



The clinical significance of small endometrial polyps



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ABSTRACT

Objective: Small endometrial polyps are relatively common in asymptomatic women and may regress spontaneously. In symptomatic women, the finding of a small polyp (<1 cm diameter) raises the question of the clinical pertinence and necessity of excision. Sparse data are available on the effectiveness of hysteroscopic excision of small polyps to manage abnormal uterine bleeding. The aim of this study was to assess outcome after hysteroscopic excision of small endometrial polyps in symptomatic patients.

Study design: This was an observational cohort study enrolling 255 premenopausal women presenting with abnormal uterine bleeding and a small endometrial polyp on office hysteroscopy, undertaken between January 2004 and February 2007. The study group was referred for polypectomy by operative hysteroscopy. The outcome of the procedure was reviewed 6–12 months later by a telephone interview to assess the pattern of uterine bleeding after the procedure and overall satisfaction.

Results: Significant improvement in the magnitude of bleeding was experienced by 70% of participants, but only 30% of them reported return to regular menses. Satisfaction with the procedure was reported by 80%. Younger patients reported a less favorable bleeding pattern and were found to be less satisfied with the outcome of the procedure.

Conclusions: Symptomatic women with small endometrial polyps can be treated safely and efficiently with hysteroscopic excision. In the younger age group of patients, however, the outcome of the procedure may be less favorable and may necessitate the addition of endometrial ablation to improve outcome and increase patient satisfaction.

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1. Introduction

Endometrial polyps are localized overgrowths of endometrial tissue containing glands, stroma and blood vessels, covered with epithelium [1]. The prevalence of endometrial polyps depends upon the population being studied and the uterine imaging technique. Using saline infusion sonohysterography, endometrial polyps could be found in 10% of asymptomatic premenopausal women older than 30 [2]. Polyps occur in all age groups but are most commonly found in women aged 40–49 years [3]. Notably, some polyps, particularly the smaller ones (<1 cm) in asymptomatic premenopausal women appear to regress spontaneously [4,5]. Polyps may be an incidental asymptomatic finding on routine scanning, but they may also be associated with abnormal uterine bleeding in both pre- and postmenopausal women. Their

prevalence ranges from 20% in symptomatic premenopausal women up to 40% [6,7] in the postmenopausal period.

Abnormal uterine bleeding (AUB) has a significant deleterious effect on the quality of life of women. It is one of the most common reasons cited by women attending gynecology outpatient clinics [8]. It is believed that the severity of the bleeding symptoms of endometrial polyps depends on the size of the polyp [4].

In the past, patients often underwent hysterectomy to halt severe bleeding, but today improvement in endoscopic diagnosis has led to more individualized management. Hysteroscopic polypectomy has been considered effective in treating menorrhagia and menometrorrhagia. While earlier studies have investigated small polyps, they did not specifically address the question of the effect of small polyp removal on bleeding patterns or quality of life [9–12], rather focusing on malignant potential or fertility outcomes. In these patients the bleeding disorder may be related to endometrial polyps, but could be dysfunctional endocrinological uterine bleeding with relative hyperestrogenic status. The aim of this study was to assess outcome after hysteroscopic excision of small endometrial polyps in patients with abnormal uterine bleeding.

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2. Materials and methods

2.1. Study population

This was an observational cohort study, conducted from January 2004 to February 2007. The study group ($n = 255$) included premenopausal women complaining of menorrhagia who were diagnosed with a single small endometrial polyp (<1 cm) who underwent hysteroscopic polypectomy. Menorrhagia was defined as use of more than 5 pads a day or prolonged menstruation of more than 7 days by patient report. Prior medical treatment with progestins or estrogen–progesterone preparations to regulate bleeding was recorded. Informed consent for the procedure was obtained from all subjects. The diagnosis of a small endometrial polyp was made pre-operatively by transvaginal ultrasonography (TVUS) and confirmed qualitatively during diagnostic hysteroscopy by experienced operators. Patients with adenomyosis or diffused thick endometrium were not enrolled in the study group. Final diagnosis of endometrial polyp was obtained by histological examination. Diagnostic hysteroscopy was not performed in 8 patients because of either patient intolerance or technical difficulty. Excluded from the study group were women found to have submucosal uterine leiomyomas (9 patients) more than one polyp or diffuse thickened endometrium (16 patients), adenomyosis (2 patients), or pathologic findings of endometrial hyperplasia or carcinoma (2 patients).

2.2. Measurements

The operative hysteroscopic procedures were performed with either a monopolar (Storz, Germany) (69 patients) or a bipolar system (Gynecare, USA) (186 patients). The procedures were carried out in a university teaching hospital setting by a professional team including two senior physicians and three physicians in training under supervision.

