ENDOMETRIAL ATYPICAL HYPERPLASIA

HORMONE TREATMENT USING A PROGESTOGEN IUD

the women's
the royal women's hospital
victoria australia

This fact sheet is for women who have been told that the lining of their uterus (endometrium) has become thicker and contains abnormal cells – a condition known as Endometrial Atypical Hyperplasia (EAH). It will explain what an intrauterine device (IUD) is, and the benefits and problems of using a progestogen IUD to treat this condition.

Throughout this fact sheet we will refer to Endometrial Atypical Hyperplasia as EAH.

EAH is not cancer, but over time it may become cancer. If you have EAH, your doctor will usually recommend that you have an operation to remove your endometrium, uterus and cervix (known as a **total hysterectomy**), fallopian tubes (**salpingectomy**) and ovaries (**oophorectomy**).

This is the standard treatment because between 25 to 30 per cent (or one in three to four) women with EAH will already have early endometrial cancer – it just won't have been detected yet.

Using a progestagen intrauterine device (IUD) to treat EAH is unusual but it may be an option if:

- you strongly don't want a hysterectomy (or want to delay it) so you can have (more) children
- you have other health problems (like obesity) or diseases (particularly of the heart) which would make surgery unsafe for you.

Using a progestogen IUD to treat EAH will not be possible if:

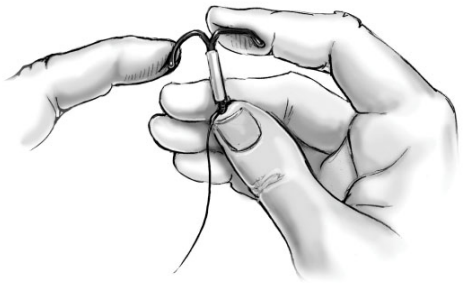
- you already have endometrial cancer and it has invaded the wall of your uterus, into the cervix or moved beyond your uterus.

What is a progestogen IUD and how does it work?

An IUD is a small, usually plastic device that sits inside your uterus and changes the environment in a way that prevents pregnancy.

A progestogen IUD releases a small amount of a synthetic female hormone inside your uterus. This kind of IUD is often used to treat heavy periods, menstrual bleeding and prevent pregnancy.

Progestogen IUDs can also help to thin the lining of the uterus (or endometrium), which is why they may be useful in treating EAH in certain situations.



How is an IUD put in place?

The IUD will be put into your uterus through your vagina. At the Women's, this can be done in an outpatient or day clinic where you will be given an injection of local anaesthetic to numb the area around your cervix. It can also be done in the operating theatre where you will be given an injection of anaesthetic to put you to sleep.

Most women will not feel the IUD when it is in place. Some women may feel the strings of the IUD within their vagina. Your partner should not be able to feel it during sex.

What happens after it is in place?

You will need to have a check-up every 6 to 12 months. Regular check-ups are essential to make sure the EAH has not developed into endometrial cancer.

At each check-up, your doctor will examine and take samples of your endometrium using a fine tube in the clinic called a pipelle or with the aid of a fine camera (a procedure known as a **hysteroscopy**) in the day centre or sometimes under general anaesthetic in the operating theatre.

What are the possible problems of using a progestogen IUD?

Risk	How often does it happen?
Headache	Very common – Around 1 in 10 patients
Pain in your abdomen or pelvis	Very common – Around 1 in 10 patients
Bleeding changes (including greater/lesser period bleeds and/or spotting) which may last for three to six months	Very common – Around 1 in 10 patients
Depressed mood, nervousness, lower sex drive	Common – Between 1 and 10 in 100 patients
Cysts on your ovaries that may cause pain and need to be removed in an operation	Common – Between 1 and 10 in 100 patients
Painful breasts and nipples	Common – Between 1 and 10 in 100 patients
Pimples, increase in body hair and weight gain	Common – Between 1 and 10 in 100 patients
Swollen limbs	Uncommon – Between 1 and 10 in 1000 patients
Hives or rashes	Rare – Between 1 and 10 in 10,000 patients
IUD pushing through your uterus and needing to be removed in an operation	Rare – Between 1 and 10 in 10,000 patients

Your IUD may also slip out of place. If it does, you will need to see your doctor to put it back in place or try another treatment.

