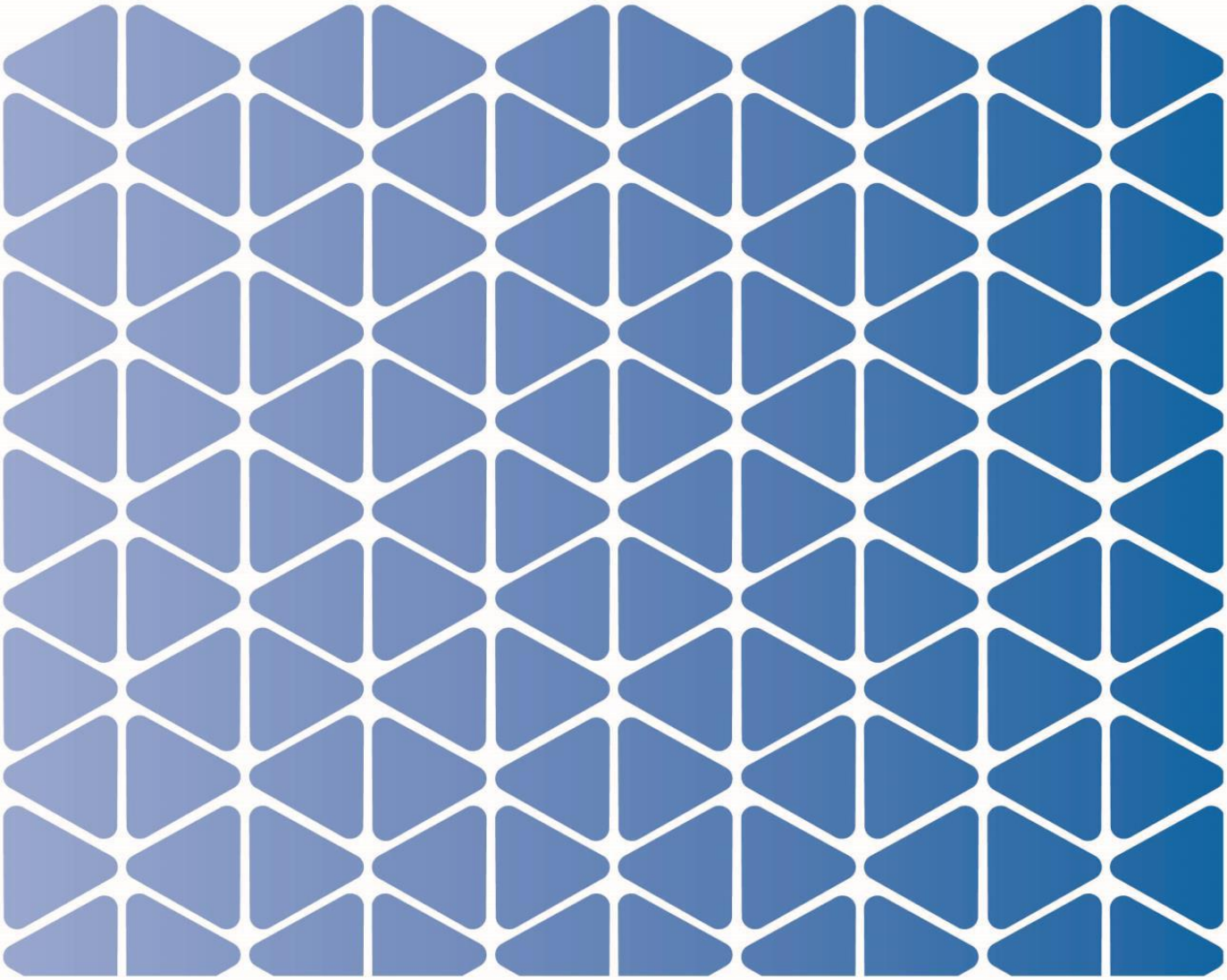
PATIENT INFORMATION

ENDOMETRIAL HYPERPLASIA WITHOUT ATYPIA



We hope that this information leaflet will help you to understand your care options. We hope that you will feel comfortable to ask questions of your health professional so that you can work together to make a plan that meets your needs and priorities.

