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Research Article

**A CROSS SECTIONAL STUDY ON THE SYMPTOMS OF
UTERINE POLYPS AND VARIATIONS IN SIZE AND SHAPES**

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Abstract:

Objective: In this research, our objective was to determine an association between clinical signs, size and location of uterine polyps.

Methodology: Our cross-sectional design research was completed at Mayo Hospital Lahore. We evaluated all the patients who experienced office hysteroscopy and also diagnosed polyp through hysteroscopic assessment. These patients formed the research population as we assessed them for hysteroscopic outcomes such as polyp's location, size and various other clinical presentations like AUB (Abnormal Uterine Bleeding), infertility, dysmenorrhea, discharge and discharge and spotting.

Results: We evaluated 124 patients who experienced office hysteroscopy and also diagnosed polyp through hysteroscopic assessment. The polyp was commonly located at two sights which include AUB and cervical canal with various clinical features; moreover, cornea and cervical canal had a polyp size of (≤ 1) centimetres. On the other hand, the reported size of polyp near internal os and the uterine cavity was (> 1) centimetres.

Conclusion: It is reported in the outcomes of the research paper that the important factor of polyp which cannot be neglected as its location. The polyp was mostly found in the area of the uterine cavity in the patients diagnosed with AUB; whereas, it was reported in the cervical canal in the patients who experienced discharge and spotting.

Keywords: Polyp, Curettage, Asymptomatic, Postmenopausal Bleeding, Menstrual Cycle, Coexists, Transvaginal Sonography.

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INTRODUCTION:

Endometrial polyp results in the shape of metrorrhagia and menorrhagia; furthermore, it has an association with the incidence of dysmenorrhea which is reported by an author [1]. The diagnosis of the uterine polyp is possible through microscopic evaluation whether through biopsy obtained tissue in curettage specimen or in an office. On the other hand, it may also be evaluated through visualization whether son-hysterography or hysteroscopy. An asymptomatic cervical polyp may result in the form of an intermenstrual bleeding, heavy menses, postcoital bleeding, vaginal discharge and postmenopausal bleeding. Additionally, about 25% of cervical polyp cases also present an associated endometrial polyp which coexists. Therefore, the evaluation of the endometrial cavity becomes mandatory in such cases.

There is a relation of the endometrial polyp with a reduced length of the menstrual cycle, reduced parity and endometriosis [2]. Abnormal bleeding is a result of large polyp sizes which is difficult to manage and causes blood loss in the patients. A normal transvaginal sonography misses about 21% of the lesions can possibly be managed through the guidelines of the hysteroscopy either performed at local anaesthesia or at a locally available clinic [3]. Information obtained through hysteroscopic diagnostic is not possible through blind endometrial specimen selection which includes submucous leiomyomas or endometrial polyp detection [4, 5]. There is a proved superior specificity (95%) and sensitivity (100%) of the office hysteroscopy for endometrial cavity evaluation [6]. An author reported 33% polyps in symptomatic premenopausal women who were above the age of twenty-nine years and also underwent the incidence of an abnormal act of bleeding than other asymptomatic women (10%) [7]. In this research, our objective was to determine an association between clinical signs, size and location of uterine polyps.

METHODOLOGY:

Our cross-sectional design research was completed at Mayo Hospital Lahore. We evaluated all the patients

who experienced office hysteroscopy and also diagnosed polyp through hysteroscopic assessment. These patients formed the research population as we assessed them for hysteroscopic outcomes such as polyp's location, size and various other clinical presentations like AUB (Abnormal Uterine Bleeding), infertility, dysmenorrhea, discharge and spotting. The polyp was commonly located at two sights which include AUB and cervical canal with various clinical features; moreover, cornea and cervical canal had a polyp size of (≤ 1) centimetres. On the other hand, the reported size of polyp near internal os and the uterine cavity was (> 1) centimetres. Outcomes were analyzed through SPSS software. We also used the STORZ Hysteroscopic model, 26153 BI (sheet), 26153 BO (outer sheet), 26120 BA (lens) and thirty degrees. Media was selected as normal saline in this series.

