

The Management of Endometrial Hyperplasia at Imperial College Healthcare NHS Trust

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Background

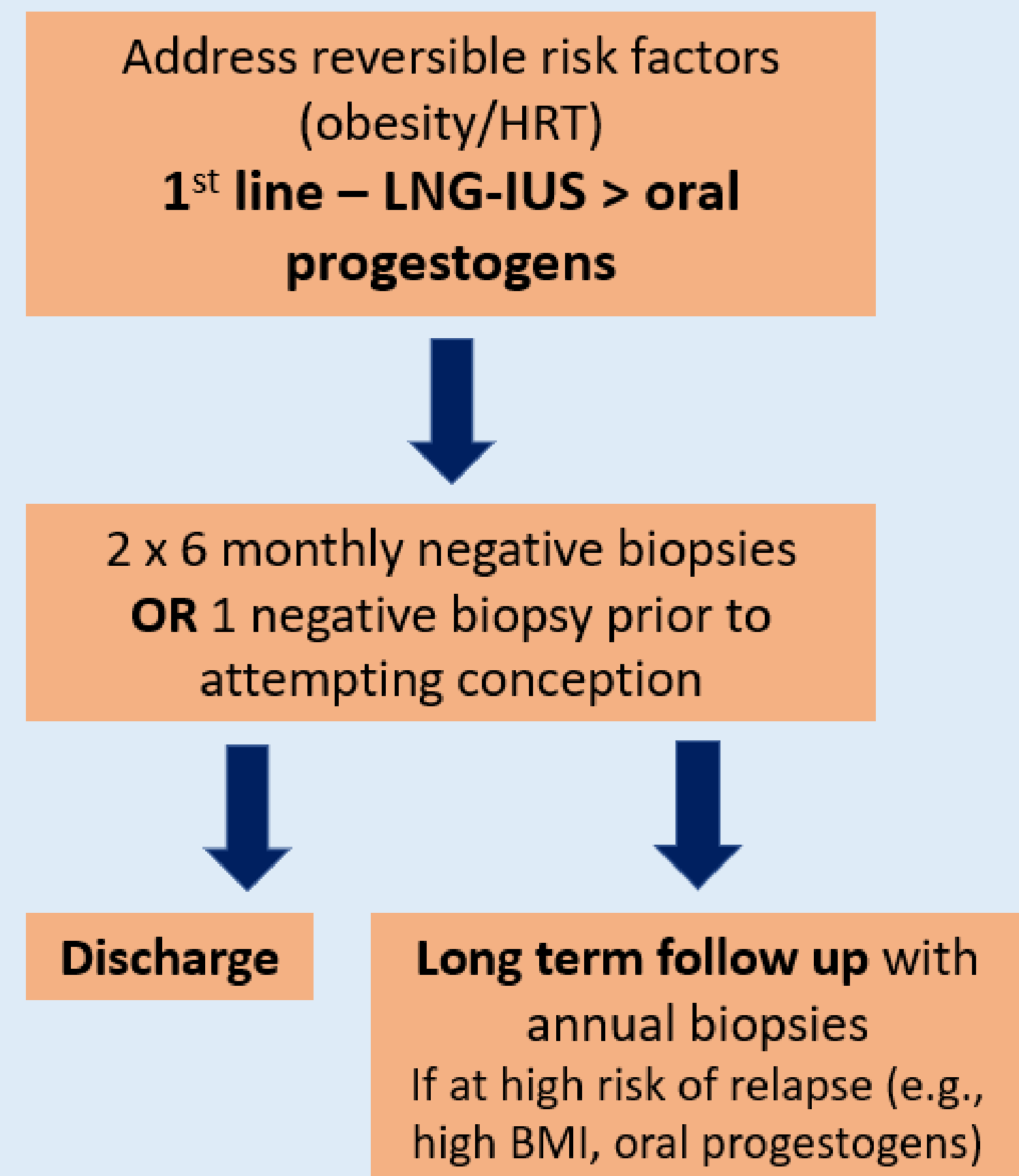
- Endometrial hyperplasia (EH) precedes the commonest gynaecological malignancy in the Western world: endometrial cancer
- RCOG and BSGE released a guideline for the management of EH in 2016, which classifies the management of EH according to the absence or presence of cellular atypia
- We aimed to determine how women with EH were managed at Imperial College Healthcare NHS Trust (ICHT), before and after publication of the guideline