The following parameters were recorded for each subject: age, parity, weight, duration of symptoms, pre-procedure hemoglobin level, duration of the procedure and the time elapsed since the procedure. A telephone interview was obtained by a single non-physician, highly-trained interviewer, six to twelve months following the procedure (Fig. 1).

Two hundred and twenty-nine women (89.8%) agreed to respond to the telephone questionnaire in the second stage of the study. This time-frame was chosen to provide optimal perspective on the procedure with the least recall bias. The following data were obtained from the telephone questionnaire: pattern of bleeding before and after the procedure, hysteroscopic complications, and overall satisfaction from the procedure. The

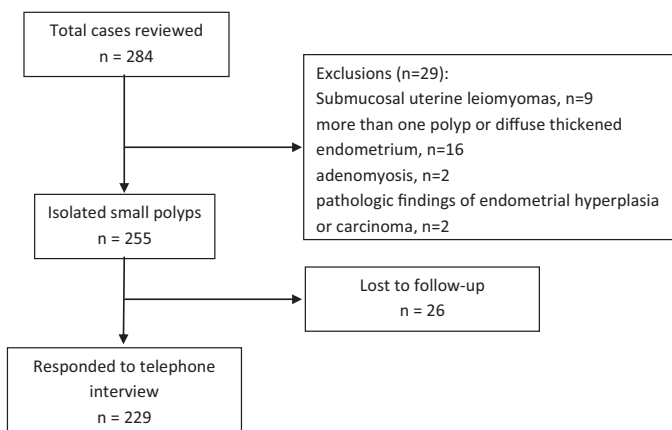


Fig. 1. Collection of cases, exclusions, and losses to follow-up.

main outcome measure was the effect of the procedure on abnormal uterine bleeding. The secondary outcome was patient satisfaction up to one year post-procedure. The participants were asked to grade change in menstrual pattern on a scale of 1–4: 1: no improvement; 2: slight improvement; 3: significant improvement; and 4: return to normal cycle. For analysis purposes grades 1–2 and 3–4 were merged into two groups, failed and effective. Patients rated their satisfaction: 1: not satisfied; 2: somewhat satisfied; 3: satisfied; and 4: highly satisfied. Again, for statistical analysis satisfaction level was grouped into unsatisfied (1–2) and satisfied (3–4).

2.3. Statistical analysis

We used Chi-square or Wilcoxon test, as appropriate, to compare the characteristics for the dichotomies effectiveness and satisfaction with treatment. Two logistic regression models were performed. Effectiveness and procedure satisfaction served as dependent variables and age, weight, parity, hemoglobin level, duration of symptoms, duration of the procedure and time elapsed from the procedure were entered as covariates. $P < 0.05$ was considered a significant result. All statistical analyses were performed with SAS 9.1 (SAS Institute, Cary, NC).

3. Results

A total of 255 premenopausal women were eligible for the study. Patients' characteristics are summarized in Table 1. Mean age was 44.9 ± 3.8 years, and mean duration of menorrhagia complaints was 16.9 ± 11.2 months. Prior hormone treatment to regulate bleeding had been prescribed in 44% ($n = 112$) of women without satisfactory outcome. Anemia with hemoglobin below 12 g% was diagnosed in 34% of the women and 9.4% had a hemoglobin level below 10 gm%. All cases had a final histological diagnosis of small endometrial polyp.

Two hundred and twenty-nine women responded to the telephone interview. Subjective improvement in magnitude of bleeding was reported by 70% ($n = 160$) of women, but only 26% ($n = 59$) experienced return to regular menses. Additionally, 80% ($n = 183$) of the subjects reported satisfaction with the procedure. Fewer than 5% of the patients experienced substantial pain following the procedure, and only 18% ($n = 42$) remained overnight in the hospital. No serious complications were recorded. Six women suffered minor complications, such as transient fever, pelvic inflammatory disease, cervical laceration and false route.

A univariate logistic regression model comparing the subgroups of women reporting improvement in the magnitude of menstrual bleeding (favorable outcome) vs. those reporting a lack of change (failed outcome) for the following parameters: age, parity, weight, pre-procedure hemoglobin level, duration of symptoms, duration of the procedure and time elapsed from operative hysteroscopy to interview, revealed that patient age and parity differed significantly between the groups (Table 2). When

Table 1
Baseline characteristics of the study cohort.

	Mean \pm SD	Median	Range
Age (years)	44.9 \pm 3.8	46	29–53
Parity	3.7 \pm 1.7	4	0–12
Weight (kg)	62.8 \pm 7.9	62	46–89
Duration of symptoms (months)	16.9 \pm 11.2	12	4–60
Hemoglobin level at time of procedure (g%)	11 \pm 1.3	11.1	6–14.4
Duration of procedure (min)	25.8 \pm 6.4	25	14–55
Time elapsed between procedure and interview (months)	8.3 \pm 1.8	8	6–14

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