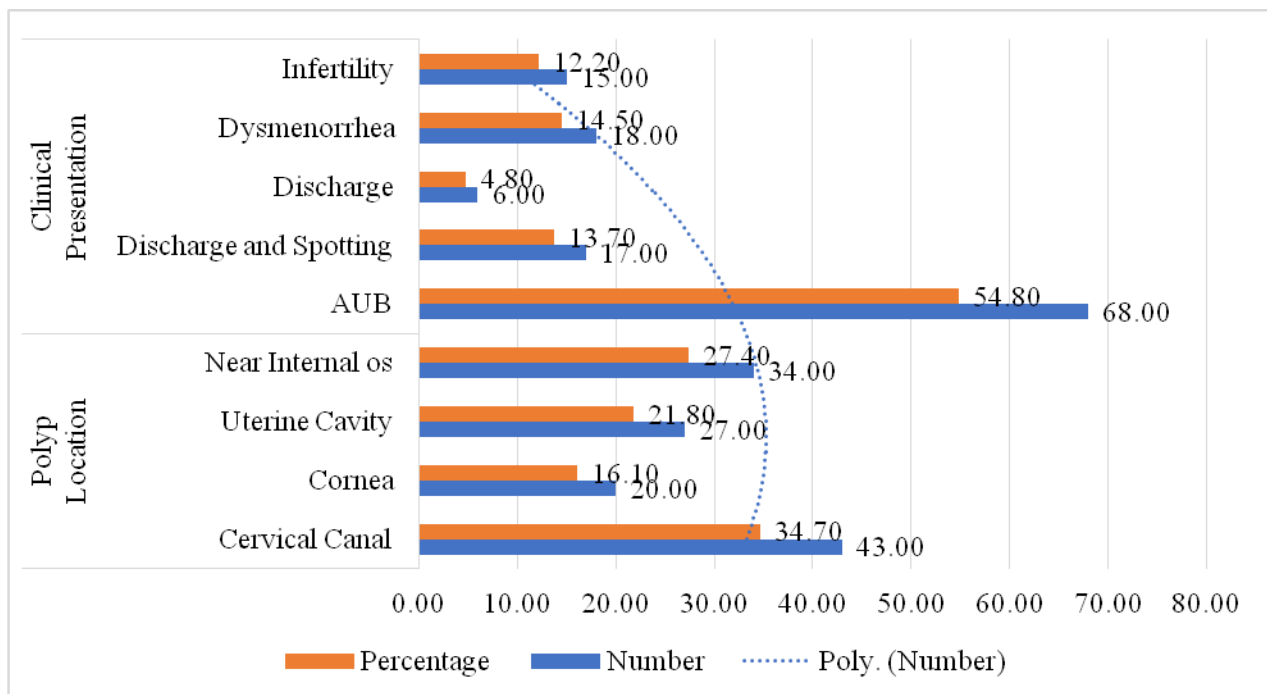
RESULTS:

We evaluated 124 patients who experienced office hysteroscopy and also diagnosed polyp through hysteroscopic assessment. The age bracket for this research ranged from 22 years to 55 years of age with a mean age of thirty-seven years. The polyp was commonly located at two sights which include AUB (54.8%) and cervical canal with various clinical features; moreover, cornea and cervical canal had a polyp size of (≤ 1) centimetres. On the other hand, the reported size of polyp near internal os and the uterine cavity was (> 1) centimetres.

Mostly polyp was located at uterine cavity (39.7%) in AUB patients. All the patients also suffered due to dysmenorrhea were not reported for polyp at the uterine cavity. Sixty percent polyp was located in Cornea among the infertile patients; whereas, among the patients suffering from discharge plus spotting and discharge were reported at cervical canal having respective proportions of 94.1% and 100% (polyp location). A detailed outcomes analysis of the polyp clinical presentation, location and size are given in Table – I, II, III & IV. Outcomes are presented in percentage; whereas, the polyp size is presented in centimetres.