These are the side effects of using an IUD for contraception or for heavy menstrual bleeding. It is not known whether using an IUD to treat EAH has the same or different side effects.

You may have some or all of these side effects – or you may have none of them. The side effects may be minor, moderate or major problems for you. They can last for different amounts of time and can sometimes be permanent.

There are also some risks with having a general anaesthetic. Your doctor can explain the risks to you.

How successful is using an IUD?

The IUD may not cure EAH – it may only slow or stop its growth. The safety and success of this treatment in the short term is high but the long-term safety is not yet really known because doctors have only started using IUDs to treat EAH in the last 10 years.

At the Women's, we have used a progestogen IUD to treat EAH in more than 100 women.

Of the women who had not had menopause:

- four in five had an endometrium which became less abnormal or returned to normal
- none had EAH which developed into endometrial cancer.

Of the women who had already had menopause (i.e. their periods had stopped for at least 12 months):

- two in five had an endometrium which became less abnormal or returned to normal
- some had EAH which developed into endometrial cancer.

For most women, there was a change to their endometrium around six months after having the IUD inserted.

What if I want to become pregnant?

It is true that an IUD is designed to prevent pregnancy. But pregnancy is not recommended when you have EAH. An IUD will allow you to avoid (or delay) a hysterectomy and may help your endometrium to return to normal. It is only when the endometrium has become normal again that it is safe to try for pregnancy.

Younger women with EAH often have other health problems which prevent them from becoming pregnant. If you want to become pregnant and are using an IUD to treat EAH, it may be a good time to address these problems to ensure you have the best chance of becoming pregnant and having a healthy pregnancy after treatment. Talk to your doctor or reproductive specialist about what you can do to improve your health and fertility.

Will I eventually need a hysterectomy?

An IUD may help your endometrium to return to normal in the short term but it cannot control the things that cause EAH. This means that it is likely that you continue to be at risk of developing EHA and endometrial cancer unless you have a hysterectomy. This is why your doctor usually recommends hysterectomy when you finish having children.

Things to remember

- EAH can become endometrial cancer and many women with this condition already have early endometrial cancer.
- Treating EAH with an IUD may mean you can
- have children later on but it may not stop you from getting endometrial cancer.
- **Women using an IUD as a treatment option must see their gynaecological oncologist every six months and undergo a short procedure to ensure that cancer has not developed.**

Questions to ask your nurse, doctor or gynaecologist

- Can I delay surgery if I try using an IUD first?
- How long can I try the IUD?
- What happens to the EAH during pregnancy?
- How long after pregnancy would I need to start treatment again?
- If I decide to have a hysterectomy, can you harvest eggs from my ovaries so a surrogate could have my baby?
- Do I have any other options for having a baby?

For more information or support

If you are a patient at the Women's

Gynaecological Oncology Unit
Royal Women's Hospital
T: (03) 8345 3566

Related fact sheets

- Endometrial Atypical Hyperplasia
- Hysteroscopy

References

Reed SD, Newton KM, Garcia RL, Allison KH, Voigt JF, Jordan CD, et al 2010, *Complex hyperplasia with and without atypia: Clinical outcomes and implications of progestin therapy,* American College of Obstetrics and Gynaecology, vol. 116, pp. 365–373.

Trimble CL, Kauderer J, Zaino R, Silverberg S, Lim PC, Burke JJ, et al 2006, *Concurrent endometrial carcinoma in women with a biopsy diagnosis of atypical endometrial hyperplasia: a gynaecologic oncology group study*, Cancer; vol. 106, no. 4, pp. 812–9