Royal College of Obstetricians & Gynaecologists

Information for you

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Endometrial hyperplasia

About this information

This information is for you if you have been told you have endometrial hyperplasia, or may be at risk of developing this.

This information may also be helpful if you are a partner, relative or friend of someone who may have endometrial hyperplasia.

The information here aims to help you better understand your health and your options for treatment and care. Your healthcare team is there to support you in making decisions that are right for you. They can help by discussing your situation with you and answering your questions.

Key points

- Endometrial hyperplasia happens when there is overgrowth of the lining of the uterus (endometrium).
- Some women with endometrial hyperplasia may experience heavy or unexpected vaginal bleeding, including bleeding after the menopause. Some women will not have any symptoms.

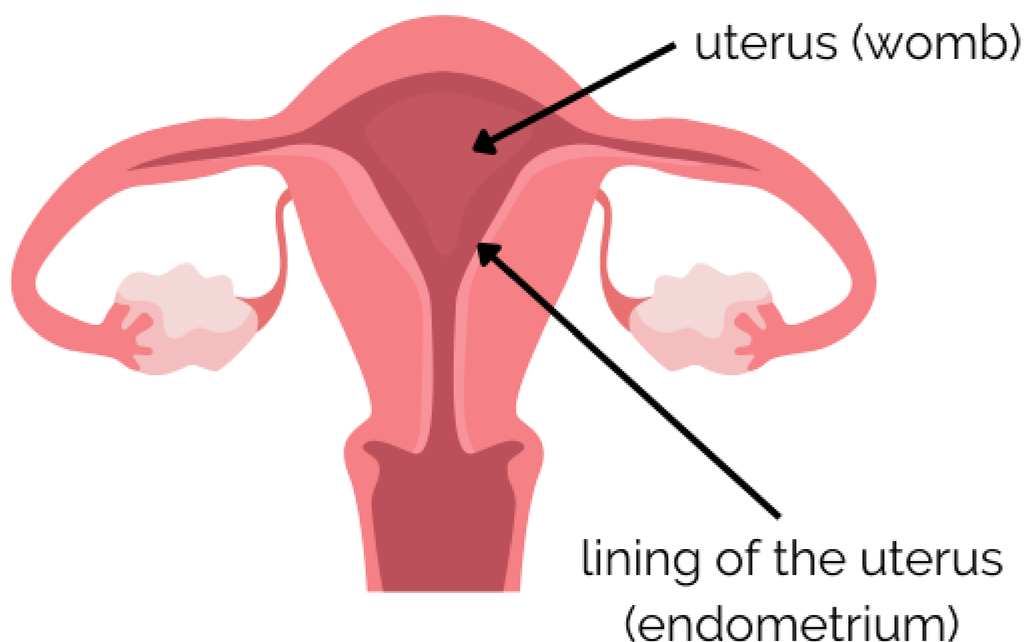
- It is often suspected from an ultrasound scan, but you will need an endometrial biopsy (a sample of endometrium) to confirm the diagnosis.
- In many cases, endometrial hyperplasia goes away with time, even without treatment. In some cases, endometrial hyperplasia can progress into cancer of the uterus.
- If endometrial hyperplasia is found, you will usually be offered treatment with the hormone progesterone to lower the risk of progression to cancer. You will also be offered follow-up with a repeat biopsy every few months.
- If there is a high risk of cancer, the option of a hysterectomy (an operation to remove the uterus) will be discussed with you.

Within this information we may use the terms 'woman' and 'women'. However, we know that it is not only people who identify as women who may want to access this information. Your care should be appropriate, inclusive and sensitive to your needs whatever your gender identity.

A glossary of all medical terms is available on the RCOG website at: rcog.org.uk/for-the-public/a-z-of-medical-terms/.

What is endometrial hyperplasia?

Endometrial hyperplasia happens when the lining of the uterus (endometrium) grows too thick or in a less ordered way than expected.



Endometrial hyperplasia can lead to cancer of the uterus over time. Follow-up and/or treatment is recommended to prevent cancer or pick it up early.

