Endometrial Hyperplasia
Clinical Guideline

V1.0

February 2024
Summary - endometrial hyperplasia without atypia pathway.

Diagnosis of hyperplasia without atypia obtained via pipelle biopsy.

Endometrial sampling during hysteroscopy +/- polypectomy +/- Mirena IUS.

Internal referral to Endometrial Hyperplasia Clinic. Referrals triaged by clinic lead for phone or face to face appointment. Standard letter and patient information leaflet sent to patient.

Phone appointment.
History recorded on clinical database.
Counselling and management plan.
+/- EPMA outpatient prescription.
Letter to GP and patient.

Face to face consultation for:
- Mirena coil.
- Hysteroscopy.
- Patient preference.
History/ examination/ procedure recorded on clinical database.
+/- EPMA outpatient prescription.
Letter to GP and patient.

Face to face follow up at 6 and 12 months for pipelle biopsy.

2 consecutive biopsies negative and no additional risk factors.

2 consecutive biopsies negative but additional risk factors (BMI >35, or oral progesterone, PCOS, tamoxifen).

If treatment fails (persistence of hyperplasia after 1 year or persistent bleeding or hyperplasia reoccurs), consider hysterectomy.

Discharge to GP.
Consider yearly follow up with biopsy.

2 consecutive biopsies negative and no additional risk factors.

Continuous progestogens (medroxyprogesterone 10-20mg/ day or norethisterone 10-15mg/ day should be used for women declining LNG-IUS for a minimum of 6 months.

Summary: atypical endometrial hyperplasia pathway.

1. Diagnosis of hyperplasia with atypia established.
2. See in Gynaecology Oncology Clinic by Gynaecology Oncology Consultant.
3. Planned for hysterectomy.
4. NOT suitable for hysterectomy.
   - First choice Mirena coil.
   - Oral progestogens.
   - +/- anastrazol.
5. Follow up via Gynaecology Oncology Clinic at 3 months with TVUS and pipelle biopsy +/- hysteroscopy.
6. Persistent hyperplasia.
7. Further Management by Gynaecology Oncology Consultant.
   - 3 months follow up with TVUS results for pipelle biopsy in the Hyperplasia Clinic.
   - 2 negative consecutive samples.
   - Follow up every 6 to 12 months with TVUS and pipelle biopsy in the Hyperplasia Clinic.
9. Local gynae-oncology MDT discussion if review of histology necessary or management questions such as discharge from follow up via rch-tr.ref12cancerservices@nhs.net.
1. **Aim/Purpose of this Guideline**

This guideline applies to all patients diagnosed with endometrial hyperplasia, and the staff involved in their healthcare. The provision of a dedicated clinic for patients with endometrial hyperplasia ensures that all patients are seen swiftly after diagnosis, achieving equality of access for all, regardless of the route of referral. Ensuring that patients are seen by clinicians with an appropriate skill set means that consultations are responsive to patients’ concerns and needs. The one-stop model reduces fragmentation of care and delay, whilst promoting efficiency and protecting scare healthcare resource.

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**Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.**

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust  rch-tr.infogov@nhs.net

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2. **The Guidance**

**Endometrial hyperplasia without atypia**

2.1. Patients who are diagnosed with endometrial hyperplasia without atypia have a risk of progression into endometrial cancer of less than 5% over 20 years. Endometrial hyperplasia is often associated with multiple identifiable risk factors and assessment should aim to identify and monitor these factors.

2.2. Patients with endometrial hyperplasia without atypia can be referred to the specialized clinic after diagnosis has been made histologically (either after pipelle biopsy in an outpatient setting or by hysteroscopy and endometrial sampling). The referrals will be on a non-urgent basis.

2.3. Before booking the appointment, the referrals will be reviewed and triaged for:

2.3.1. Counselling only (phone or face to face depending on patient preference, information leaflets will be provided).

2.3.2. Counselling +/- insertion of LNG-IUS (levonorgestrol intrauterine system).

2.3.3. Counselling and hysteroscopy (especially if ? endometrial polyp or discrete lesion) +/- insertion of LNG-IUS.
2.4. The endometrial hyperplasia leaflet will be sent out with the booking appointment letter.