Methods

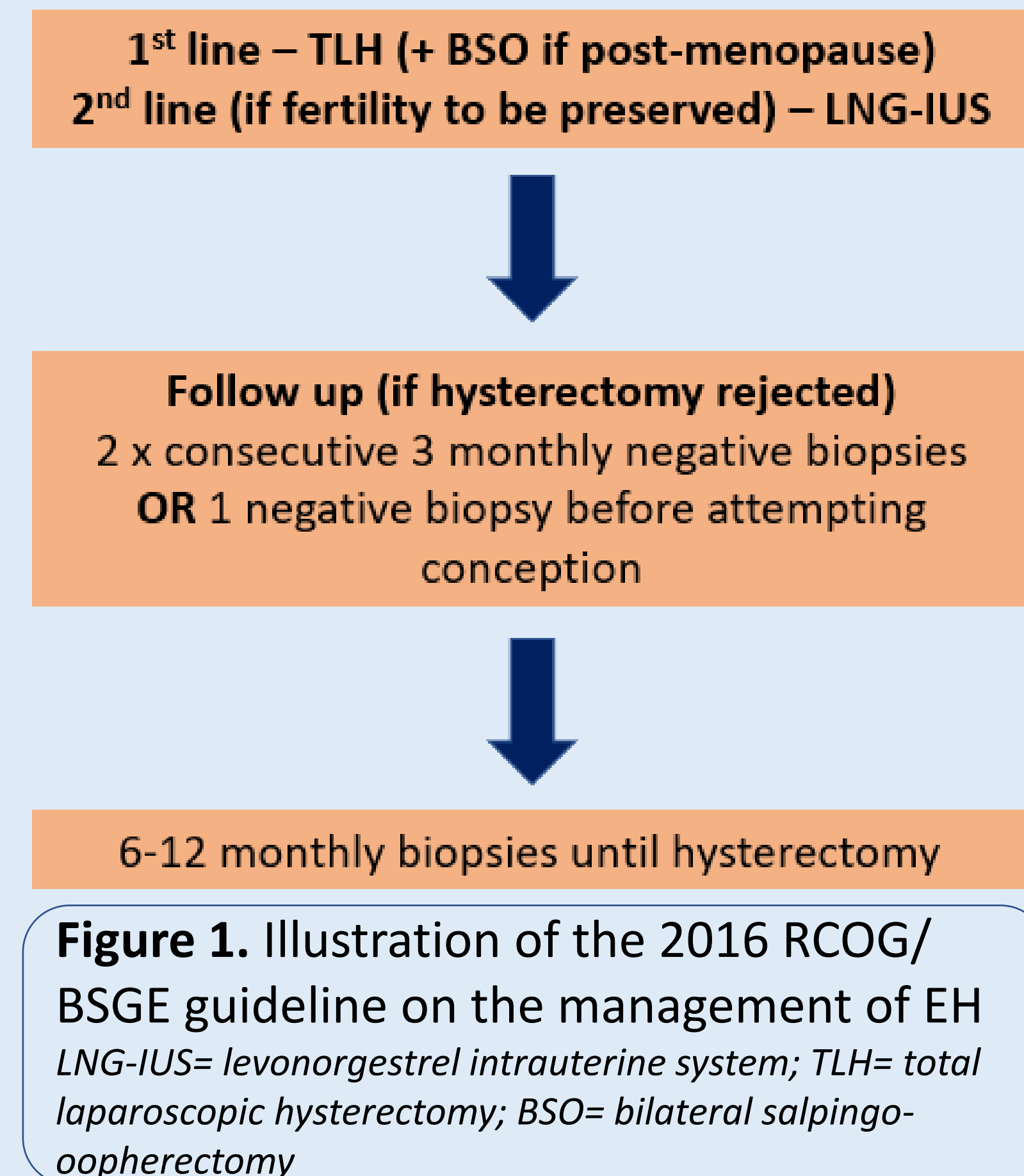
- 84 women were diagnosed with EH without atypia and 72 women with atypical EH between 2010 to Spring 2021
- Data was obtained from structured notes from Rapid Access Clinics, gynaecology outpatient follow-up appointments, pathology results and discharge summaries
- Patients were grouped based on the date of their diagnosis being before or after the guideline was published

