Endometrial polyps

Approved by The Norwegian Society of Obstetrics and Gynecology in 2015

Recommendations

- Instillation of saline into the uterine cavity (hydrosonography) is recommended when intrauterine pathology such as endometrial polys are suspected during transvaginal ultrasound examination in women with abnormal vaginal bleeding, infertile women and postmenopausal women.
- Endometrial polyps should be removed in symptomatic women, infertile women and women who have an increased risk of endometrial malignancy.
- Endometrial polyps should be removed by transcervical resection (hysteroscopy). Curettage is not recommended for removal of endometrial polyps.
- Preoperative treatment using local estradiol reduces the risk of complications during transcervical resection of endometrial polyps in postmenopausal women

Strategy of literature search

A literature search was performed using the words ”endometrial polyp” in PubMed, Medline and The Cochrane Library (including the Cochrane Database of Systematic Reviews) and Up to Date (www.uptodate.com).
A search using the words ”endometrial polyp” was also performed in guidelines at Royal College of Obstetrics and Gynaecology (www.rcog.org.uk), American College of Obstetrics and Gynecology (www.ACOG.org) and American Association of Gynecologic Laparoscopy (www.aagl.org).

Definition

Endometrial polyps are localized tumors within the mucosa of the uterine cavity. Endometrial polyps may be pediculate or sessile, and the size may vary from a few millimeters to 3-4 centimeters.

Occurrence

Endometrial polyps are common findings, both in women with and without gynaecological symptoms. The prevalence of endometrial polyps is reported to be 7.8 % - 34.9 % depending on the population studied. In two Scandinavian studies, the prevalence of endometrial polyps were 8 % and 12 %, respectively.[1,2]

Symptoms

Most endometrial polyps are asymptomatic. Symptomatic premenopausal women with endometrial polyps most commonly suffer from abnormal uterine bleeding (inter-menstrual bleedings/spotting and/or menorrhagia). Previous studies have reported that the prevalence of endometrial polyps is increased in infertile women, and the results of a randomized controlled trial indicates that removal of endometrial polyps may improve fertility in infertile women. [3,4] Postmenopausal

bleeding is the most common symptom of endometrial polyps in postmenopausal women.

Aetiology/pathogenesis

The aetiology and pathogenesis of endometrial polyps is unknown. Endometrial polyps are commonly benign. The occurrence of malignant endometrial polyp varies with the population studied, and are reported to be up to 13 %.[5] Postmenopausal women with symptomatic polyps (postmenopausal bleeding) carry the highest risk of malignant endometrial polyp.[5]

Risk factors

- Increasing age (the prevalence increases with age in the reproductive age, it is not known whether the prevalence increases with age in postmenopausal women).
- Obesity
- Use of Tamoxifen
- Hypertension
- A possible association between endometrial polyps and other benign gynaecological conditions such as fibroids, cervical polyps and endometriosis has been reported.

Examinations

Endometrial polyps are diagnosed by transvaginal ultrasound examination, by hysteroscopy or by histological examination. Installation of saline in the uterine cavity increase the sensibility of the examination and is recommended when the occurrence of endometrial polyp is suspected based on ultrasonic findings in women with abnormal uterine bleeding, infertile women and in postmenopausal women.[6] Women with postmenopausal bleeding should be examined within 4 weeks because of a relatively high risk of endometrial cancer (5-10 %). (Please see the guideline entitled ”Postmenopausal bleeding”).

Differential diagnosis

Submuceous fibroids.

Treatment

Indications of treatment of women with endometrial polyps are:

- Symptomatic endometrial polyp (most commonly abnormal uterine bleeding)
- Obesity
- Infertility
- In order to exclude malignancy

About 25 % of all endometrial polyps regress spontaneously.[2,7] Small polyps (< 10 mm) are more likely to regress spontaneously compared to larger polyps. Consequently, small polyps in asymptomatic women without increased risk of malignancy may be left untreated. The risk of malignant endometrial polyp is highest in women with postmenopausal bleeding and in asymptomatic postmenopausal

women with larger polyps and other known risk factors for endometrial cancer.[5,6]

Endometrial polyps should be removed by transcervical resection (hysteroscopy).[6]
Treatment of endometrial polyps by curettage is not recommended as the risk of leaving the polyp behind is relatively large.[8]
Transcervical resection of endometrial polyps is effective in women suffering from spotting/inter-menstrual bleedings and postmenopausal bleeding.[5] In women with endometrial polyps and menorrhagia, a concomitant resection of the endometrium in perimenopausal women should be considered in order to reduce periodic blood loss and the risk of recurrent menorrhagia.[9]
When atypical hyperplasia or malignancy is diagnosen by histopathological examination within an endometrial polyp, the woman should be treated in accordance with the guidelines for treatment of atypical endometrial hyperplasia or endometrial cancer, respectively.