Remember you can always ask the healthcare professional to explain things differently, explain things again, or to write down information for you.

Endometrial hyperplasia without atypia

What is Endometrial hyperplasia (EH)?

Endometrial hyperplasia is when the lining of the uterus/womb (endometrium) becomes excessively thick.
This is not cancer, but EH can lead to cancer of the lining of womb (endometrial cancer) in some women.
Endometrial hyperplasia has 2 types:

1. Endometrial hyperplasia without atypia.

2. Endometrial hyperplasia with atypia (not covered within this leaflet);

What Causes Endometrial Hyperplasia?

The most likely cause is an imbalance between the two female hormones, oestrogen and progesterone. Oestrogen stimulates the lining of the womb to grow and is counteracted by progesterone. These hormones are mainly produced by the ovary. When oestrogen levels are too much for progesterone to counteract, hyperplasia occurs.

There are several reasons why hormonal imbalance can happen:

1. Obesity
2. Polycystic Ovarian Syndrome (PCOS), as ovulation (egg formation) is affected causing excess estrogen.
3. Perimenopause (the period around age of menopause).
4. Age
5. Diabetes
6. Hypertension
7. Using a medication that acts like estrogen on the womb lining (e.g. Tamoxifen)
8. Using Estrogen medication as part of HRT without enough progesterone.

9. Having an ovarian mass that secretes estrogen (uncommon).
10. Rare genetic conditions

What are the symptoms of endometrial hyperplasia?

The most common symptom of endometrial hyperplasia is abnormal vaginal bleeding. If you have not gone through the menopause, this can include heavier and longer periods or bleeding between your periods.
For ladies who have gone through the menopause the most common symptom is unexpected vaginal bleeding (post-menopausal bleeding).

How is endometrial hyperplasia diagnosed?

A doctor may suspect endometrial hyperplasia might be suspected if you have symptoms and risk factors or if you had an ultrasound showing an abnormal womb lining. The only way to diagnose EH is by taking a sample of the womb lining and looking at the cells under the microscope. Usually this is done using a Pipelle biopsy. A thin tube is passed through the neck of the womb to reach the cavity and get a sample. This is usually well tolerated but can cause crampy period like pain. The biopsy usual lasts 20-30 seconds.

The biopsy may also be taken at the same time as a procedure called a hysteroscopy. For this a small telescope is inserted through neck of womb. This allows the lining of the womb to be directly visualized. Hyperplasia may also be present in a polyp (small skin tag) that can be detected at the time of hysteroscopy.

A separate leaflet is available on hysteroscopy that you may find useful.

What is the treatment of endometrial hyperplasia without atypia?

Treatment of Endometrial hyperplasia without atypia is mainly by giving enough progesterone to counteract the effect of oestrogen and taking steps to control any excess oestrogen in your body.

This can be done by

1. Progesterone releasing intrauterine coil (Mirena): This is inserted inside the womb at outpatient clinic and should stay in for at least 6 months and ideally up to 5 years. This is the most effective treatment with least side effects.
2. Continuous progesterone tablets which you take daily for at least 6 months. (more side effects, less regression rate and more likely to require hysterectomy)
3. Weight reduction is very important. Aim to achieve normal weight (BMI 18-25) if

applicable, as this reduces the excess oestrogen, minimizes the risk of medication not working, helps with bleeding issues and reduces the risk of recurrence of disease after treatment.

4. Hysterectomy (removing the whole womb) only in specific cases where there is no response to treatment or persistent bleeding.
5. If you are on HRT, your treatment will need to be reviewed to decide whether it needs to be stopped or modified.
6. If you are on Tamoxifen, this will need to be reviewed by your oncologist.
7. If you have PCOS and don't get regular periods, treatment options will be discussed with you.

What is the outcome of endometrial hyperplasia without atypia?

In most cases, endometrial hyperplasia without atypia is successfully treated with the hormone progesterone. Over the 20 years after diagnosis, fewer than 5 out of every 100 women who have it develop cancer of the womb (uterus). Even though this rate seems low, it is important we treat it to reduce the risk as much as possible.
The hyperplasia can return after treatment. It appears more likely to return if you are overweight with a body mass index (BMI) of more than 35.