RCOG/BSGE Guidance¹

EH without atypia



Atypical EH



Results

EH without atypia

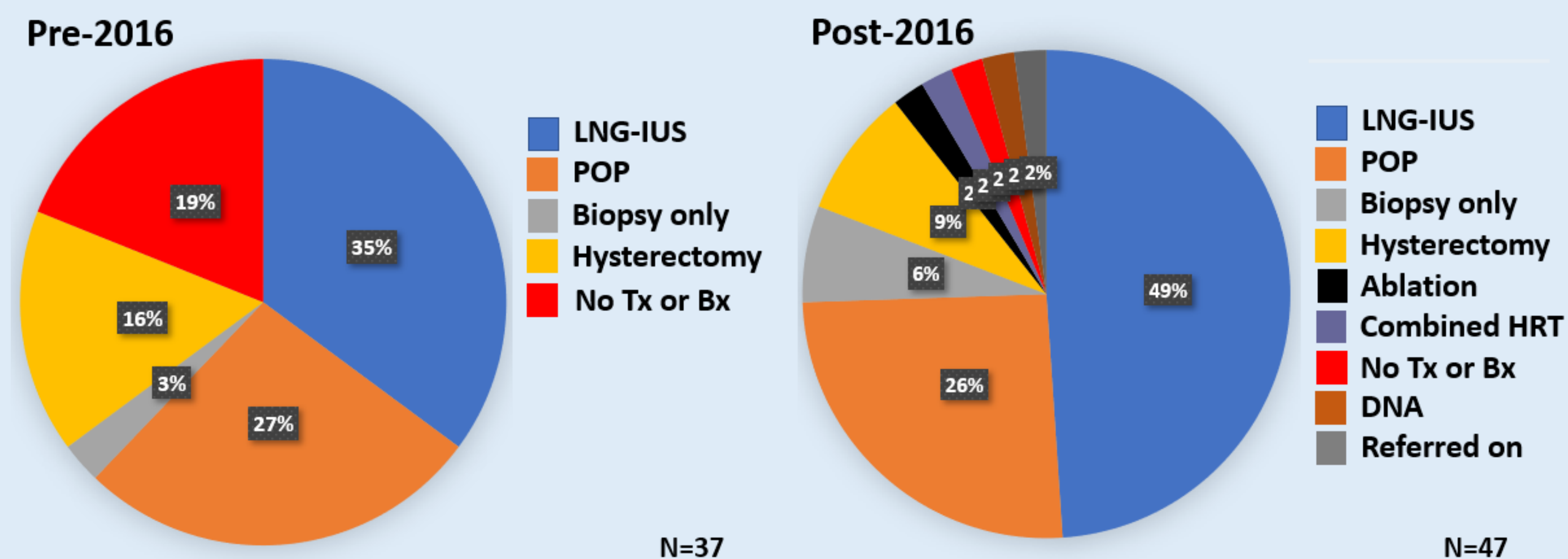


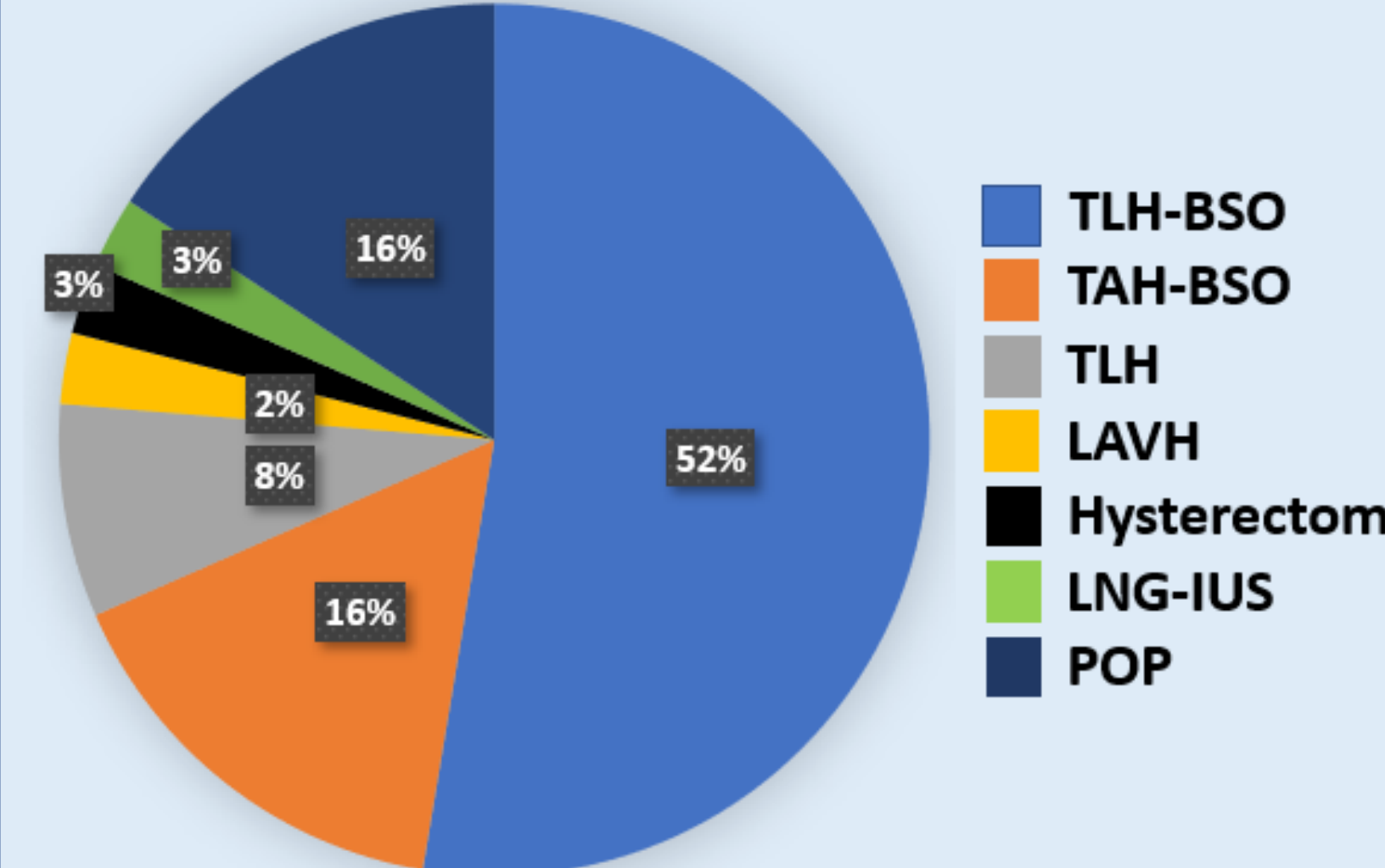
Figure 2. Pie-chart displaying the management of women with EH without atypia before and after introduction of the RCOG guideline. POP= progesterone only pill; Tx=treatment; Bx=biopsy; DNA= did not attend follow-up

