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A case report of management of atypical endometrial hyperplasia in a young female with primary subfertility.

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Background: Endometrial cancer is the most common gynaecological malignancy in the Western world and endometrial hyperplasia is a precursor. The incidence of endometrial hyperplasia is estimated to be at least three times higher than endometrial cancer and if left untreated it can progress to cancer. Early-stage endometrial cancer and complex atypical hyperplasia are treated with hysterectomy and bilateral salpingo-oophorectomy. An emerging issue among younger women affected is the possibility of a fertility-sparing treatment with progestogen therapy (eg: Levonorgestrel releasing intrauterine system) and close follow-up.

Case: In 2017 March, a 26 year old female presented to us with abnormal uterine bleeding for one year and primary subfertility for four years. She has had heavy and prolonged bleeding occurring at irregular and frequent intervals which has worsen during the last two months. She denied a history of smoking and has undergone a laparoscopic dye test and drilling two years ago. She did not have a family history of endometrial, breast or colonic carcinomas. Her body mass index (BMI) was 26.8kg/m^2 and evidence of mild to moderate hirsutism and acne were noted. Gynaecological examination revealed no abnormalities. The trans vaginal ultrasound scan showed a thickened endometrium (12mm) and evidence of polycystic ovaries. Hysteroscopy and endometrial sampling was carried out and revealed multiple endometrial polyps with increased vascularity and the histology reported as complex glandular atypical hyperplasia. Her CA-125 was normal. Considering the patient's age and her strong desire to preserve fertility a conservative management plan was proposed and Levonorgestrel releasing intrauterine system (LNG-IUS) was inserted and advice on weight reduction was given. A repeat endometrial sampling was planned in three months while keeping the LNG-IUS insitu, following which fertility treatment would be planned provided the sampling showed regression of the disease.

Conclusion: It is always challenging to treat a young patient having fertility wishes with atypical endometrial hyperplasia and the clinician should be aware of the best available treatment modalities and the proper plan of follow-up with the counselling of the patient in order to achieve optimal outcome.