Complications

Complications during transcervical resection of endometrial polyps is most frequently related to the dilatation of the cervix in nulliparous and postmenopausal women. Preoperative treatment with local oestradiol is recommended in order to reduce the risk of such complications in postmenopausal women.[10]

References

1. Dreisler E, Stampe Sorensen S, Ibsen PH et al. Prevalence of endometrial polyps and abnormal uterine bleeding in a Danish population aged 20-74 years. Ultrasound Obstet Gynecol. 2009; 33:102–108.

2. Lieng M, Istre O, Sandvik L, Qvigstad E. Prevalence, 1-year regression rate, and clinical significance of asymptomatic endometrial polyps: cross-sectional study. J Minim Invasive Gynecol. 2009; 16:465–471.

3. Hinckley MD, Milki AA. 1000 office-based hysteroscopies prior to in vitro fertilization: feasibility and findings. JSLS 2004; 8:103–107.

4. Perez-Medina T, Bajo-Arenas J, Salazar F et al. Endometrial polyps and their implication in the pregnancy rates of patients undergoing intrauterine insemination: a prospective, randomized study. Hum Reprod 2005; 20:1632–1635.

5. Lieng M, Istre O, Qvigstad E. Treatment of endometrial polyps: a systematic review. Acta Obstet Gynecol Scand. 2010; 89:992–1002.

6. AAGL Practice Report: Practice Guidelines for the Diagnosis and Management of Endometrial Polyps. J Minim Invasive Gynecol. 2012; 19:3-10.

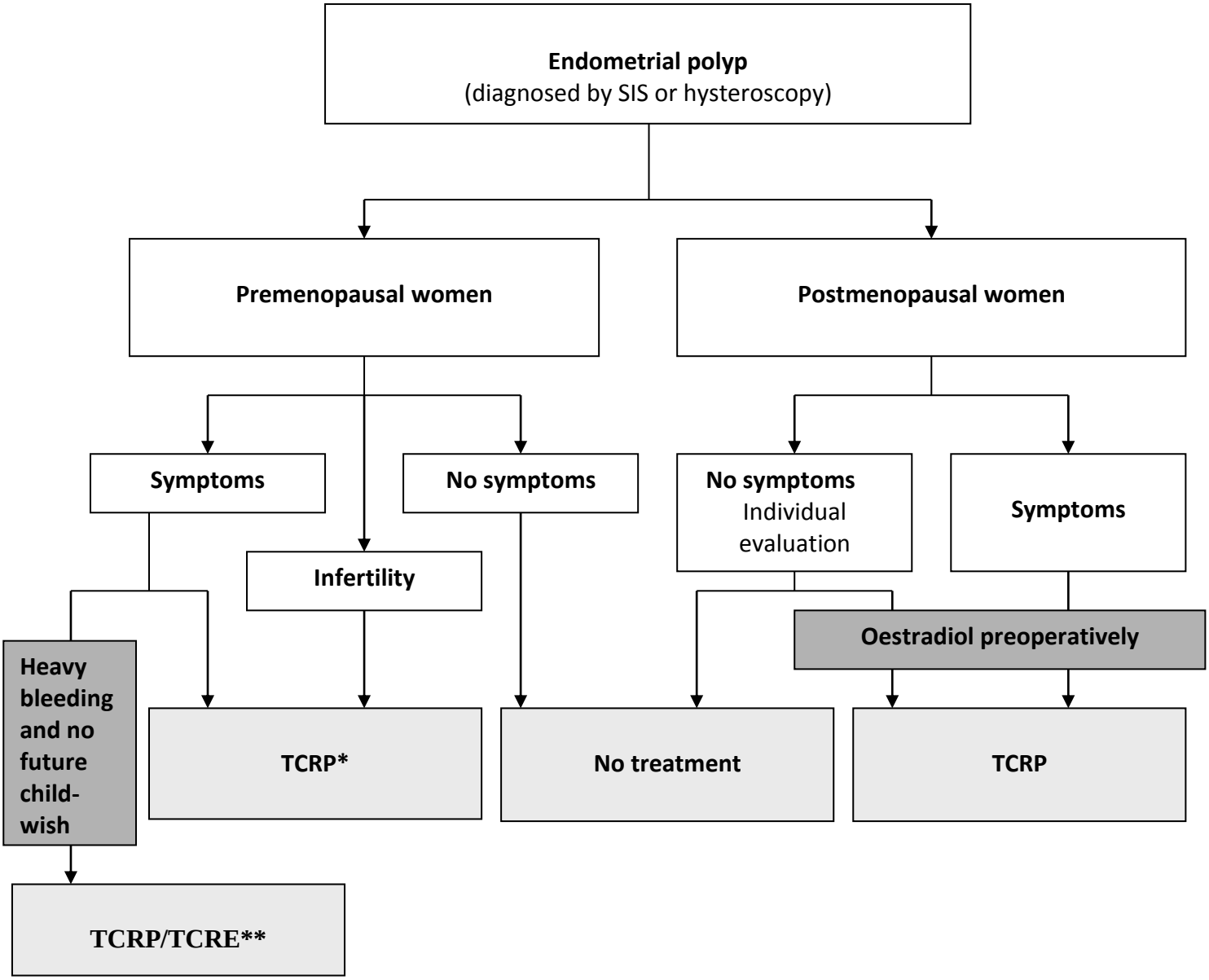
7. DeWaay DJ, Syrop CH, Nygaard, IE, et al. Natural history of uterine polyps and leiomyomata. Obstet Gynecol. 2002; 100:3-7.