Table – I: Polyp Location and Clinical Presentation

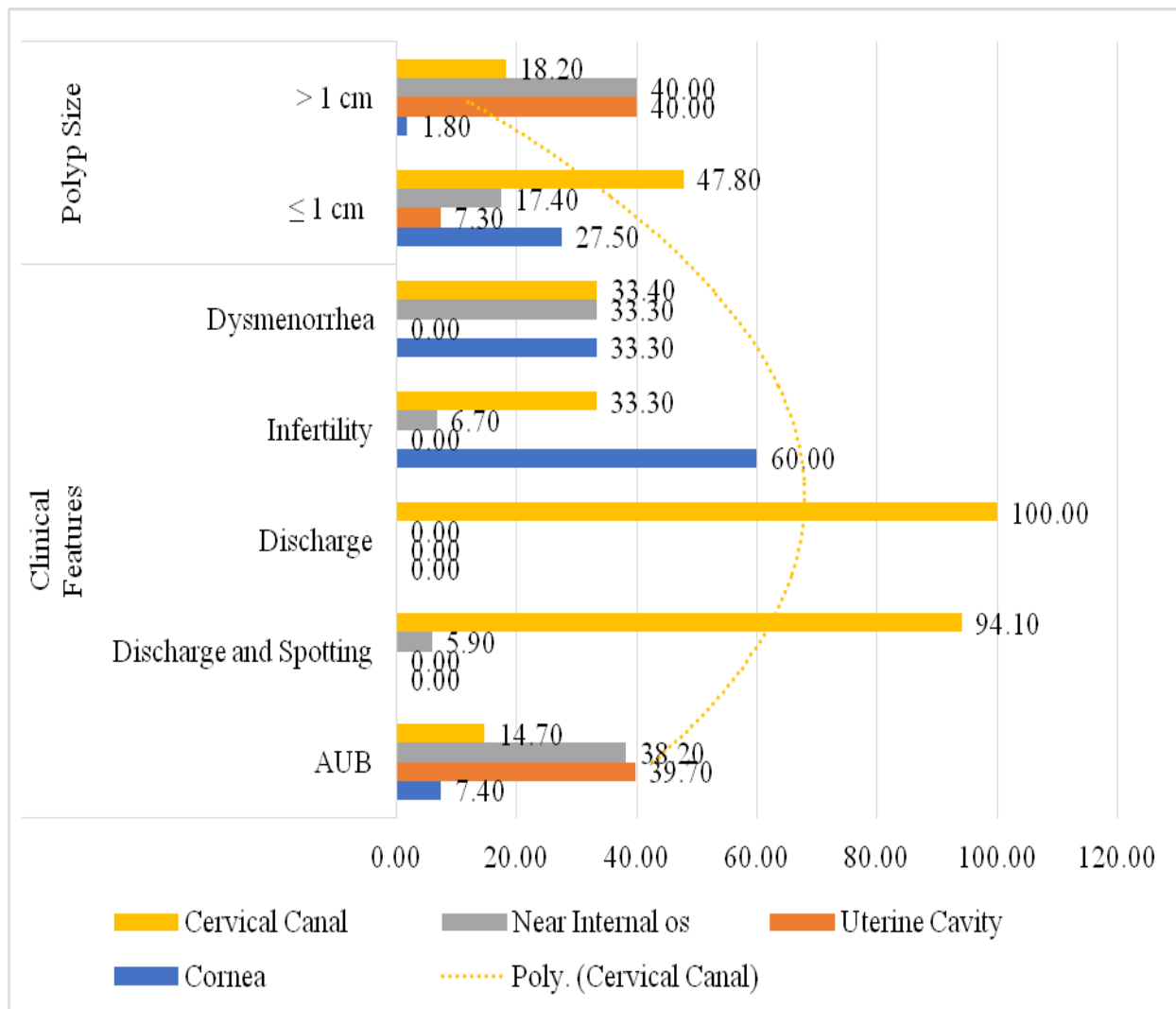
Details		Number	Percentage
Polyp Location	Cervical Canal	43.00	34.70
	Cornea	20.00	16.10
	Uterine Cavity	27.00	21.80
	Near Internal os	34.00	27.40
Clinical Presentation	AUB	68.00	54.80
	Discharge and Spotting	17.00	13.70
	Discharge	6.00	4.80
	Dysmenorrhea	18.00	14.50
	Infertility	15.00	12.20



Polyp location was reported at Cervical Canal, Cornea, Uterine Cavity and Near Internal os with a respective number of 43, 20, 27 and 34 patients and respective proportion in the total population as 34.70%, 16.10%, 21.80% and 27.40% respectively (Table – I). Clinical presentation was AUB, Discharge plus Spotting, Discharge, Dysmenorrhea and Infertility reported in respectively 68, 17, 6, 18 and 15 patients with the respective proportion of 54.80%, 13.70%, 4.80%, 14.50% and 12.20% (Table – I).

