HMJ

OLGU SUNUMU/CASE REPORT

Postmenopozal Bir Kadında Dev Endometriyal Polip

Giant Endometrial Polyp in a Postmenopausal Woman

Ayhan Atıgan[1], ORCID No: 0000-0002-7257-0593, Soner Gök[1] ORCID No: 0000-0001-8940-1879, Yeliz Arman Karakaya[2] ORCID No: 0000-0002-6669-9972

[1]Pamukkale Üniversitesi Tıp Fakültesi, Kadın Hastalıkları ve Doğum Ana Bilim Dalı, Denizli, Türkiye.
[2]Pamukkale Üniversitesi Tıp Fakültesi, Tıbbi Patoloji Ana Bilim Dalı, Denizli, Türkiye.

Geliş Tarihi/Received: 12.01.2020
Kabul Tarihi/Accepted: 20.02.2020
Yazışma Adresi/Address for Correspondence:
Araş. Gör. Dr. Ayhan Atıgan, Pamukkale Üniversitesi Tıp Fakültesi, Kadın Hastalıkları ve Doğum Ana Bilim Dalı, Denizli, Türkiye.
e-posta: dratigan@hotmail.com

Anahtar Sözcükler:
Dev endometriyal polip
Kalın endometriyum
Postmenopozal kanama

Key Words:
Giant endometrial polyp
Postmenopausal bleeding
Thick endometrium

ÖZ

Dev polip, genellikle rahim ağzından endometriyuma olağandışı uzanan, bir kadın genital sistem patolojisidir. Servikal veya endometrial maligniteyi taklit edebilir ve tanısal bir ikileme veya gereksiz agresif müdahaleye neden olabilir. 63 yaşındaki menopoz sonrası bir kadında son derece nadir görülen dev bir endometrial polip vakası klinisyenler arasında farkındalık yaratacak şekilde tarif edilmektedir. Böyle bir olguya yaklaşım, ayırıcı tanı ve literatür taraması da sunulmaktadır.

ABSTRACT

Giant polyp is an unusual female genital tract pathology, commonly arising from the cervix than the endometrium. It is a great masquerader of cervical or endometrial malignancy and can lead to a diagnostic dilemma and unnecessary aggressive interventions. Experience in one such case of an extremely rare protruding giant endometrial polyp in a 63-year-old postmenopausal female is being described herewith so as to create awareness among the dealing clinicians. The approach to such a case, differential diagnosis, and review of the literature is also presented.

Introduction

Endometrial polyps are localized overgrowth of endometrial glands and stroma through the uterine cavity. This benign disease affects 25% of women (1). Postmenopausal bleeding (PMB) accounts for 5% of the gynecological visits and it is usually seen in up to 10% of women aged over 55 years (2). This abnormal genital bleeding arises from both the intrauterine as well as extrauterine sources. The most common cause attributed to it is the atrophy of vagina or endometrium owing to the postmenopausal hypoestrogenism (3). Nevertheless, several other conditions such as endometrial hyperplasia, cervical/ endometrial polyps, submucosal fibroids, tumours of endometrium/cervix/ovaries, bleeding from non-gynecological sites, such as the urethra, bladder, anus/rectum/ bowel, or perineum have also been implicated as its important etiologies (2). Among the polyps, the uterine or endometrial polyps are benign masses of the endometrium that bulge into the uterine lumen. They can be single or multiple and can appear as pedunculated or sessile. In rare especially the pedunculated ones can protrude through the cervix into the vagina (4). Their size ranges from a few millimeters to several centimeters. Most of them are usually <2 cm in diameter, however, polyps can occasionally attain a size of >4 cm and then they are designated as giant polyps (4). Most of the giant endometrial polyps reported in the literature are mainly associated with postmenopausal tamoxifen or raloxifene treatment, reflecting that they are affected by the hormone levels and grow in response to the circulating estrogen (5). These rare giant endometrial polyps are clinically important as they may cause concern to both the patient and the dealing clinician for the suspicion of a malignancy, especially because of their size and associated clinical symptoms leading to unnecessary diagnostic and therapeutic interventions. Herein is described an extremely rare case of a giant endometrial polyp with bleeding in complicated patient such as cardiologic problems.

Case Report

A 63-years-old female; gravida 2 labor 2, presented to the gynecological out-patient department with lower abdominal pain and bleeding per vaginum since the past 30 days. She gave a history of intermittent PMB of 5 years duration and recently in the past 8 months. However, she never approached any gynecologist for these complaints until now. She had two full-term normal vaginal deliveries and had attained menopause 20 years back. She denied any use of drugs especially hormone derivatives, recent intercourse or vaginal trauma. She has heavy cardiologic disease, hypercholesterolemia and diabetes mellitus in her medical history. Her drugs were acetylsalicylic acid 100mg, clopidogrel, atorvastatin, benidipine hydrochloride 4mg. She has no prior surgery as well as family history of any cancer (breast/uterine/colon/ovarian) was contributory.