8. Bettocchi S, Ceci O, Vicino M, et al. Diagnostic inadequacy of dilatation and curettage. Fertil Steril. 2001; 75:803–805.

9. Lieng M, Istre O, Sandvik L, et al. Clinical effectiveness of transcervical polyp resection in women with endometrial polyps: randomized controlled trial. J Minim Invasive Gynecol. 2010; 17:351–357.

10. Oppegaard KS, Nesheim BI, Istre O et al. Comparison of self-administered vaginal misoprostol versus placebo for cervical ripening prior to operative hysteroscopy using a sequential trial design. Br J Obstet Gynaecol. 2008;115:663,e1-e9.

Flowsheet of Endometrial polyps



*TCRP: transcervical resection of polyp
**TCRE: Transcervical resection of endomtrium

The original Norwegian guideline

Endometriepolypp

Marit Lieng

Anbefalinger

- Installasjon av saltvann i livmorhulen (væskesonografi) anbefales ved mistanke om endometriepolypp ved transvaginal ultralydundersøkelse hos kvinner med blødningsforstyrrelse, infertile og postmenopausale kvinner
- Endometriepolypper anbefales fjernet hos kvinner med symptomer, hos infertile og hos kvinner med øket risiko for malignitet
- Endometriepolypper anbefales fjernet ved transcervical reseksjon (hysteroskopi). Abrasio anbefales ikke for fjerning av endometriepolypper.
- Forbehandling med lokal estradiol reduserer risiko for komplikasjoner ved transcervical reseksjon av endometriereseksjon hos postmenopausale kvinner

ICD 10 kode

N94.0 Endometriepolypp

Søkestrategi

Litteratursøk med søkeord ”endometrial polyp” i PubMed, Medline og The Cochrane Library (inkludert the Cochrane Database of Systematic Reviews) og Up to Date (www.uptodate.com).
Søkeord ”endometrial polyp” i guidelines hos Royal College of Obstetrics and Gynaecology (www.rcog.org.uk), American College of Obstetrics and Gynecology (www.ACOG.org) og American Association of Gynecologic Laparoscopy (www.aagl.org).

Definisjon

Endometriepolypper er lokaliserte tumores i livmorslimhinnen i livmorhulen. En endometriepolypp kan være stilket eller ha en bred base og størrelsen kan variere fra få millimeter til flere centimeter.