What are the symptoms of endometrial hyperplasia?

The most common symptom is abnormal vaginal bleeding.

Some women have:

- heavy bleeding or long periods
- bleeding between their periods, or
- unexpected bleeding after the menopause

Some women have no symptoms at all, and it is suspected when they have a scan for other reasons.

If you are worried you may have endometrial hyperplasia, you should speak to your healthcare professional. Depending on your symptoms, your GP may arrange for you to have further tests, or may refer you directly to a gynaecologist.

Why does endometrial hyperplasia happen?

You are more likely to develop endometrial hyperplasia if you:

- are overweight (have a BMI above 25) or obese (have a BMI above 30)
- are not ovulating regularly, which may happen when you have polycystic ovary syndrome (PCOS), or are approaching the menopause
- take medication that can stimulate growth of the lining of the uterus, for example tamoxifen, (often used as part of treatment for breast cancer) or estrogen therapy without adequate protection by progesterone.

You can lower your risk of developing endometrial hyperplasia, or it progressing, by keeping your weight within a healthy range.

What are the different types of endometrial hyperplasia?

Endometrial hyperplasia has two types:

- Hyperplasia without atypia: this usually goes away, but it does have a small risk of progressing to cancer over many years. Less than 5 in 100 women with endometrial hyperplasia without atypia will develop endometrial cancer over 20 years. If it gets better, you will usually be discharged from follow-up after a period of monitoring.
- Hyperplasia with atypia: this has a higher risk of progressing into cancer. The risk is thought to be 28 out of every 100 women within 20 years. There is also a risk of cancer being already present that was not found in the biopsy.

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Does endometrial hyperplasia have a risk of cancer?

Endometrial hyperplasia can be precancerous. **However:**

Endometrial hyperplasia **without atypia** usually settles on its own in eight in ten women.

Less than 5 in 100 women who have endometrial hyperplasia **without atypia** will develop endometrial cancer **within 20 years**

28 in 100 women who have endometrial hyperplasia **with atypia** will develop endometrial cancer **within 20 years**

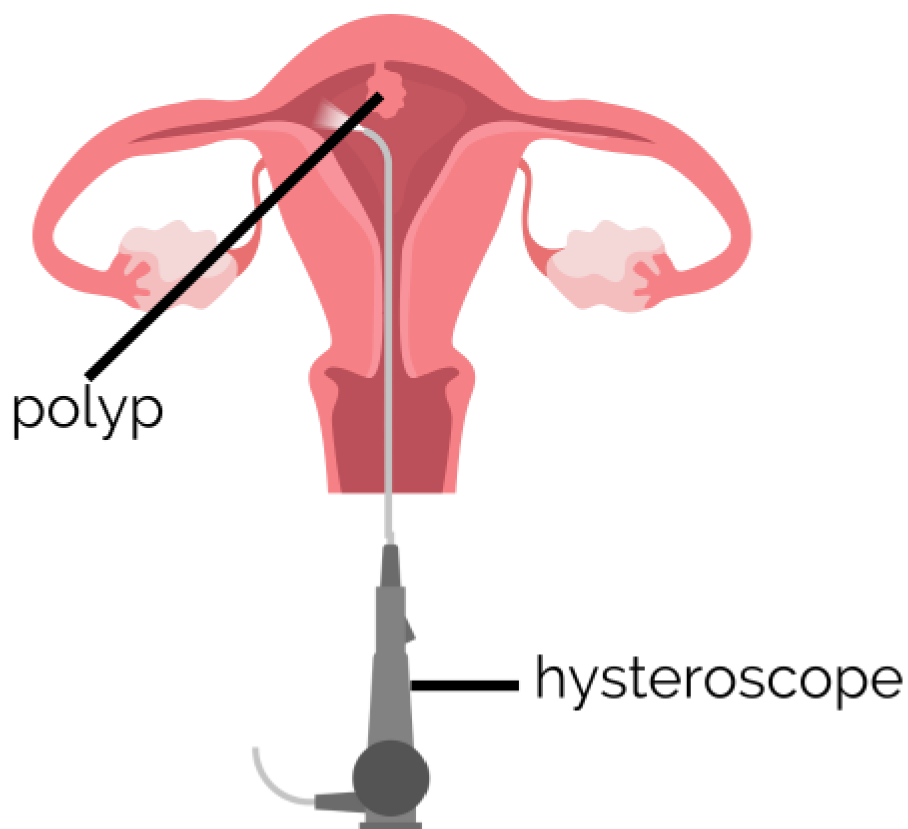
There is also a risk of cancer already being present that was not found in the biopsy.