- The median age at diagnosis was 53 (N=84): 68% of patients were obese (BMI>30), at least 15% had T2DM and 44% were nulliparous.
- The proportion of women managed with progestogen treatment increased from 62% pre-2016 to 75% post-2016, with LNG-IUS uptake increasing from 35% to 49%.
- A further 16% received a hysterectomy pre-2016, and 9% received hysterectomy post-2016.
- Reasons for declining LNG-IUS included attempting conception, pain concerns, preferring to trial a watch and wait approach, and a history of breast cancer
- The proportion of women undergoing two 6-monthly biopsies (or one if attempting conception) increased from 35% pre-2016 (n=31) to 68% so far post-2016 (n=37).
- The proportion attempting conception, therefore only requiring one negative biopsy, may be higher than reported.

Atypical hyperplasia

- The median age at diagnosis was 53 (N=72): 73% of patients were obese (BMI>30), at least 14% had T2DM and 38% were nulliparous.
- 59/72 (82%) of women diagnosed with atypical EH both pre- and post-2016 have been managed with a hysterectomy. 13/72 women have not.
- 41% of hysterectomy specimens analysed from patients diagnosed with atypical EH contained endometrial cancer at histology, consistent with previous findings²

Pre-2016



Post-2016

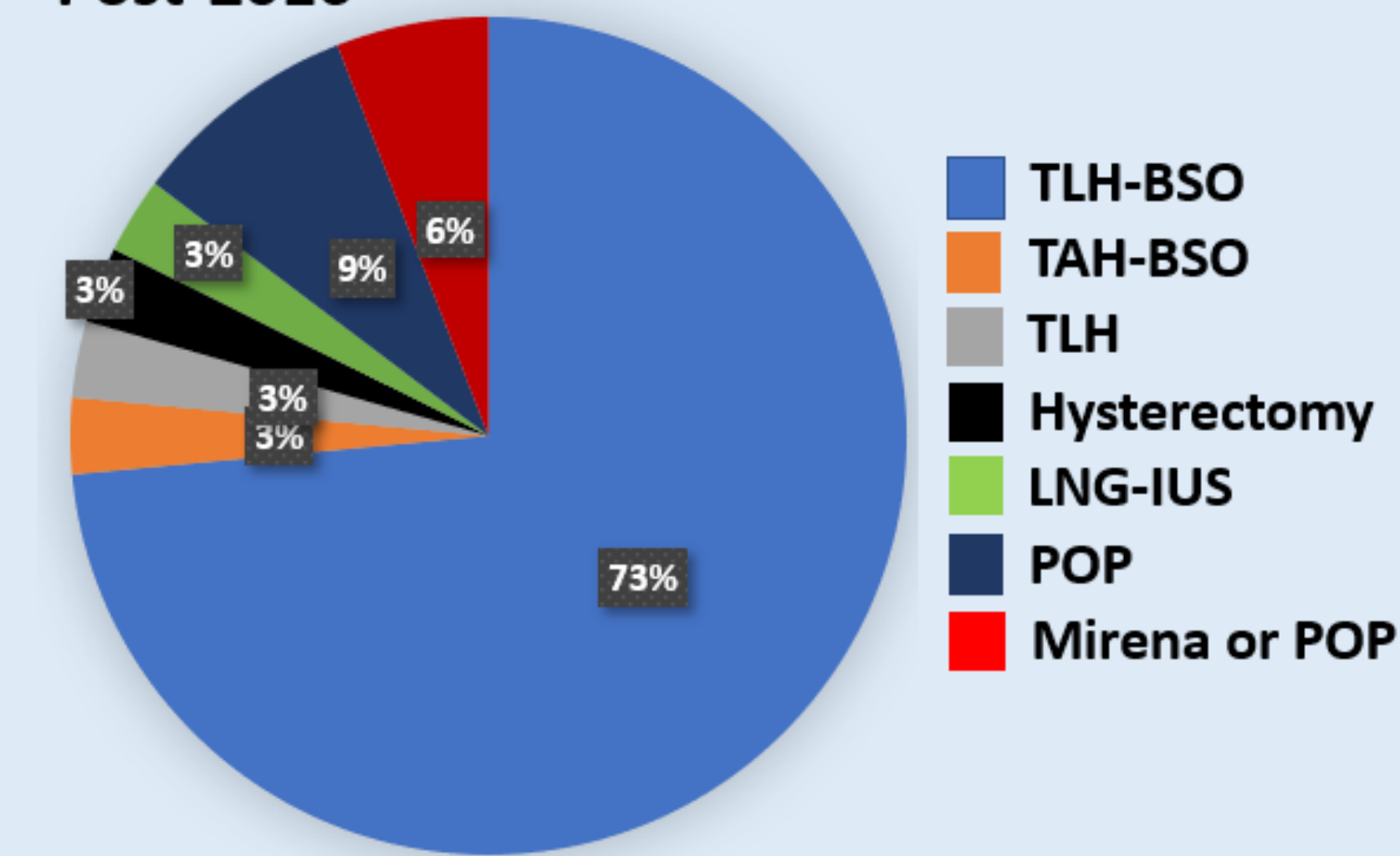


Figure 3. Pie-chart displaying the final management of women with atypical EH before and after introduction of the RCOG guideline. TAH= total abdominal hysterectomy; LAVH= laparoscopy assisted vaginal hysterectomy

- All women who initially declined hysterectomy, usually because they were attempting to conceive, were treated with progestogens and received at least 1 negative biopsy before attempting conception.
