ENDOMETRIAL HYPERPLASIA

Premalignant lesions of the enometrium are classified as hyperplasia. The risk of developing malignancy is based on the degree of cellular abnormality identified.

RISK OF MALIGNANCY —

Simple hyperplasia without atypia --	1%
Complex hyperplasia without atypia --	3%
Simple hyperplasia with atypia--	8%
Complex hyperplasia with atypia--	29%

Risk of cancer—

The risk is 10 fold higher with unopposed estrogen therapy. The risk of progressing to cancer is elevated in obesity, diabetes, chronic anovulation, hypertension and heridary non-polyposis colorectal cancer (Lynch syndrome).

Treatment—

Treatment with progestins is recommended for three to six months. The response rate to progestins is highest in women without atypia and with therapy of at least 12 to 14 days per month. In a representative example, a series of 376 women with varying degrees of endometrial hyperplasia treated with a progestin for 7, 10, or 13 days each month for three to six months reported complete regression in 81, 98, and 100 percent of patients, respectively[1].

Endometrial hyperplasia may also be treated with a levnorgestrel containing IUD (Mirena). If medical management of hyperplasia is elected, follow-up should include repeat endometrial biopsy three to six months after starting therapy. If no benefit is realized from the progestin treatment, surgical therapy is warrented.

Definitive treatment, particularly for women finished with childbearing, is hysterectomy. Many women who are family status complete will elect hysterectomy as opposed to treatment with progestins and repeat D&C.

Additional information can be found at WebMD, UpToDate or similar, lay accessible, websites.

REFERENCES

1. Gambrell RD Jr. Progestogens in estrogen-replacement therapy. Clin Obstet Gynecol 1995; 38:890.

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