ORIGINAL RESEARCH PAPER

Gynaecology

Endometrial Intraepithelial Neoplasia

KEY WORDS: EIN, endometrial carcinoma, Hysterectomy

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ABSTRACT

The EIN classification system is gaining widespread acceptance in diagnostic surgical pathology, clinical gynecology, and basic science fields. EIN is the histologic manifestation of an underlying molecular progression in endometrial carcinogenesis and is a lesion that can be diagnosed for purposes of therapeutic decisions. The EIN system accurately stratifies patients who have a high risk of developing endometrioid (type I) endometrial carcinoma. A biopsy diagnosis of EIN imparts a 45-fold increased risk of progression to carcinoma after the first year. Hysterectomy following the diagnosis of EIN is appropriate because there is a high rate of concurrent, as well as future, endometrioid endometrial carcinoma in women with EIN. One such case is reported from a tertiary care hospital in Mumbai. 52yrs, P2L2, postmenopausal since 12 yrs, came with c/o bleeding per vagina since 12 days. On examination, she was vitally stable and on per speculum examination, cervix and vagina were healthy. Per vaginal examination revealed a bulky uterus with bl free adnexae. USG was s/o ET 11mm with endometrial collection ?hematometra with bulky uterus. Pt was subjected for Dilatation and Curettage with cervical biopsy. During the procedure, pyometra was detected and drained. HPR was s/o atypical endometrial hyperplasia (Endometrial ca-in-situ) with papillary endocervicitis. Pt was then subjected for MRI which was s/o bulky uterus and cervix with no free fluid in peritoneum and no e/o lymphadenopathy. Pt was then subjected for Total Abdominal Hysterectomy with BL salpingo-oophorectomy and post operative period was uneventful.

INTRODUCTION:

Endometrial hyperplasia is of clinical significance because it is often a precursor lesion to adenocarcinoma of the endometrium. The precursor lesion of type I endometrioid adenocarcinoma is endometrial intraepithelial neoplasia. Estrogenic stimulation of the endometrium, unopposed by progestins, causes proliferative glandular epithelial changes. This finding, due to prolonged hormonal exposure, is biologically distinct from true precancerous lesions and true neoplasia. Making the distinction between hyperplasia and true precancerous lesions or true neoplasia has significant clinical effect because their differing cancer risks must be matched with an appropriate intervention to avoid undertreatment or overtreatment.

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Discussion[3]:

Sensitive and accurate diagnosis of true premalignant endometrial lesions can reduce the likelihood of developing invasive endometrial cancer. Based on available data and expert opinion, the American College of Obstetricians and Gynecologists and the Society of Gynecologic Oncology make the following consensus recommendations:

- The endometrial intraepithelial neoplasia schema seems to be preferable to the 1994 four-class World Health Organization (WHO94) schema. Pathologic diagnosis of premalignant lesions should use criteria and terminology that clearly distinguish between clinicopathologic entities that are managed differently. At present, the endometrial intraepithelial neoplasia schema is tailored most closely to this objective, incorporating modified pathologic criteria based upon evidence that has become available since the creation of the more widely used WHO94 schema (in which atypical hyperplasia is equated with precancerous behavior). The preferred terminology is "endometrial intraepithelial neoplasia" (rather than "atypical endometrial hyperplasia").
- Regarding tissue sampling, hysteroscopy, while not required, is recommended with directed dilation and curettage (D&C) to include any discrete lesions as well as the background endometrium. This will provide the best opportunity to confirm the diagnosis of a true premalignant endometrial lesion and exclude an associated endometrial carcinoma. When clinically appropriate, total hysterectomy for endometrial intraepithelial neoplasia provides definitive assessment of a possible concurrent carcinoma and effectively treats premalignant lesions.
- Supracervical hysterectomy, morcellation, and endometrial ablation are unacceptable for treatment of endometrial intraepithelial neoplasia.
- Systemic or local progestin therapy is an unproven but commonly used alternative to hysterectomy that may be appropriate for women who are poor surgical candidates or who desire to retain fertility.
- Posthormonal treatment surveillance after nonsurgical management of endometrial intraepithelial neoplasia may

include serial endometrial sampling every 3–6 months, but the appropriate frequency has not yet been determined.

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