2.5. The clinic is scheduled fortnightly and consists of 30 minutes for triage/admin, and approximately 6 slots depending on complexity of patients.

2.6. The clinician will take a detailed history using the endometrial hyperplasia clinic proforma and will record findings on the database. Reversible risk factors should be identified and addressed if possible. Women on HRT should have the indication and preparation reviewed as this may be an opportunity to influence the likelihood of spontaneous regression.

2.7. A management plan is discussed and agreed with the patient and documented on the proforma.

2.8. The insertion of an LNG-IUS can be offered in the same appointment. If the patient declines IUS and opts for oral progestogens, these will be prescribed as EPMA outpatient prescription in the first instance and continued by the GP.

2.9. Treatment with oral progestogens or the LNG-IUS should be for a minimum of 6 months in order to induce histological regression. If adverse effects are tolerable and fertility is not desired, women should be encouraged to retain the LNG-IUS for up to 5 years as this reduces the risk of relapse.

2.10. Progestogen treatment is indicated in women with endometrial hyperplasia without atypia who fail to regress following observation alone for 12 months.

2.11. Red flag symptoms will be discussed, and the patient will receive information about point of contact.

2.12. The follow up appointments for patients with endometrial hyperplasia without atypia will be scheduled in 6 monthly intervals (unless earlier review indicated) with a minimum of 2 consecutive biopsies. Prior to the follow up a TVUS (trans vaginal ultrasound) for ET (endometrial thickness) will be arranged. The follow up appointments will be face to face appointments to review symptoms and to achieve an outpatient endometrial biopsy.

2.13. If there are concerns about the reliability of endometrial sampling via Pipelle or if a focal lesion is noticed on scan, a hysteroscopy can be offered (depending on capacity either in the endometrial hyperplasia clinic or via the PMB (post-menopausal bleeding) hysteroscopy clinic).

2.14. The biopsy results will be sent out to patient and GP using a letter template.

2.15. Checking investigation results and informing patients/referrers about results and ongoing management plans is the responsibility of individual clinicians. The results will not be checked by the administration team.

2.16. If 2 consecutive endometrial samples show a regression of the hyperplasia, the patient can be discharged if there are no further risk factors.

2.17. If risk factors are identified such as hyperplasia with atypia, BMI>35, PCOS, treatment with tamoxifen, on oral progestogens, a long-term plan needs to be agreed with the patient depending on the risks and patients’ preferences. The
decision for ongoing follow up will be at the discretion of the responsible consultant.

2.18. In case of persistent bleeding despite treatment, the hormone dose can be adjusted depending on additional risk factors.

2.19. Hysterectomy should not be considered as a first line treatment for hyperplasia without atypia.

Indications for hysterectomy:

- Progression to atypical hyperplasia.
- No histological regression after 12 months of treatment.
- Relapse.
- Persistence of bleeding despite reversal.
- Women who decline endometrial surveillance and/or medical treatment.

Atypical endometrial hyperplasia

2.20. Patients who are diagnosed with atypical endometrial hyperplasia have a risk of progression into endometrial cancer of 30%. Endometrial hyperplasia is often associated with multiple identifiable risk factors and assessment should aim to identify and monitor these factors.

2.21. Patients with atypical hyperplasia can be referred to the hyperplasia clinic by the GO consultant for conservative management if hyperplasia has resolved on the follow up biopsy. The patient will be referred with a management plan agreed by the GO consultant and a referral for TVUS before the follow up clinic appointment will be booked.

2.22. The follow up appointments are scheduled 3 monthly until 2 negative biopsy results are obtained, then the follow up appointment can be scheduled every 6 months.

2.23. Management issues such as discharge from follow up or review of histology results can be discussed in the local gynae-oncology meeting via referral to rch-tr.ref12cancerservices@nhs.net.

