

“A Rare Case Of Global Multiple Adenomyomatous Endometrial Polyps: Developed Just After Menarche, With Giant Polyp Protruding Throgh Cervix”

Dinesh Kumar¹, L Somenkumar Singh², S Randhoni Devi³, Ch Pritamkumar Singh⁴, L Ranjit Singh⁵, R K Praneswari Devi⁶, Keni Riba⁷, Rushulo Khing⁸

¹Postgraduate Student Department of obstetrics and gynecology, RIMS, Imphal, (Manipur)

^{3,5}Professor Department of obstetrics and gynecology, RIMS, Imphal, (Manipur)

^{4,6}Associate Professor Department of obstetrics and gynecology, RIMS, Imphal, (Manipur)

²Senior Resident Department of obstetrics and gynecology, RIMS, Imphal, (Manipur)

^{7,8}Postgraduate student Department of obstetrics and gynecology, RIMS, Imphal, (Manipur)

Abstract: A 37 years old infertile nulligravida married for last 17 years admitted with chief complaint of frequent heavy prolonged menstrual bleeding with weakness since two months. She was a known case of chronic menorrhagia since menarche (last 26 yrs). She had a history of repeated dilatation and curettage followed by diagnostic hysteroscopy two years back but no reports. On examination, pallor was present with tachycardia. On per speculum examination, bleeding was present, os dilated, multiple polyps looking like bunch of grapes were present with one giant polyp 4x3x2 cm protruding from the cervix. Transvaginal sonography showed multiple submucous fibroids/polyp like lesions. She was managed conservatively with tranexamic acid, blood transfusion and repeated set of dilation and curettage but did not respond. Then, she underwent total abdominal hysterectomy with right salpingo-oophorectomy. On gross examination of the uterus, there were multiple endometrial polyps. Histopathology reports showed adenomyomatous endometrial polyps. Section showed endometrium with dilated endometrial glands in the underlying myometrium surrounded by bundles of smooth muscles with chronic cervicitis.

Keywords: Polyp, Adenomyomatous, Fibroid, Infertility.

I. Introduction

Endometrial polyps represent a limited focal, circumscribed overgrowth of the endometrium. Their aetiopathogenesis has not been completely explained yet. The patient's risk factors include increased age, obesity, tamoxifen use [1]. They are often found in perimenopausal women. During the reproductive period, they are less common. It may be pedunculated or sessile, single or multiple. Pedunculated polyps are more common than sessile ones [2]. Estrogen and progesterone have been implicated in their growth. These hormones elongate endometrial glands, stromal tissues and spiral arteries, leading to creation of polypoid appearance. Although malignant changes in these lesions are uncommon, numerous studies confirmed this association especially with endometrial serous and clear cell carcinoma.

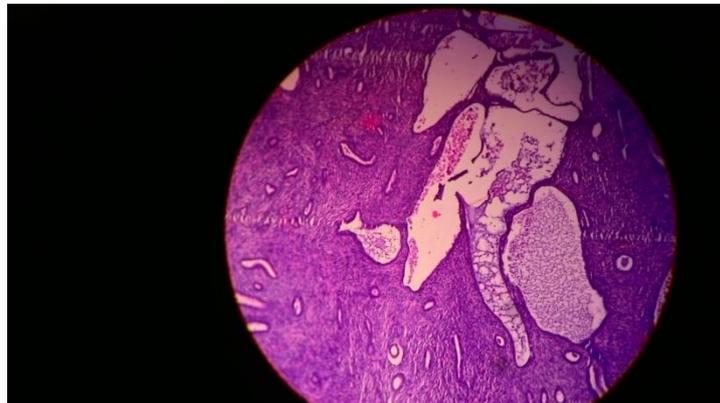
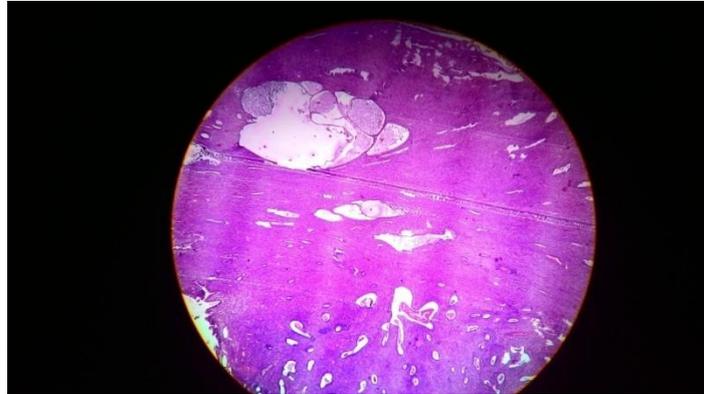
Specific rearrangement of 12p15 and 6p21 resulting in HMGI-C and HMGI(Y) dysregulation have been reported in stromal cells of endometrial polyps, identical p53 mutation in multiple sites and alteration in Ki67 indicates metastatic origin. Uterine contractions may cause elongation of the pedicle of a polyp, trying to extrude it from the uterine cavity.