How is suspected endometrial hyperplasia investigated?

Transvaginal (internal) ultrasound scan:
This will show if the endometrium is thickened, contains polyps, or shows changes in its blood supply. If your endometrium is thicker than expected, your healthcare professional will recommend a biopsy (or removal of polyps).

Endometrial biopsy:
A biopsy is usually taken in an outpatient clinic. This is done by using a speculum and passing a very thin tube through the cervix to remove a small sample from the endometrium.

A biopsy can also be taken during a hysteroscopy. This is when a narrow telescope is passed into your uterus through your vagina and cervix. Biopsies can be taken of areas that look thickened, and polyps can be removed.



For some women, a speculum examination, biopsy or hysteroscopy causes mild pain, but others find these procedures more painful. Your healthcare professional will discuss your options for pain relief. This can include pain relief medications or injections given in clinic, sedation, or an anaesthetic, either regional or general.

A specialist then looks at the biopsy under a microscope to make the diagnosis.

Sometimes, the first biopsy is not enough to give a diagnosis. This is often reassuring, but if your scan or symptoms suggest that hyperplasia is likely, then your healthcare professional may discuss doing the biopsy again.

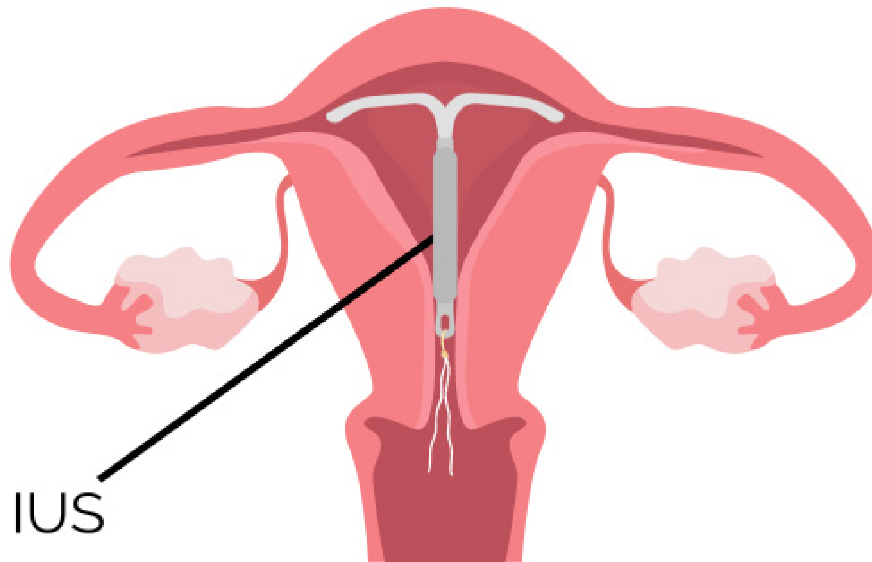
How is endometrial hyperplasia without atypia treated and monitored?

Endometrial hyperplasia without atypia will go away over time without treatment in 7-8 out of every 10 women. Treatment with the hormone progesterone has been shown to make it more likely that endometrial hyperplasia will go away, in 9 out of every 10 women.

If you have troublesome bleeding as a symptom, treatment with progesterone may also make this bleeding better.

Progesterone can be given by tablet, such as norethisterone or medroxyprogesterone. It is usually suggested that you take tablets for six months.

