CLINICAL ASPECTS OF ENDOMETRIAL HYPERPLASIA IN CONTEMPORARY GYNECOLOGICAL PRACTICE

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1 RELEVANCE

Endometrial hyperplasia (EH) is a common gynecological condition and one of the main causes of abnormal uterine bleeding across different age groups.

EH is clinically significant due to its potential for progression to endometrial carcinoma, particularly in cases with atypia.

The risk of EH is associated with chronic anovulation (including PCOS), obesity, metabolic syndrome, diabetes mellitus, hypertension and prolonged exposure to unopposed estrogen.

Timely identification and appropriate management of EH are essential to prevent malignant transformation, preserve reproductive potential and improve quality of life.

2 AIM

To analyze current evidence-based approaches to the clinical assessment, management and follow-up of endometrial hyperplasia in contemporary gynecological practice, with an emphasis on individualized treatment strategies and risk-based clinical decision-making in accordance with current national and international guidelines.

CLINICAL ASPECTS OF ENDOMETRIAL HYPERPLASIA

Etiology and risk factors

- Unopposed estrogen exposure
- Chronic anovulation (PCOS)
- Obesity and metabolic syndrome
- Diabetes mellitus
- Hypertension
- Late menopause
- Exogenous estrogen use
- Other endocrine and lifestyle factors



Clinical presentation

- Abnormal uterine bleeding (pattern, duration, severity)
- Menstrual irregularities
- Infertility (in reproductive-aged women)
- Often asymptomatic (in postmenopausal women)

Histopathological classification



Hyperplasia without atypia | Atypical hyperplasia / EIN | Endometrial carcinoma

Clinical significance

- Risk of progression to endometrial carcinoma, especially in cases with atypia
- Influence on reproductive health and quality of life
- Need for individualized management based on symptoms, histology and fertility plans

3 MANAGEMENT ALCORITHM ACCORDING TO CURRENT GUIDELINES

Endometrial hyperplasia (suspected or confirmed)

Hyperplasia without atypia

- **Progestin therapy** (LNG-IUS or oral progestins)
- Consider risk factor modification (weight reduction, control of metabolic disorders, management of PCOS, etc.)

Follow-up with endometrial sampling (usually at 3–6 months according to guidelines)

If regression → continue management and follow-up
If persistence/recurrence → reassess and consider alternative treatment

Atypical hyperplasia / EIN

- Women who wish to preserve fertility
  - High-dose progestin therapy with close follow-up (every 3–6 months)
  - If no response → consider definitive treatment
- Women who have completed childbearing
  - **Hysterectomy** (recommended treatment)
  - Consider evaluation for concurrent endometrial carcinoma

4 DISCUSSION

Individualized patient-centered approach

- Management should consider age, symptoms, histology, risk factors and fertility goals.
- Different strategies are required for reproductive-aged, perimenopausal and postmenopausal women.
- Shared decision-making is essential, especially in women with atypia who wish to preserve fertility.

Medical management

- Progestin therapy is the first-line treatment for hyperplasia without atypia.
- The levonorgestrel-releasing intrauterine system (LNG-IUS) is effective and can be considered as first-line therapy.
- Oral progestins are an alternative when LNG-IUS is not suitable.
- Treatment response should be monitored by repeated endometrial sampling according to guideline recommendations.

Surgical management

- Hysterectomy is recommended for atypical hyperplasia/EIN in women who have completed childbearing.
- Surgical management should be considered when conservative treatment is ineffective, not feasible or not desired.

Special clinical situations

- In reproductive-aged women, conservative management with close follow-up may be considered in selected cases.
- In postmenopausal women, a higher risk of concurrent carcinoma requires careful evaluation and appropriate management.
- Management of EH should also include control of modifiable risk factors (e.g. weight reduction, treatment of metabolic and endocrine disorders).

Follow-up

- Regular follow-up with clinical assessment and endometrial sampling is recommended.
- The duration and interval of follow-up depend on histology, treatment response and individual risk factors.
- Persistent or recurrent hyperplasia requires reassessment and consideration of alternative treatment options.

5 CONCLUSIONS

Endometrial hyperplasia is a clinically important condition that requires a comprehensive, individualized approach in modern gynecological practice.

Effective management is based on current evidence and guideline recommendations, with consideration of histology, symptoms, fertility goals and individual risk factors.

Progestin therapy is effective for hyperplasia without atypia, while hysterectomy is recommended for atypical hyperplasia/EIN in women who have completed childbearing.

Timely diagnosis, appropriate treatment and structured follow-up can reduce the risk of progression to endometrial carcinoma and improve long-term outcomes.