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Original Research Article

Hysteroscopic evaluation and analysis of uterine cavity: a retrospective institutional study

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ABSTRACT

Background: Hysteroscopy provides direct visualization of the cervical canal and uterine cavity and is widely used for the diagnosis and management of intrauterine abnormalities. It allows identification of lesions such as endometrial polyps, submucosal fibroids, uterine septa, and endometrial hyperplasia, with the advantage of permitting therapeutic intervention when indicated. Objective was to evaluate the hysteroscopic findings among patients undergoing diagnostic or operative hysteroscopy and to assess their relationship with clinical presentation, ultrasonographic findings, and histopathological outcomes.

Methods: This retrospective observational study was conducted in the department of gynecology and obstetrics, Holy Family Red Crescent Medical College and Hospital (HFRCMCH), from July 2024 to June 2026. A total of 32 patients who underwent rigid hysteroscopy were included. Normal saline was used as the uterine distension medium. Data regarding demographic characteristics, clinical indications, ultrasonographic findings, hysteroscopic findings, histopathological results, and procedure-related complications were retrieved from the medical records and analyzed.

Results: Among the 32 patients who underwent hysteroscopy, abnormal intrauterine findings were identified in 29 (90.6%) cases. The largest proportion of patients belonged to the 41-50-year age group (31.3%), and 93.8% were multiparous. Postmenopausal bleeding was the most common indication for hysteroscopy (34.38%). Endometrial polyps were the most frequently identified hysteroscopic abnormality (34.38%). No procedure-related complications were documented during the study period.

Conclusions: In this institutional series, hysteroscopy identified intrauterine abnormalities in the majority of patients and was performed without documented procedure-related complications. The findings support its clinical utility as a minimally invasive method for direct assessment of the uterine cavity in appropriately selected patients.

Keywords: Abnormal uterine bleeding, Endometrial hyperplasia, Endometrial polyp, Intrauterine pathology, Hysteroscopy

INTRODUCTION

Hysteroscopy is a minimally invasive procedure that allows direct visualization of the cervical canal and uterine cavity through a hysteroscope. It has become an important diagnostic and therapeutic tool in modern gynaecological practice because intrauterine abnormalities can be identified directly and, when appropriate, treated during the same procedure. Compared with indirect imaging methods, hysteroscopy provides a direct view of the endometrial cavity and allows targeted assessment of suspected lesions.[1] Over the years, advances in hysteroscopic instruments, optics, and uterine distension techniques have made the procedure safer and more practical in both outpatient and operating-room settings. Normal saline and other low-viscosity distension media are commonly used for diagnostic and operative procedures, particularly with modern bipolar instruments.[2] A systematic examination of the cervical canal and uterine cavity generally includes assessment of the endometrium,

uterine fundus, both tubal ostia, and the anterior, posterior, and lateral walls of the cavity.[3] Abnormal uterine bleeding (AUB) remains one of the most common reasons for gynaecological consultation and is an important indication for hysteroscopic evaluation. The PALM-COEIN classification provides a standardized framework for categorizing the structural and non-structural causes of AUB. Structural causes include endometrial polyps, adenomyosis, leiomyoma, and endometrial hyperplasia or malignancy, while non-structural causes include coagulopathy, ovulatory dysfunction, endometrial disorders, iatrogenic causes, and conditions that are not otherwise classified.[4,5] Endometrial polyps are among the most frequently detected intrauterine abnormalities in women presenting with abnormal uterine bleeding. These focal proliferations of endometrial glands and stroma may occur at different sites within the uterine cavity and can be readily identified during hysteroscopy. Hysteroscopic removal allows the lesion to be treated while providing tissue for histopathological examination.[6,7] Hysteroscopy also has an important role in the evaluation of suspected endometrial hyperplasia and other focal endometrial abnormalities. Direct visualization can help identify areas that appear irregular or suspicious and facilitates targeted biopsy for histopathological assessment.[8] The clinical application of hysteroscopy extends beyond abnormal uterine bleeding. It may be used in the assessment of infertility and recurrent pregnancy loss, particularly when intrauterine adhesions, congenital uterine anomalies, endometrial polyps, or submucosal fibroids are suspected. Intrauterine adhesions, commonly referred to as Asherman's syndrome when associated with the appropriate clinical setting, can be directly visualized and treated hysteroscopically. Hysteroscopy may also facilitate the retrieval of misplaced or embedded intrauterine contraceptive devices.[9,10] This targeted approach may be particularly useful when focal pathology is suspected, as blind endometrial sampling may not adequately represent a localized lesion.[11,12] Despite the increasing use of hysteroscopy, published institutional data describing the spectrum of hysteroscopic findings in Bangladesh remain relatively limited. Available reports from Bangladeshi gynaecological units indicate that a range of intrauterine abnormalities can be identified during diagnostic hysteroscopy, but further institutional documentation is needed to better describe the clinical pattern in local practice.[13-15] HFRCMCH is a tertiary-care center providing comprehensive gynaecological services. This study was conducted to describe hysteroscopic findings and their relationship with clinical and ultrasonographic findings, histopathological results, and procedure-related complications among patients undergoing hysteroscopy at the institution.