On general physical examination, she was anemic and overweight (body mass index-29.2 kg/m^2). Per abdomen examination revealed mild tenderness in the lower abdomen with no evidence of ascites or any organomegaly. Per speculum examination showed a mild-bleeding. Bimanual pelvic examination revealed anteverted multiparous sized uterus with free bilateral fornices and without palpable adnexal masses. On per rectal examination, the rectal mucosa was free. All other systemic examinations were within normal limits. Kidney and liver function tests were normal. Serum antibodies to the human immunodeficiency virus, hepatitis B surface antigen, syphilis were negative. X-ray chest was normal. Transvaginal sonography (TVS) showed heterogeneous irregular endometrium of 27 mm thickness. Based on the history, clinical and radiological findings, an endometrial or a cervical malignancy was suspected. On the basis of these histopathological findings, a final diagnosis of a giant endometrial polyp was made. First line therapy was performed by blind curettage. However result of curettage was only proliferative endometrium. Patient had been suffering same symptoms after this operation. In addition, our patient had a complaint of uterine prolapse. She was advised hysterectomy and she was willing to undergo the procedure.

Figure 1. Macroscopic view on cut section.

Gross examination of the specimen from the container labeled polyp showed a pedunculated polypoidal smooth gray-brown soft-tissue piece which measured 6 cm × 3,5 cm × 1 cm in size (Figure 1). On microscopic examination (hemotoxylin eosin (H&E), x 200) loose edematous stroma and conjugate vessel structures were

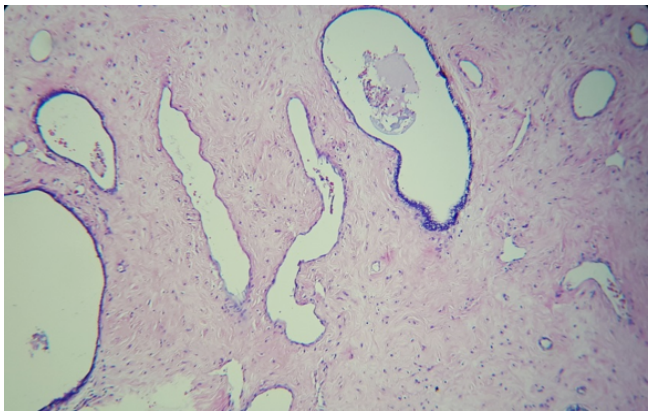

Figure 2. Loose edematous stroma and conjugate vessel structures were seen on microscopic examination.

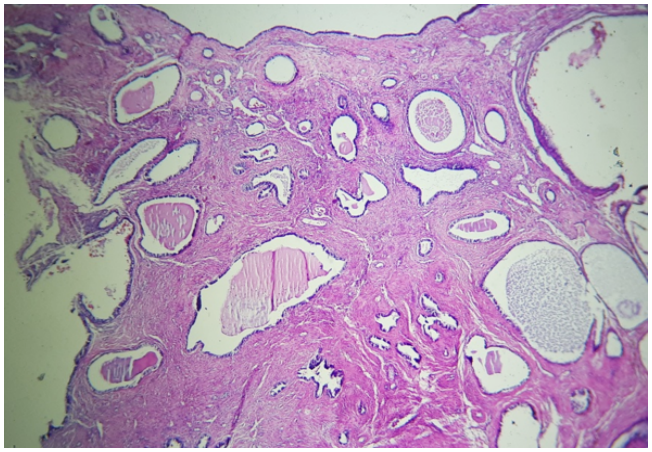

Figure 3. Cystic dilated gland structures were identified on microscopic examination.

seen (Figure 2). However, cystic dilated gland structures (Figure 3) and conjugate vessel structures (Figure 4) were also identified on microscopic examination. On follow-up, her symptoms completely resolved and there were no fresh complaints.

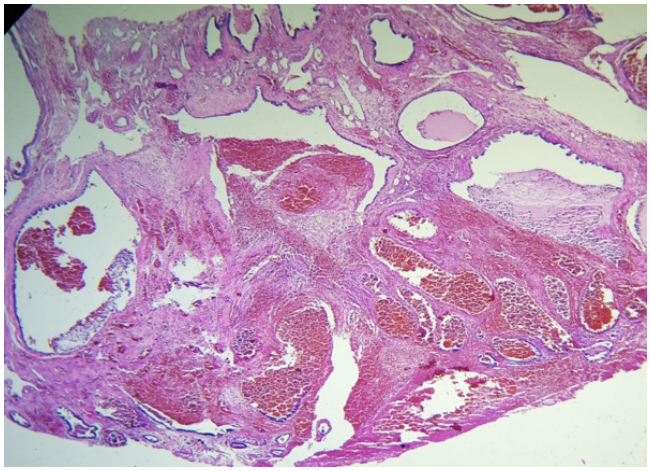

Figure 4. Conjugate vessel structures were seen on microscopic examination.