- Of the 11 women diagnosed pre-2016 who initially declined a hysterectomy, 4 returned for hysterectomy, 3 returned for follow-up biopsies which are ongoing, and 4 did not return for follow-up.
- Of the 9 women diagnosed post-2016 who initially declined a hysterectomy, 7 were attempting fertility. Of these, 3 returned for hysterectomy and 4 are still being followed up. 2 other women declining hysterectomy had received 3 or more consecutive negative biopsies at the time of data collection.

Conclusion

- The proportion of women diagnosed with EH without atypia being managed with LNG-IUS at ICHT has increased since the introduction of the guideline in 2016, and endometrial surveillance with regular biopsies has increased
- Further documentation of reasons for refusal of LNG-IUS may help address patient concerns and increase uptake further in the future
- The proportion with atypical EH receiving hysterectomies has remained high at 82%. Signposting from fertility services back to gynaecology follow-up may help to further increase the proportion of women who are attempting conception to eventually undergo hysterectomy.

References

- Royal College of Obstetricians and Gynaecologists. Management of Endometrial Hyperplasia (Green-Top Guideline No.67). February 2016. Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/green-top-guidelines/gtg_67_endometrial_hyperplasia.pdf
- Trimble C, Kauderer J, Zaino R. Concurrent endometrial carcinoma in women with a biopsy diagnosis of atypical endometrial hyperplasia: a Gynecologic Oncology Group study. Cancer 2006; 106 (4): 812–819

Declaration of interests

No competing interests. For more information, please email rjg17@ic.ac.uk