Endometrial Polypectomy following Medical Dilatation of Cervix

Lt Col K Kapur*, Gp Capt GS Joneja+, Lt Col M Biswas#

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Introduction

Abnormal uterine bleeding is one of the commonest complaints of patients reporting to the gynaecological out patient department (OPD). A common, but often missed condition responsible for abnormal uterine bleeding is an endometrial polyp. Benign polyps are reported in 5–10% of patients with abnormal uterine bleeding [1] and in 20–25% women presenting with postmenopausal bleeding [2, 3]. Endometrial polyps not available for visual examination, were generally missed till the advent of hysteroscopy (Fig 1). Once endometrial polyps are diagnosed, they have to be resected out of the uterine cavity or removed with polypectomy forceps under general anaesthesia.

Case Report

A 41-year-old female, presented with complaints of increased bleeding per vaginum during periods for the past 2 – 3 years. The patient with previously regular periods of 3/30, now had periods of 6 – 7 /30. The bleeding increased, associated with passage of clots and mild pain abdomen. The patient gave history of intermenstrual spotting and

Fig. 1 : Endometrial polyp as seen on office hysteroscopy

occasional foul discharge per vaginum. Obstetrically, the patient was a para 3 with normal deliveries and the last childbirth was 10 years ago, when she underwent tubectomy. Clinically her general, gynaecological and systemic examination was within normal limits. On investigation, her haematological parameters were within normal limits. An ultrasound examination of the pelvis revealed no abnormality. The patient was taken up for office hysteroscopy, which revealed a huge endometrial polyp occupying more than half of the uterine cavity. Traditionally this polyp would require hysteroscopic resection under general anaesthesia.

The patient was given 2 tablets of misoprostol (400 microgm) per vaginally in the evening and asked to report the next morning. An internal check up, revealed that the tip of the polyp was protruding out of the uterine cavity through the cervical canal. The polyp was held with an Allis forceps and twisted in a clockwise fashion till it was avulsed from its base and removed. A repeat hysteroscopy done at this time revealed a normal uterine cavity.

The polyp, with an endometrial biopsy was submitted for histopathological examination, which confirmed endometrial polyp and endometrium in secretory phase.

Discussion

Although endometrial polyps are a frequent cause of abnormal uterine bleeding they were rarely diagnosed, till the introduction of hysteroscopy and they had to be removed by resection using a resectoscope or by avulsion with polypectomy forceps. This procedure is generally done under general anaesthesia, although the diagnosis is routinely made by hysteroscopy, as an OPD procedure (office hysteroscopy).

Operative hysteroscopy requires the cervix to be dilated and we normally use tablet misoprostol 200-400 microgm, inserted in the vagina a few hours before surgery. A number of studies have proven the benefits of using tab misoprostol before hysteroscopy to reduce

*Classified Specialist (Obs & Gyn) & Endoscopic Surgeon, *Senior Advisor (Obs & Gyn), #Classified Specialist (Obs & Gyn and Gyn Oncologist), Army Hospital (R & R), Delhi Cantt.

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time and complications of hysteroscopy by easier cervical dilatation [4,5]. On retrospective analysis, we found that in cases where endometrial polyps or submucous fibroids were occupying more than half the uterine cavity and the tumour was seen protruding through the cervical os after tablet misoprostol, the tumour could easily be removed by avulsing it with an Allis forceps by twisting it on its pedicle.

Tablet misoprostol, a prostaglandin analogue, acts in two ways on the uterus and cervix. Firstly, it effects uterine contractions, which partly expels the intra uterine lesion like an endometrial polyp through the cervical os and secondly it causes softening and dilatation of the cervix.

In view of our experience, we decided that once a patient was diagnosed as having an endometrial polyp occupying more than half the uterine cavity on office hysteroscopy, patient would be given 400 microgm of tablet misoprostol in the posterior fornix of the vagina at night and called the next morning. On reexamination if the polyp was seen protruding out of the cervical os, it would be removed by grasping the protruding part of the polyp and twisting its pedicle.

So far we have used this procedure in six cases and we could remove the endometrial polyp in all cases without subjecting the patient to hospital admission,

general anaesthesia or the risks of operative hysteroscopy. There were no postoperative complications like excessive bleeding, pain or uterine perforation.

We found this technique to be both patient and surgeon friendly. The number of cases in this study were small and perhaps this could be a standard technique used by gynaecologists in the future.

Conflicts of Interest

None identified

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