Discussion

Endometrial polyps are composed of endometrial glands (normal/cystic/hyperplastic), an increased amount of fibrous tissue, and can contain smooth muscle (1). These polyps can occur at any age, but most frequently they are seen in women around menopause. Patients may either be asymptomatic or can present with abnormal bleeding patterns (intermenstrual bleeding, menorrhagia, or PMB) and infertility. Its prevalence ranges from 10% to 24% in women presenting with dysfunctional uterine bleeding while it occurs in 24.3% of PMB cases (4). The exact pathogenesis of endometrial polyps still remains unclear. Researchers have documented its causative link to aging, obesity, tamoxifen therapy, hypertension, unbalanced estrogen receptors and progestins, unopposed estrogen therapy, and estrogen-like effect (1).

Giant endometrial polyps, as seen in the present case study, are exceedingly rare variants of classical polyps. On reviewing the handful of cases mentioned till date, various clinicopathological features of this rare entity draws the attention. These giant endometrial polyps are mainly seen in Turkish origin postmenopausal women with associated conditions such as obesity, heart ailments, and diabetes mellitus. The most common presenting symptom is vaginal bleeding and only a few of them presented with an introital mass (4,5). The polyp size varied from 4.5–12 cm in its greatest dimension. Maximum of the cases developed with the use of selective estrogen receptor modulators such as tamoxifen or raloxifene or a phytoestrogen (thyme) (1,5). Nevertheless, few asymptomatic cases without any drug/hormone use or vaginal bleeding have also been documented (1). Transvaginal sonography has been the first line of investigation in most of the cases. The patients have been managed equally by both the hysteroscopic polypectomy and total abdominal hysterectomy with or without bilateral salpingo-oophorectomy. The histopathological examination of the resected specimens was performed in all the cases which revealed no hyperplasia, atypia or malignancy in maximum cases.

In the current patient, the polyp developed spontaneously in an overweight female and presented as postmenouposal bleeding with a mass. The transvaginal sonography revealed a 27 mm thick endometrium. All these clinico-radiological findings lead to a suspicion of malignancy and warranted further evaluation of the patient. Nevertheless, 10%–25% of the symptomatic giant endometrial polyps may contain hyperplastic foci while the risk of its malignant transformation has been observed in about 0%–12.9% cases. Several factors have been linked to malignancy arising within the polyp such as advanced age, menopausal status, obesity, diabetes, arterial hypertension, use of tamoxifen, and large size of the polyp (6).

Therefore, the basis for removing these protruding polyps followed by histopathological examination is not only for symptomatic relief of the patient, suspicion of malignancy but it is also for assessing the polyps own malignant potential. Hysteroscopic polypectomy remains the mainstay for the operative management and histopathological evaluation of giant endometrial polyps because of the minimal morbidity associated with it as compared to a hysterectomy. Our patient had a complaint of uterine prolapse as well, that's why the patient underwent hysterectomy in stead of hysteroscopy. The blind curettage is unsuccessful in many cases in terms of incomplete removal of the polyp, therefore, it should not be used as a diagnostic or therapeutic intervention (6).

As a conclusion, giant endometrial polyp is a rare entity which should be kept in mind while dealing with PMB cases as they can develop spontaneously and can mimic as an endometrial or a cervical malignancy. The assessment of such patients should include a detailed history, complete abdominal/pelvic and speculum examinations along with identification of its risk factors. Hysteroscopy is quite beneficial in the differential diagnosis, but the histopathological examination is mandatory for its definitive diagnosis. However, more insight and exploration is required of the factors involved in its pathogenesis and for determining its oncogenic potential in near future.

Peferences

1. Unal B, Doğan S, Karaveli FŞ, Simşek T, Erdoğan G, Candaner I, et al. Giant endometrial polyp in a postmenopausal woman without hormone/drug use and vaginal bleeding. Case Rep Obstet Gynecol 2014:51-83.
2. Newell S, Overton C. Postmenopausal bleeding should be referred urgently. Practitioner 2012;256:13–15.
3. Smith PP, O'Connor S, Gupta J, Clark TJ. Recurrent postmenopausal bleeding: A prospective cohort study. J Minim Invasive Gynecol 2014;21:799–803.
4. Çil AS, Bozkurt M, Kara D, Güler B. Giant endometrial polyp protruding from the external cervical os in a postmenopausal woman: magnetic resonance imaging and hysteroscopic findings. Proc Obstet Gynecol 2013;3:3-9.
5. Erdemoğlu E, Güney M, Keskin B, Mungan T. Tamoxifen and giant endometrial polyp. Eur J Gynaecol Oncol 2008;29: 198–199.
6. Papadia A, Gerbaldo D, Fulcheri E, Ragni N, Menoni S, Zanardi S, et al. The risk of premalignant and malignant pathology in endometrial polyps: Should every polyp be resected? Minerva Ginecol 2007;59:117–124.