II. Case Report

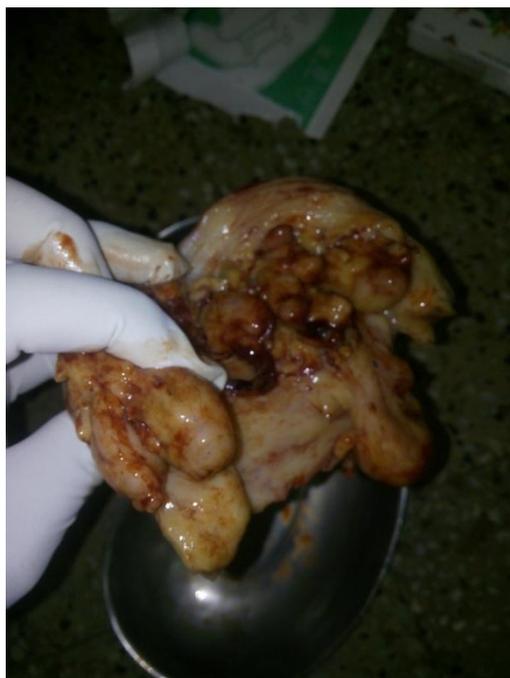
A 37 years old infertile nulligravida married for last 17 years admitted with chief complaint of frequent heavy prolonged menstrual bleeding with weakness since two months. She was a known case of chronic menorrhagia since menarche. She had many episodes of irregular heavy bleeding for last 26 years. She belonged to the low socioeconomic status and low education level. She had a history of repeated dilatation and curettage followed by a diagnostic hysteroscopy 2 years back. She had no other significant medical, surgical and familial history. She had the history of incompletion with the treatment.

On examination, she was poorly built and pallor was present. Blood pressure was 110/70 mm of Hg. Tachycardia with pulse rate 110 beats per min. Systemic examination detected no abnormalities. On per vaginal examination, uterine size was 8 weeks, anteverted. Bleeding was present, bilateral fornices were free with no cervical motion tenderness and multiple polyps were felt. On per speculum examination, bleeding was present, os dilated, multiple polyps looking like bunch of grapes were present with one giant polyp (4x3x2) cm protruding from the cervix. All routine investigations including coagulation profiles were within normal limits except haemoglobin 6 gm%. Transvaginal sonography showed multiple submucous fibroid/polyp like lesions.

She was managed conservatively initially with hormones and six units of blood were transfused. She didn't respond well with conservative management. She underwent total abdominal hysterectomy with right salpingoophorectomy on 20th June 2015. Cut section in operation theatre showed multiple global endometrial polyps with some protruding the cervix including one giant polyp. Histopathology reports showed adenomyomatous polyps. Section showed endometrium with dilated endometrial glands in the underlying myometrium surrounded by bundles of smooth muscles with chronic cervicitis.



(endometrium with dilated endometrial glands in the underlying myometrium surrounded by bundles of smooth muscles)





(Gross appearance)

III. Discussion

Polyps are biphasic benign endometrial lesions that classically have been defined as ‘benign nodular protrusions above the endometrial surface, consisting of irregularly distributed endometrial glands and stroma. Its prevalence rate ranges from 10% to 40% in women with abnormal uterine bleeding [4] depending on characteristics of the population studied and detecting methods. Malignancy is found in endometrial in 0.8% to 8% cases[5]. Larger polyps are associated with a higher risk of malignancy. Lee et al reported in a metaanalysis the prevalence rate of premalignancy and malignancy in endometrial polyps of 3.57% [6].

Infertility has been linked indirectly with endometrial polyp. Metalloproteinases associated with implantation and cytokine that impact embryo development have been implicated, alternatively polyp found near the tubal ostia may hinder ostium function and block sperm migration [7].

Up to 25% of women with unexplained infertility have endometrial polyps on hysteroscopy(8). Main diagnostic tool for evaluation are TVS, saline infusion sonography, hysteroscopy and endometrial biopsy. Many of these polyps spontaneously resolves or slough .

More recent research shows that, if the agent causing the loss of sensitivity of the receptors (progesterone) is present in circulation over a longer time period, changes may also appear at the DNA molecular level, i.e. in the cell genome itself. This, in turn, may lead to the beginning of the process of oncogenesis and the formation of tumorous tissue.

Our case is rare , as generally polyp is associated with chronic use of tamoxifen/hormonal therapy and develops perimenopausal age ,but she was having large global multiple adenomyomatous polyps with one giant polyp without any tamoxifen use .she developed polyps since puberty.

In our case she was a known case of chronic menorrhagia since menarche (last 26 yrs). She had a history of repeated dilatation and curettage followed by diagnostic hysteroscopy two years back but no reports. She was managed conservatively with tranexamic acid , blood transfusion and repeated set of dilation and curratage but didnot respond. Then, She underwent total abdominal hysterectomy with right salpingoophorectomy. . we could not save uterus as polyp were multiple and present all over the uterine walls and resistant to dilation and curratage/polypectomy, so underwent total abdominal hysterectomy. Histopathology reports showed adenomyomatous polyps. Section showed endometrium with dilated endometrial glands in the underlying myometrium surrounded by bundles of smooth muscles.

IV. Conclusion

Polyps must be removed if symptomatic, if malignancy considered likely or if associated with long term established infertility. It should be noted that endometrial polyps especially the symptomatic , larger one ,leading to infertility and the polyps developed in postmenopausal patients have tendency to show malignant change, hence careful histological examination of lesion should be done.

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