Chapter 6: Fertility-sparing therapy

CQ32

When patients with atypical endometrial hyperplasia desire for fertility preservation, is progesterone therapy recommended?

Recommendations:

Progesterone therapy is considered in patients with atypical endometrial hyperplasia (Grade C1).

[See Fig. 6]

CQ33

When patients with endometrioid adenocarcinoma (corresponding to G1) desire for fertility preservation, is progesterone therapy recommended?

Recommendations:

Progesterone therapy is considered for patients with endometrioid adenocarcinoma (corresponding to G1) suspected to be confined to the endometrium (Grade C1).

[See Fig. 6]

CQ34

What are suitable follow-up periods and examinations?

Recommendations:

Endometrial biopsy and transvaginal ultrasonography are considered every 3 months after completion of progesterone therapy (Grade C1).

[See Fig. 6]

CQ35

What treatments are recommended for patients with recurrence after fertility preservation therapy?

Recommendations:

1. Total hysterectomy is recommended for patients with recurrent disease, an incomplete response, or progressive disease (Grade B).
2. The effectiveness of retreatment with progesterone has not been established in patients with recurrent disease. Retreatment with progesterone is not recommended for routine practice (Grade C2).

[See Fig. 6]

CQ36

Is ovulation induction permissible in patients after fertility preservation therapy?

Recommendations:

Induction of ovulation for pregnancy is considered (Grade C1).

[See Fig. 6]

Fig. 6 Strategies for fertility-sparing therapy (atypical endometrial hyperplasia and endometrioid adenocarcinoma (corresponding to G1)