Table – II: Polyps Clinical Location and Size Percentage

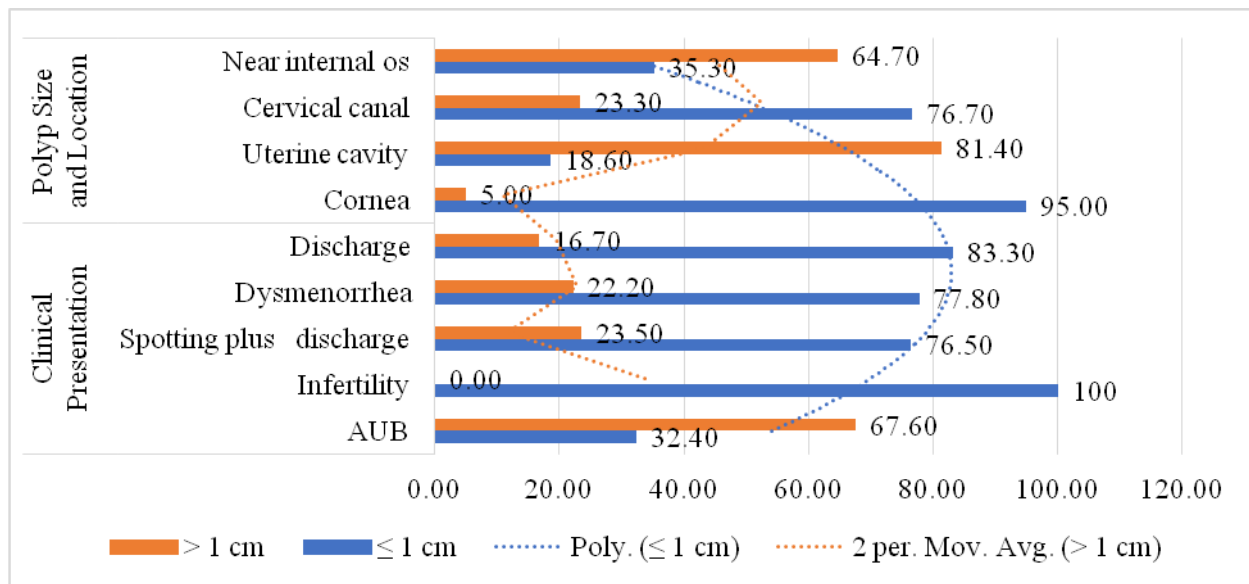
Details		Cornea	Uterine Cavity	Near Internal os	Cervical Canal
Clinical Features	AUB	7.40	39.70	38.20	14.70
	Discharge and Spotting	0.00	0.00	5.90	94.10
	Discharge	0.00	0.00	0.00	100.00
	Infertility	60.00	0.00	6.70	33.30
	Dysmenorrhea	33.30	0.00	33.30	33.40
Polyp Size	≤ 1 cm	27.50	7.30	17.40	47.80
	> 1 cm	1.80	40.00	40.00	18.20



Clinical features of AUB, Discharge plus Spotting, Discharge, Infertility and Dysmenorrhea were reported at various sites of the cornea, uterine cavity, cervical canal and neat internal os. Polyp size of ≤ 1 and > 1 centimetres was also reported at various sites of the cornea, uterine cavity, cervical canal and neat internal os (Table – II).

Table – III: Polyp Location, Size and Clinical Presentation Frequency

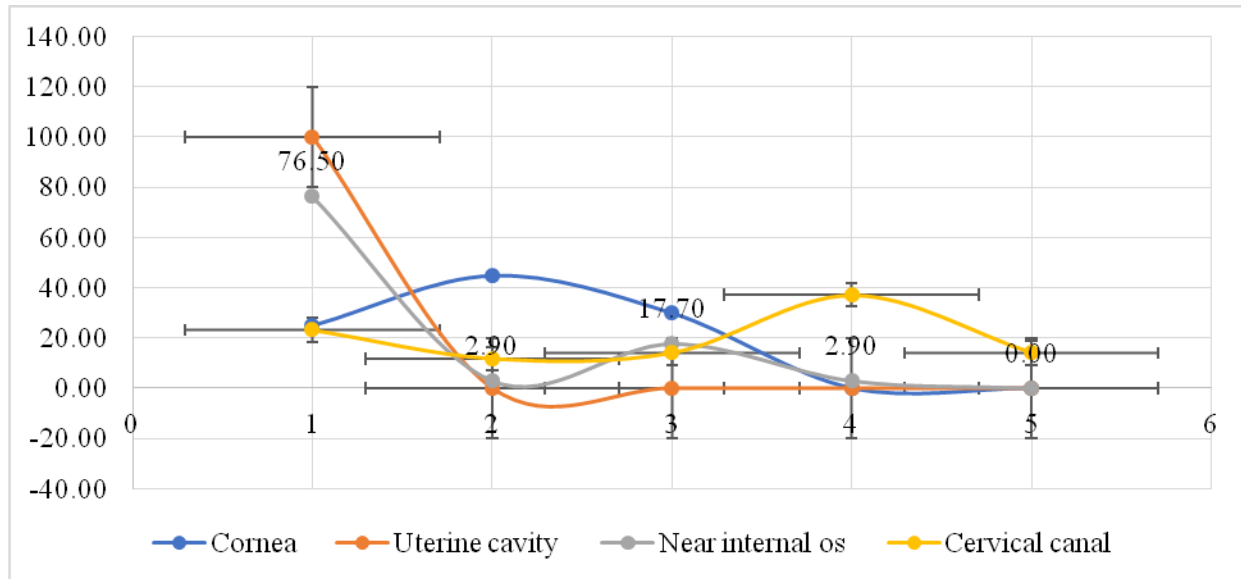
Details		≤ 1 cm	> 1 cm
Clinical Presentation	AUB	32.40	67.60
	Infertility	100	0.00
	Discharge and Spotting	76.50	23.50
	Dysmenorrhea	77.80	22.20
	Discharge	83.30	16.70
Polyp Size and Location	Cornea	95.00	5.00
	Uterine cavity	18.60	81.40
	Cervical canal	76.70	23.30
	Near internal os	35.30	64.70



