

LOCATION, SIZE AND CLINICAL SYMPTOMS OF UTERINE POLYPS

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ABSTRACT

Objective: In this study we tried to find relationship between location, size and clinical symptoms of uterine polyps.

Methodology: Our cross sectional study was performed during the year 2008 in Ahwaz Imam Khomayni Hospital. Patients who underwent office hysteroscopy were evaluated and those with hysteroscopic diagnosis of polyp were entered in the study. Hysteroscopic findings of location and size of polyps and clinical presentations of Abnormal Uterine Bleeding (AUB) dysmenorrhea, infertility, discharge, spotting plus discharge were evaluated.

Results: One hundred and twenty four patients were evaluated. The most common location of polyp and clinical presentation were cervical canal and AUB, respectively. Polyp sizes of equal or less than 1 cm are commonly seen in cervical canal and cornea and more than 1 cm polyps are commonly found in uterine cavity and near internal os.

Conclusion: In this study we showed that location of polyp is important in clinical presentation. Patients presented with AUB had polyps more common in uterine cavity, patients with spotting plus discharge had polyps more in cervical canal.

KEYWORDS: Uterine polyp, office hysteroscopy, Abnormal Uterine Bleeding.

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INTRODUCTION

Endometrial polyp causes menorrhagia and metrorrhagia and may be associated with dysmenorrhea.¹ Uterine polyp diagnosis is based on either visualization (hysteroscopy or sonohysterography) or microscopic assessment (tissue obtained by biopsy in an office or curettage specimen). Symptomatic cervical polyps may cause intermenstrual bleeding, postcoital bleeding, heavy menses, postmenopausal bleeding and vaginal discharge. In addition, up to 25% of patients who have cervical polyp have also a coexisting endometrial polyp, so it is necessary to evaluate endometrial cavity.

Endometrial polyp is associated with decreased menstrual cycle lengths, endometriosis, and decreased parity.² Larger polyps are more likely to cause abnormal bleeding. Twenty

Table-I: Anatomic location of polyps

<i>Location of polyp</i>	<i>No.</i>	<i>Percent</i>
Cervical canal	43	34.7
Near internal os	34	27.4
Uterine cavity	27	21.8
Cornea	20	16.1
Total	124	100

one percent of lesions which were missed by normal transvaginal sonography are more successfully treated by hysteroscopic guidance, which can often be performed in a clinic by local anesthesia.³ Diagnostic hysteroscopy provides information which is not obtained by blind endometrial sampling,⁴ such as detection of endometrial polyps or submucous leiomyomas.⁵ Office hysteroscopy has been proven to have superior sensitivity (100%) and specificity (95%) in evaluation of the endometrial cavity.⁶ In one study, polyps were found in 33% of symptomatic premenopausal women older than 29 years who experienced abnormal bleeding versus 10% in asymptomatic women.⁷ In this study we tried to find relationship between location, size and clinical symptoms of uterine polyps.

METHODOLOGY

This cross sectional study was performed during the 2008 in Ahwaz Imam Khomayni Hospital. Patients who underwent office hysteroscopy (for different reasons) were evaluated and those with hysteroscopic diagnosis of polyp were entered the study. Hysteroscopic findings of location (cornual, uterine cavity, near internal os and cervical canal) and size (equal or less

Table-II: Clinical presentation of polyps

<i>Clinical presentation</i>	<i>No.</i>	<i>Percent</i>
AUB	68	54.8
Dysmenorrhea	18	14.5
Spotting plus discharge	17	13.7
Infertility	15	12.2
Discharge	6	4.8
Total	124	100

than 1cm, and more than 1cm) of polyps were defined. Also, clinical presentations were divided into AUB, dysmenorrhea, infertility, discharge, spotting plus discharge. Then hysteroscopic findings (location and size) and clinical presentations were evaluated, and SPSS 13 was used for data analysis. Hysteroscope model was STORZ, sheet 26153 BI, outer sheet 26153 BO, lens 26120 BA and 30 degree. Normal saline was used as media.

RESULTS

One hundred and twenty four ladies were evaluated. The participants were 22-55 years with mean age of 37 years. Location of polyps which are obtained by hysteroscopy, are shown in Table-I. According to that table, the most common location of polyp is cervical canal. Clinical presentations in studied patients are shown in Table-II and according to the table, the most common clinical presentation is AUB(54.8%).