Forekomst

Endometriepolypp er en vanlig gynekologisk tilstand, og insidensen er ukjent siden mange kvinner med endometripolypp er uten gynekologiske plager/symptomer. Prevalensen av endometriepolypp er rapportert å være 7.8 % - 34.9 % avhengig av studiepopulasjonen. I to skandinaviske studier var prevalensen av endometriepolypp 8 % og 12 % (II).[1,2]

Symptomer

De fleste endometriepolypper er asymptomatiske. Hos premenopausale kvinner gir endometriepolypper vanligvis symptomer i form av blødningsforstyrrelser (intermenstruelle blødninger/spotting og/eller monorrhagi) (II). Studier tyder på at forekomsten av endometriepolypp er øket hos kvinner med infertilitet, og resultatet

av en randomisert studie har vist at fjerning av endometriepolypp kan bedre feritiliteten hos infertile (II). [3,4] Hos postmenopausale kvinner er postmenopausal blødning det vanligste symptomet på endometriepolypp.

Etiologi/patogenese

Endometriepolyppers etiologi og patogenese er lite kjent.
Endometriepolypper er oftest benigne. Forekomsten av malign endometriepolypp varierer med studiepopulasjonen og oppgis i litteraturen å være opp til 13 %.[5]
Postmenopausale kvinner med symptomer (postmenopausal blødning) har størst risiko for malign endometriepolypp (II).[5]

Risikofaktorer

- Økende alder (prevalensen øker med økende alder i reproduktiv alder, det er usikkert om prevalensen øker med økende alder etter menopause).
- Overvekt
- Tamoxifenbruk
- Hypertensjon
- Mulig assosiasjon mellom forekomst av andre godartede gynekologiske tilstander (myom, cervixpolypp og endometriose) og endometriepolypp

Utredning

Endometriepolypper diagnostiseres ved transvaginal ultralydundersøkelse, hysteroskopi eller histologisk undersøkelse. Installasjon av saltvann i livmorhulen (væskesonografi) anbefales ved mistanke om endometriepolypp ved transvaginal ultralydundersøkelse hos kvinner med blødningsforstyrrelse, infertile og postmenopausale kvinner (II).[6]
Kvinner med postmenopausal blødning bør undersøkes innen 4 uker på grunn av høy risiko for endometriecancer (5-10 %) (se kapitelet ”Postmenopausal blødning” i veilederen).

Differensialdiagnose

Submukøst myom

Behandling

Indikasjoner for behandling av kvinner med endometriepolypp:

- Symptomatisk endometriepolypp (vanligvis blødningsforstyrrelser)
- Overvekt
- Infertilitet
- Utelukkelse av malignitet

Omlag 25 % av endometriepolyppene går tilbake spontant (II).[2,7] Det er størst sannsynlighet for spontan regress av små polypper (< 10 mm). Følgelig kan man avstå fra behandling ved påvisning av endometriepolypp hos asymptomatiske kvinner uten økt risiko for malignitet.
Risiko for malignitet er høyest hos postmenopausale kvinner med blødning og hos asymptomatiske postmenopausale kvinner med stor polypp og andre risikofaktorer for endometriecancer (se Veileder i Gynekologisk Onkologi) (II).[5,6]

Endometriepolypper anbefales fjernet ved transcervical reseksjon (hysteroskopi) (II).[6] Fjerning av endometriepolypp ved abrasio anbefales ikke da det er stor risiko for at man ikke får fjernet polyppen (II).[8]
Transcervical reseksjon av endometriepolypp har god effekt på symptomene hos kvinner med spotting/intermenstruelle blødninger og postmenopausal blødning (II).[5]
Ved menorrhagi og endometriepolypp bør samtidig endometriereseksjon vurderes hos perimenopausale kvinner for bedre blødningsreduksjon og mindre risiko for vedvarende eller tilbakevendende menorrhagi (II).[9]
Ved histologisk påvist atypisk hyperplasi eller malignitet hos kvinne med endometriepolypp, se kapitlet "Endometriehyperplasi" i veilederen eller Veileder i gynekologisk onkologi (endometriecancer).

Komplikasjoner

De vanligste komplikasjonene ved transcervical reseksjon av endometriepolypp er knyttet til dilatasjonen av cervix hos nullipara og postmenopausale kvinner (II). Forbehandling med lokal estradiol anbefales for å redusere risiko for slike komplikasjoner hos postmenopausale kvinner (II).[10]

Referanser

1. Dreisler E, Stampe Sorensen S, Ibsen PH et al. Prevalence of endometrial polyps and abnormal uterine bleeding in a Danish population aged 20-74 years. Ultrasound Obstet Gynecol. 2009; 33:102–108.

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