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Case Report

Dilatation And Curettage For Treatment Of Endometrial Polyp With Cervical Fibroid

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ABSTRACT:
Endometrial polyps are found in more than 50% cases of abnormal uterine bleeding (AUB) and most of these women are in the age group of 40-49 years. Treatment of such cases includes hysteroscopic polypectomy as the gold standard but in resource poor settings such as developing and underdeveloped countries, management may depend on the available resources.
Keywords: Endometrial polyp; cervical fibroid; abnormal uterine bleeding; dilatation and curettage; perimenopausal bleeding

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CASE REPORT
A 44 years old lady presented to the out patient department (OPD) with chief complaints of irregular menstrual cycles since 1 year. She had attained menarche at the age of 12 years. Her past menstrual cycles were of 28 to 32 days interval ,bleeding lasted for 3 to 4 days and she used 2 to 3 pads daily. She did not have any symptoms of pain during her cycles. Since the past 1 year, her cycles were of a variable duration of 15 to 35 days, lasted 7 to 8 days and she used 3 to 4 pads per day. She complained of passage of clots during the first 2 to 3 days of bleeding. She had pain on and off during cycles but was never severe enough to take any medication for the same. The patient did complain of dyspareunia since the past few months.
The patient has been married since 22 years. She has 3 children aged 20, 19 and 13 years respectively. All were vaginal births and the antenatal as well as the post-partum periods were uneventful. The method of contraception used is barrier. Her past and family history were not significant.

EXAMINATION:
On general examination, her blood pressure was 114/72 mm Hg and heart rate was 86 bpm. She was afebrile and her SpO2 was 99% on room air. Her BMI was 24.5. Per- abdomen examination did not reveal any abnormal findings.
Per- speculum examination revealed a mass about 3x4 cm in size seen arising from the anterior lip of cervix. It was smooth, irregular, non-tender and did not bleed on touch. A punch biopsy was taken from it and sent for Histopathological examination. Posterior lip of the cervix was not visible on per-speculum examination.
Per- vaginum examination revealed that the anterior lip of cervix was not felt separately from the mass. Its margins were well defined and was mobile with movement of cervix. The uterus was anteverted. The fornices were free and the posterior lip of cervix had been pushed further by the same mass. The os was open. An ultrasound was done which revealed the uterus was 6.3x4.8 cm in size with 12mm endometrial thickness (ET). The cervix was reported as bulky with a hypoechoic lesion of size 3.1x3.1cm which was likely a leiomyoma. Another ill-defined lesion measuring 10mm

with posterior shadow abutting endometrial cavity was noted, which was suggestive of a polyp. Bilateral adnexa were normal. Her hematological investigations revealed her hemoglobin (Hb) was 9g/dL, while rest of the parameters were within normal limits.

MANAGEMENT:

The final diagnosis of abnormal uterine bleeding owing to polyp (AUB- P) with a coincidental finding of a cervical fibroid was made and therapeutic dilatation and curettage combined with the use of polypectomy forceps was done under sedation. Uterine contents were sent for histopathological examination. The cervical biopsy revealed chronic cervicitis and no evidence of intraepithelial neoplasia or dysplasia or malignancy. The examination of endometrial curettings revealed a benign endometrial polyp. There was no evidence of endometriris or granuloma or atypia. The patient is on iron supplementation and under follow up.

DISCUSSION:

An endometrial polyp is a growth projecting above the surface epithelium of endometrium that contains stroma, glands and blood vessels. It may be large enough to completely occupy the uterine cavity[1]. These are found in both reproductive as well as post-menopausal life[2]. Most commonly these are found in the age group of 40 to 49 years[3]. Our patient is 44 years old. These are the most commonly found uterine pathology and are usually benign[4]. However 82% of the cases were reported as asymptomatic by Dreisler et al[5] but polyps account for about 50% cases of AUB[6] and 35% cases of subfertility[7]. Their exact cause is not known, but several theories have been postulated. One suggests an increased concentration of estrogen receptors (ERs), mainly ER-alpha in glandular cells of polyps as compared to normal endometrium and a decreased expression of progesterone receptors (PRs) A and B in them as compared to normal endometrium[8]. These receptors are found in lower concentrations in stromal cells of polyps[9], preventing them from undergoing decidual changes and menstrual shedding. Risk factors include increased endogenous estrogen or estrogen administration. Tamoxifen, due to its estrogen agonist character, is also implicated in the etiology[10]. Our patient was not receiving any hormonal therapy. Post-menopausal women on hormone replacement therapy (HRT) are at a high risk due to unopposed endometrial stimulation by estrogen[11]. Diagnostic techniques include ultrasound (more specifically trans-vaginal ultrasound (TVS) with colour-flow or power doppler), hysteroscopy with or without histopathology[12,13]. Saline infusion sonography remains the gold standard for diagnosis[14]. Our patient was diagnosed on the basis of ultrasound and the diagnosis was confirmed after histopathological examination. Polyps may also undergo malignant change in about 1% cases[15]. They may commonly present as endometroid adenocarcinoma or serous adenocarcinoma. While the prognosis of the former depends on stage, the latter behaves more aggressively even in low stages. Post-menopausal women are at a higher risk, and the incidence increases with age[16,17]. Lower incidence in younger women may be attributed to cyclical regression mechanism of the endometrium[18]. Treatment of endometrial polyps varies in each patient and is based on the symptoms, risk of malignancy and fertility problems. Mainstay of treatment includes conservative surgical, radical surgical or conservative non-surgical management. Small asymptomatic polyps in younger patients can be observed and may regress spontaneously[19]. Non-surgical conservative management is generally reserved for asymptomatic cases. Although among conservative surgical treatment methods hysteroscopic polypectomy is the recommended method[20] and remains the gold standard, showing lower complication rates and better technical feasibility[21] but since the equipment for hysteroscopy is not available in our facility and due to unwillingness of the patient to go to a higher center, dilatation and curettage combined with the use of polypectomy forceps was selected as the treatment modality.

CONCLUSION:

Dilatation and curettage can be used as a treatment modality for endometrial polyps in resource poor settings where the option of hysteroscopy is not available.

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