Please see Appendix 3 for an Introductory clinic letter to be sent to the patient with the clinic appointment, and Appendix 4 for a letter following appointment with negative histology.
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Information Category</th>
<th>Detail of process and methodology for monitoring compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Element to be monitored</td>
<td>Numbers of referrals will be monitored monthly to ensure that clinic provision meets demand to allow patients to be assessed in a timely fashion. Clinic processes in terms of investigations undertaken and likely diagnosis will be monitored through the clinic database. Biopsy samples will be monitored for results and sufficiency.</td>
</tr>
<tr>
<td>Lead</td>
<td>Miss K. Fiedler, Consultant Obstetrics and Gynaecology.</td>
</tr>
<tr>
<td>Tool</td>
<td>Process and outcome data will be recorded for every patient on the clinic proforma/database.</td>
</tr>
<tr>
<td>Frequency</td>
<td>For each patient.</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Obstetrics and Gynaecology Specialty meetings</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Miss K. Fiedler, Consultant Obstetrics and Gynaecology.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within 3 months, immediately if required. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant staff/stakeholders.</td>
</tr>
</tbody>
</table>

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity And Inclusion Policy](#) or the [Equality and Diversity website](#).

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Information Category</th>
<th>Detailed Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Title:</td>
<td>Endometrial Hyperplasia Clinical Guideline V1.0</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>New Document</td>
</tr>
<tr>
<td>Date Issued/Approved:</td>
<td>February 2024</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>February 2024</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>February 2024</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Miss K. Fiedler, Consultant Obstetrics and Gynaecology.</td>
</tr>
<tr>
<td>Contact details:</td>
<td>Secretary: 01872 253162</td>
</tr>
</tbody>
</table>

**Brief summary of contents:**

This guideline applies to all patients diagnosed with endometrial hyperplasia, and the staff involved in their healthcare. The provision of a dedicated clinic for patients with endometrial hyperplasia ensures that all patients are seen swiftly after diagnosis, achieving equality of access for all, regardless of the route of referral. Ensuring that patients are seen by clinicians with an appropriate skill set means that consultations are responsive to patients’ concerns and needs. The one-stop model reduces fragmentation of care and delay, whilst promoting efficiency and protecting scarce healthcare resource.

**Suggested Keywords:**

Endometrial hyperplasia.
PMB.
Post Menopausal Bleeding.

**Target Audience:**

<table>
<thead>
<tr>
<th>RCHT:</th>
<th>Yes</th>
</tr>
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<tr>
<td>CFT:</td>
<td>No</td>
</tr>
<tr>
<td>CIOS ICB:</td>
<td>No</td>
</tr>
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</table>

**Executive Director responsible for Policy:**

Chief Medical Officer

**Approval route for consultation and ratification:**

Gynaecology Specialty Meeting

**General Manager confirming approval processes:**

Caroline Chappell
Information Category | Detailed Information
--- | ---
Name of Governance Lead confirming approval by specialty and care group management meetings: | Tamara Thirlby
Links to key external standards: | Reference Green-top guideline No. 67 Management of Endometrial Hyperplasia February 2016
Related Documents: | None required
Training Need Identified? | No
Publication Location (refer to Policy on Policies – Approvals and Ratification): | Internet and Intranet
Document Library Folder/Sub Folder: | Clinical / Gynaecology

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version Number</th>
<th>Summary of Changes</th>
<th>Changes Made by</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2022</td>
<td>V1.0</td>
<td>Initial issue.</td>
<td>Miss K. Fiedler, Consultant Obstetrics and Gynaecology.</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