It can also be given using an IUS (such as the Mirena®) which is placed inside the uterus.
The IUS is more likely to make the hyperplasia go away, may have fewer side effects and can offer ongoing treatment for 5 years.



If you are overweight, your healthcare professional can support you to lose weight. This can increase the chance of the hyperplasia going away.

You will usually be recommended to have another biopsy 6 months after diagnosis of endometrial hyperplasia without atypia, and again 6 months after that. Some women may not need any further biopsies.

If you have a BMI of more than 35, or if your treatment was with progesterone tablets, you may have a higher risk of the endometrial hyperplasia coming back. You will usually be offered biopsies every year.

If your symptoms come back after you have been discharged from follow-up for endometrial hyperplasia, you should tell your GP.

How is endometrial hyperplasia with atypia treated and monitored?

If you have completed your family, you will usually be advised to have a hysterectomy (see below). If you have a hysterectomy, you will no longer be able to get pregnant.

If you are unable or do not want to have a hysterectomy, your healthcare professional will recommend treatment with progesterone tablets or the IUS.

Although the progesterone treatment may lower your risk of endometrial cancer, it may not prevent it. You will be offered regular biopsies, usually every three months, so that any progression to cancer can be picked up sooner.

Why might I be recommended to have a hysterectomy?

You may wish to consider a hysterectomy with or without removal of your ovaries, if:

- the hyperplasia without atypia does not go away, or comes back, or
- your bleeding problems continue.

If you have endometrial hyperplasia with atypia, and have completed your family, this will usually be the recommended treatment.

This can often be done as a laparoscopic (keyhole) procedure.

Your healthcare professional will discuss your individual options and any risks or benefits. You are able to decline treatment or change your mind at any time.

If you have decided to have a hysterectomy, you may be advised to have your ovaries removed at the same time. Your gynaecologist will discuss the risks and benefits of this with you.

How is endometrial hyperplasia treated if I want to get pregnant?

You will be advised not to get pregnant until a biopsy has confirmed that the hyperplasia has gone away.

If you are taking progesterone to treat endometrial hyperplasia, your fertility will return once you stop treatment.

You should be offered the opportunity to discuss fertility treatment with a specialist, which may support you to get pregnant sooner.

Can I take Hormone Replacement Therapy (HRT)?

It is not fully known how taking HRT affects endometrial hyperplasia. If you are on HRT and have a diagnosis of endometrial hyperplasia, you should discuss this with your gynaecologist.

You may be advised to stop taking the HRT to see if the hyperplasia goes away. If you wish to continue using HRT, it may be beneficial to take progesterone throughout the month (if you are not doing so already), or to use the IUS.

What should I do if I am taking tamoxifen?

If you are on tamoxifen because you have had breast cancer, your healthcare professional may suggest seeking advice from the doctor who treated your breast cancer (your oncologist). This is so they can discuss, and explain the potential risks and benefits, of stopping or continuing tamoxifen with you.

Emotional support

Being told that you may have endometrial hyperplasia can be stressful. If you are feeling anxious or worried in any way, please speak to your healthcare team who can answer your questions and help you get support. The support may come from healthcare professionals, voluntary organisations or other services. Further information and resources are available on the NHS website:
nhs.uk/conditions/stress-anxiety-depression/

Further information

RCOG Patient information:

Treatment for the symptoms of the menopause

Outpatient hysteroscopy

Laparoscopic hysterectomy

Making a choice

Making a choice

Ask 3 Questions

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.

1. What are my options?
2. How do I get support to help me make a decision that is right for me?
3. What are the pros and cons of each option for me?

*Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011;84: 379-85

http://aqua.nhs.uk/resources/shared-decision-making-case-studie

Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the RCOG guideline Management of Endometrial hyperplasia (Green Top No.67) Published February 2016. The guideline contains a full list of the sources of evidence we have used. You can find it online at: rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/management-of-endometrial-hyperplasia-green-top-guideline-no-67/.