How will I be monitored after starting treatment?

In most women, Endometrial hyperplasia without atypia can be treated successfully with hormone treatment and does not progress to cancer.
You will be advised to undergo a follow-up biopsy (tissue sampling) of the womb lining every 6 months for the minimum of a year. The duration of monitoring will depend on how well treatment works and any other risk factors you may have. Your clinician will discuss an individualised follow up plan with you.

What if I don't want any hormone treatment?

Observation alone with follow-up biopsy of the lining of the womb may also be appropriate. The rate of regression is lower compared to treatment with progesterone though. It is suggested that there are possibly around 75% chance that the cells will go back to normal with this method, compared to more than 90% with progesterone. Other risk factors, will affect this rate and make it lower. Even though the risk of progression to cancer is small we would recommend treatment to keep this risk as low as possible.

What if I want to get pregnant?

For younger patients, fertility and family planning is an important factor. In most cases we would recommend treatment with progesterone to achieve regression of the endometrial hyperplasia before planning any pregnancy. If you are current trying to conceive we would recommend stopping to allow treatment to occur. You can discuss this more with your clinician to ensure an appropriate and personalized plan is made for you.

Having read the above information, it might be helpful to think about the following…

- What do I want to ask my healthcare professional?
- What is worrying me about my diagnosis right now?
- Who is able to support me with the care that I chose?
- Would I like someone to come with me to my appointment if possible? *Please note that there may currently be restrictions on this as a result of the Covid-19 pandemic.*

Your notes

You can fill out the following table with your healthcare professional. This will help you to think about which option is best for you, given your individual situation. Doing nothing is also an option.

My Options include…	**The Benefits** Why is this option good for me?	**The Risks** What is not so good about this option for me?
To have treatment		
To do nothing		
Alternative treatment(s)		

You might also want to ask…

- How quickly should I expect to see an improvement?
- Who should I contact if I have questions after I leave today?
- Do I need to come back to the hospital again? Or to see my GP after today?
- Where can I go to get more information?
- What lifestyle changes could I make to support my recovery?

Your notes

Remember you can always ask the Doctor to explain things differently, explain things again, or to write down information for you.

Who should I contact if I have any problems?
EGAU is open 24 hours a day, 7 days a week. If you have any concerns after your treatment you can ring EGAU to speak to one of the gynaecology nurses for advice. You can also speak to your GP.

If your symptoms or condition worsens, or if you are concerned about anything, please call your GP, 111, or 999.

Patient Experience

We know that being admitted to hospital can be a difficult and unsettling time for you and your loved ones. If you have any questions or concerns, please do speak with a member of staff on the ward or in the relevant department who will do their best to answer your questions and reassure you.

Feedback

Feedback is really important and useful to us – it can tell us where we are working well and where improvements can be made. There are lots of ways you can share your experience with us including completing our Friends and Family Test – cards are available and can be posted on all wards, departments and clinics at our hospitals. We value your comments and feedback and thank you for taking the time to share this with us.

Patient Advice and Liaison Service (PALS)

If you have any concerns or questions about your care, we advise you to talk with the nurse in charge or the department manager in the first instance as they are best placed to answer any questions or resolve concerns quickly. If the relevant member of staff is unable to help resolve your concern, you can contact the PALS Team. We offer informal help, advice or support about any aspect of hospital services & experiences.

Our PALS team will liaise with the various departments in our hospitals on your behalf, if you feel unable to do so, to resolve your problems and where appropriate refer to outside help.

If you are still unhappy you can contact the Complaints Department, who can investigate your concerns. You can make a complaint orally, electronically or in writing and we can advise and guide you through the complaints procedure.

How to contact PALS:

Telephone Patient Services: 0300 123 1732 or via email at: wah-tr.PALS@nhs.net

Opening times:

The PALS telephone lines are open Monday to Friday from 8.30am to 4.00pm. Please be aware that you may need to leave a voicemail message, but we aim to return your call within one working day.

If you are unable to understand this leaflet, please communicate with a member of staff.