Clinical presentation of AUB, Infertility, Discharge plus Spotting and Discharge was reported with a polyp size of ≤ 1 centimeter in 32.40%, 100%, 76.50%, 77.80% and 83.30% patients respectively; whereas, a polyp size of > 1 centimeters was respectively reported in 67.60%, 0.00%, 23.50%, 22.20% and 16.70% patients (Table – III). Location wise polyp size was reported ≤ 1 centimeter at cornea, uterine cavity, cervical canal and near internal os in 95.00%, 18.60%, 76.70% and 35.30% patients; whereas, a size of > 1 centimeters among 5.00%, 81.40%, 23.30% and 64.70% patients (Table – III).

Table – IV: Polyp Location Percentage

Polyp Location	AUB	Infertility	Dysmenorrhea	Discharge and Spotting	Discharge
Cornea	25.00	45.00	30.00	0.00	0.00
Uterine cavity	100	0.00	0.00	0.00	0.00
Near internal os	76.50	2.90	17.70	2.90	0.00
Cervical canal	23.20	11.60	14.00	37.20	14.00



Polyp location at the cornea, uterine cavity, near internal os and the cervical canal, was also reported in AUB, infertile, dysmenorrhea, discharge plus spotting and discharge patients respectively as given in Table – IV.

DISCUSSION:

Our research reports the polyp location as the most important clinical investigative feature. Polyp was located in AUB patients near internal os and uterine cavity with a respective proportion of 38.2% and 39.7%; whereas, in the patients of dysmenorrhea it was reported at cornea, near internal os and cervical canal with respective proportions of 33.3%, 33.3% and 33.4%; which is almost equal in presentation. Infertile, discharge and discharge plus spotting patients reported polyp respectively at the cornea, cervical canal and again cervical canal with their respective proportions of 60%, 100% and 94.1%.

We also reported that symptomatic cervical polyps caused postcoital bleeding, intermenstrual bleeding, heavy menses, vaginal discharge and post-menopausal bleeding. Hysteroscopy can best determine the size, number and location of cervical polyps [8]. Abnormal bleeding was reported because of the larger polyp sizes as observed in another series [9]. Another author reports that we may miss AUB patients for cervical canal polyps through a diagnosis of transvaginal sonography; whereas, better outcomes can be obtained through hysteroscopic diagnostics which is same as reported in our research outcomes [3].

An author reported 33% polyps in symptomatic premenopausal women who were above the age of twenty-nine years and also underwent the incidence

of an abnormal act of bleeding than other asymptomatic women (10%) [7]. Another author reported that asymptomatic women experienced a recurrence of sonohysterography after a period of two and a half years with 4 out of 7 polyps resolved in these patients [9]. A separate research can best evaluate the clinical features, size and location of the polyp; so, we aimed to determine an association between clinical signs, size and location of uterine polyps.

With the technological advancements the diagnostic facilities are also improving and more accurate outcomes are possible through high-frequency vaginal ultrasound, office hysteroscopy and saline infusion sonography in even very small uterine polyps. A previous association between AUB and uterine polyps is also existent but there are more symptoms and causes of the polyps which include discharge, dysmenorrhea and infertility. AUB is more troublesome than other minor signs. These signs are also occasionally overlooked during the diagnostic process.

CONCLUSION:

It is reported in the outcomes of the research paper that the important factor of polyp which cannot be neglected as its location. The polyp was mostly found in the area of the uterine cavity in the patients diagnosed with AUB; whereas, it was reported in the cervical canal in the patients who experienced

discharge and spotting.

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