<table>
<thead>
<tr>
<th>Information Category</th>
<th>Detailed Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of the strategy / policy / proposal / service function to be assessed:</td>
<td>Endometrial Hyperplasia Clinical Guideline V1.0</td>
</tr>
<tr>
<td>Directorate and service area:</td>
<td>Gynaecology</td>
</tr>
<tr>
<td>Is this a new or existing Policy?</td>
<td>New</td>
</tr>
<tr>
<td>Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):</td>
<td>Miss K. Fiedler, Consultant Obstetrics and Gynaecology.</td>
</tr>
<tr>
<td>Contact details:</td>
<td>Secretary: 01872 253162</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information Category</th>
<th>Detailed Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)</td>
<td>The provision of a dedicated clinic for patients with endometrial hyperplasia ensures that all patients are seen swiftly after diagnosis, achieving equality of access for all, regardless of the route of referral. Ensuring that patients are seen by clinicians with an appropriate skill set means that consultations are responsive to patients’ concerns and needs. The one-stop model reduces fragmentation of care and delay, whilst promoting efficiency and protecting scarce healthcare resource.</td>
</tr>
<tr>
<td>2. Policy Objectives</td>
<td>As above.</td>
</tr>
<tr>
<td>3. Policy Intended Outcomes</td>
<td>As above.</td>
</tr>
<tr>
<td>4. How will you measure each outcome?</td>
<td>As per section 3- ‘Monitoring compliance and effectiveness’.</td>
</tr>
<tr>
<td>5. Who is intended to benefit from the policy?</td>
<td>Patients.</td>
</tr>
</tbody>
</table>
### Information Category: Detailed Information

**6a. Who did you consult with?**

(Please select Yes or No for each category)

- Workforce: Yes
- Patients/visitors: No
- Local groups/system partners: No
- External organisations: No
- Other: No

**6b. Please list the individuals/groups who have been consulted about this policy.**

Please record specific names of individuals/groups:

- Gynaecology Specialty meeting.

**6c. What was the outcome of the consultation?**

Guideline approved.

**6d. Have you used any of the following to assist your assessment?**

National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys: No.

### 7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>(Yes or No)</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong> (male or female)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Gender reassignment</strong> (Transgender, non-binary, gender fluid etc.)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>No</td>
<td>Any information provided should be in an accessible format for the parent/carer/patient's needs - i.e., available in different languages if required/access to an interpreter if required</td>
</tr>
<tr>
<td>Protected Characteristic</td>
<td>(Yes or No)</td>
<td>Rationale</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)</td>
<td>No</td>
<td>Those parent/ carer/ patients with any identified additional needs will be referred for additional support as appropriate- i.e., to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family’s needs e.g., easy read, audio etc.</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>No</td>
<td>All staff should be aware of any beliefs that may impact on the decision to treat and should respond accordingly.</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>No</td>
<td>All staff should be aware of any marital arrangements that may have an impact on care (for example: separated parents, domestic abuse).</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)</td>
<td>No</td>
<td></td>
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</tbody>
</table>

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Kristin Fiedler, Obstetrics and Gynaecology Consultant.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here: [Section 2. Full Equality Analysis](#)
Appendix 3. Introductory clinic letter to be sent to the patient with the clinic appointment

Dear patient,

You have been referred to us because you were diagnosed with endometrial hyperplasia without atypia which is a thickening of the lining of the womb. The lining of the womb is called the endometrium. In a small number of cases if the condition is not treated, it can eventually lead to cancer of the lining of the womb, known as endometrial cancer. Because of this we recommend regular review and checkups.

Please find enclosed an information leaflet about the diagnosis and common treatments. We are inviting you to attend an appointment in our Endometrial Hyperplasia Clinic to discuss and/or initiate further management. This can be a face to face or a telephone appointment depending on your clinical needs and preference.

If you have any questions, please contact the secretaries under 01872 253162.
Appendix 4. Letter following appointment with negative histology

Dear patient,

You will be pleased to know that the biopsy we have taken from the endometrium (inner lining of the womb) during your recent visit to the Hyperplasia Clinic did not show any abnormalities. This is indeed very reassuring.

As discussed in clinic, you will be invited for a transvaginal (internal) ultrasound scan and another biopsy in the Hyperplasia Clinic in about 6 months’ time and will send you an appointment letter closer to the time.

If you have any questions or concerns, please contact us through the secretaries on 01872253162.
Appendix 7. Endometrial hyperplasia patient information leaflet