Table-III shows that uterine cavity is the most common location of polyp (39.7%) in patients who presented with AUB and ladies who suffer from dysmenorrhea have no polyp in their uterine cavity. Cornea is the most common location of polyp (60%) in patients with

Table-III: Clinical presentation and location of polyps

<i>Polyp location</i>	<i>Cornea (%)</i>	<i>Uterine cavity (%)</i>	<i>Near internal os (%)</i>	<i>Cervical canal (%)</i>	<i>Total (%)</i>
AUB	7.4	39.7	38.2	14.7	100
Dysmenorrhea	33.3	0	33.3	33.4	100
Infertility	60	0	6.7	33.3	100
Discharge	0	0	0	100	100
Spotting plus discharge	0	0	5.9	94.1	100

Table-IV: Clinical presentation and size of polyps

<i>Polyp size</i> <i>Clinical presentation</i>	<i>Equall or less than 1 cm (%)</i>	<i>More than 1 cm (%)</i>
AUB	32.4	67.6
Dysmenorrhea	77.8	22.2
Infertility	100	0
Discharge	83.3	16.7
Spotting plus discharge	76.5	23.5

infertility, and patients who present with discharge and spotting plus discharge, cervical canal is the most common location of polyp (100% and 94.1%, respectively). In patients who present with AUB, the most common polyp size was more than 1 cm and ladies who suffer from other symptoms (dysmenorrhea, infertility, discharge and spotting plus discharge), the most common polyp size is equal or less than 1 cm (Table-IV). Polyp sizes are equal or less than 1cm in 55.6% and more than 1cm in 44.4% of patients.

Location and clinical presentation of polyp is shown in Table-V. Infertility is the most common (45%) clinical presentation of patients with polyp in cornea. The most common clinical presentation of patients with uterine cavity and near internal os polyps is AUB (100% and 76.5%, respectively). Spotting plus discharge are the most common clinical presentations (37.2%) of patients with cervical canal polyp. Table-VI shows that polyp sizes of equal or less than 1

Table-VII: Location and size of polyps

<i>Polypsize</i> <i>Polyp location</i>	<i>Equall or less than 1 cm (%)</i>	<i>More than 1 cm (%)</i>
Cornea	95	5
Cervical canal	76.7	23.3
Uterine cavity	18.6	81.4
Near internal os	35.3	64.7

cm are commonly seen in cervical canal and cornea (47.8% and 27.5%, respectively) and more than 1 cm polyps are commonly found in uterine cavity and near internal os (40% equally). Location and size of polyps are shown in table-VII. Polyps that are seen in cornea and cervical canal are commonly equal or less than 1 cm (95% and 76.7%, respectively) and polyps in uterine cavity and near internal os are commonly more than 1 cm (81.4% and 64.7%, respectively).

DISCUSSION

In this study we found that location of polyp is important in clinical presentation. Patients presented with AUB had polyps more common in uterine cavity (39.7%) and near internal os (38.2%), and those with dysmenorrhea had c polyps in cervical canal (33.4%), near internal os (33.3%) and cornea (33.3%). Patients with infertility had polyps more in cornua (60%) and those with discharge had polyps only in cervical canal (100%) and patients with spotting plus discharge had more polyps in cervical canal (94.1%).

Table-V: Location and clinical presentation of polyps

<i>Clinicalpresentation</i> <i>Polyp location</i>	<i>AUB(%)</i>	<i>Dysmenorrhea(%)</i>	<i>Infertility(%)</i>	<i>Discharge (%)</i>	<i>Spotting plusdischarge (%)</i>
Cornea	25	30	45	0	0
Uterine cavity	100	0	0	0	0
Near internal os	76.5	17.7	2.9	0	2.9
Cervical canal	23.2	14	11.6	14	37.2

Table-VI: Size and location of polyps

<i>Polyp location</i> <i>Polyp size</i>	<i>Cornea (%)</i>	<i>Uterine cavity (%)</i>	<i>Near internal os (%)</i>	<i>Cervical canal (%)</i>	<i>Total (%)</i>
Equall or less than 1 cm	27.5	7.3	17.4	47.8	100
More than 1 cm	1.8	40	40	18.2	100

In one study, symptomatic cervical polyps may cause intermenstrual bleeding, postcoital bleeding, heavy menses, postmenopausal bleeding and vaginal discharge. Location, number and size of cervical polyps are best determined by diagnostic hysteroscopy.⁸ In another study, larger polyps were more likely to cause abnormal bleeding.⁹ In other study, they concluded that in patients with AUB, cervical canal polyps may be missed by transvaginal sonography and can be diagnosed by hysteroscopy.³ Findings of these studies are similar to our results.

In one study, polyps were found in 33% of symptomatic premenopausal women older than 29 years who experienced abnormal bleeding versus 10% in asymptomatic women.⁷ In another study, asymptomatic women underwent repeated sonohysterography after 2.5 years and found that four of seven polyps resolved. These polyps tended to be smaller than those that did not resolve.⁹ Our study was done during the year 2008, and we focused on location, size and clinical symptoms of polyps. So, it is better to evaluate the tendency of polyp to resolve in a separate study.

Advances in diagnostic tools such as vaginal ultrasound with high frequency probes, saline infusion sonography and office hysteroscopy leads to more accurate diagnosis of uterine polyps even small types.

Relationship between uterine polyps and AUB were previously diagnosed but polyps can cause other symptoms such as discharge, infertility and dysmenorrhea. These minor symptoms may have less importance than AUB but they are troublesome and occasionally missed.

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