Objectives

General objective

To describe the hysteroscopic findings and their relationship with clinical presentation, ultrasonographic findings, and histopathological results among patients undergoing hysteroscopy at the department of gynecology and obstetrics (silver unit), Holy Family Red Crescent Medical College and Hospital (HFRCMCH), Dhaka.

Specific objectives

To describe the demographic and clinical characteristics of patients undergoing hysteroscopy, including age and parity. To identify and classify the hysteroscopic findings, including endometrial polyps, endometrial hyperplasia, submucosal myoma, uterine septum, Cu-T, and normal uterine cavity. To describe the relationship between hysteroscopic findings and the main clinical indications for the procedure, including postmenopausal bleeding, menorrhagia, irregular menstruation, infertility, and missing Cu-T. To compare hysteroscopic findings with available preoperative ultrasonographic and histopathological findings.

METHODS

Study design

This retrospective observational study was conducted in the department of gynecology and obstetrics (silver unit), Holy Family Red Crescent Medical College and Hospital (HFRCMCH), Dhaka. The study included patients who underwent diagnostic and/or operative hysteroscopy between July 2024 and June 2026. A total of 32 eligible cases were identified from the departmental hysteroscopy records.

Sampling formula

Given the retrospective nature of this institutional audit and the fixed study population of all eligible hysteroscopy cases performed during the defined study period, census sampling was employed, with all 32 patients who met inclusion criteria constituting the total study population.

$$n = \frac{Z^2 \times P \times (1 - P)}{d^2}$$

Where:

n = minimum required sample size

Z = standard normal deviate at 95% confidence level =1.96

P = estimated prevalence of abnormal hysteroscopic findings = 0.80 (based on published institutional data)

d = acceptable margin of error =0.139

Data collection and study procedure

Relevant information was obtained from the departmental hysteroscopy register, patient case records, operative

notes, ultrasonography reports, and histopathology reports using a structured data collection form. The recorded variables included age, parity, presenting symptoms, indication for hysteroscopy, preoperative ultrasonographic findings, hysteroscopic findings, histopathological diagnosis where tissue was obtained, procedure duration, and any documented procedural complications. Hysteroscopy was performed in the operating theatre under appropriate anaesthesia by a consultant gynaecologist or under direct consultant supervision. Patients were placed in the lithotomy position, and cervical dilatation was performed when required. A rigid hysteroscope was introduced through the cervical canal, and the uterine cavity was systematically examined, including the endometrium, fundus, and tubal ostia. Abnormal findings were documented, and therapeutic procedures such as removal of identified intrauterine lesions were performed when indicated.

Inclusion criteria

Patients of any age who underwent hysteroscopy during the study period for one or more of the following indications were included: postmenopausal bleeding, menorrhagia or other abnormal menstrual bleeding, irregular menstruation, primary or secondary infertility requiring evaluation of the uterine cavity, missing intrauterine contraceptive device (Cu-T).

Exclusion criteria

Patients were excluded if they had: active heavy uterine bleeding that prevented adequate visualization of the uterine cavity, confirmed cervical or uterine malignancy diagnosed before the planned hysteroscopy, confirmed pregnancy, cervical stenosis preventing safe transcervical insertion of the hysteroscope.

Statistical analysis

Data were coded, entered, and analyzed using IBM SPSS Statistics version 25.0. Categorical variables were summarized using frequencies and percentages. Age, parity, clinical indications, ultrasonographic findings, hysteroscopic findings, and histopathological diagnoses were presented descriptively. The relationship between ultrasonographic and hysteroscopic findings was assessed descriptively according to the available records.

Ethical considerations

Ethical approval was obtained from the ethics review committee of HFRCMCH before data collection. The study was conducted in accordance with the principles of the Declaration of Helsinki. As this was a retrospective review of existing clinical records without direct patient contact or additional intervention, individual informed consent was waived in accordance with the institutional requirements for retrospective studies. Patient information was kept confidential and analyzed in an anonymized form.

RESULTS

Table 1 shows that the 41-50-year age group was the most frequently represented category (31.3%), followed by 51-60 years (25.0%). Multipara patients constituted a substantial majority of 93.8%, with nullipara representing only 6.2%. Abnormal intrauterine pathology was identified in 90.6% of all procedures (29 of 32 cases), with only 3 cases (9.4%) demonstrating a macroscopically normal uterine cavity on hysteroscopic examination.

Table 1: Age distribution, parity and hysteroscopic cavity status of study population (n=32).

Variables	Category	Frequency	Percentage
Age group (years)	20-30	3	9.4
	31-40	7	21.9
	41-50	10	31.3
	51-60	8	25.0
	61-70	4	12.5
Parity	Multipara	30	93.8
	Nullipara	2	6.2
Hysteroscopic cavity status	Normal uterine cavity	3	9.4
	Abnormal pathology identified	29	90.6

Table 2: Clinical indications for hysteroscopy distribution by presenting complaint (n=32).

Clinical Indication	Sub-category	Frequency	Percentage
Abnormal Uterine Bleeding (AUB)	Postmenopausal bleeding (PMB)	11	34.38
	Irregular menstruation	8	25.0
	Menorrhagia	7	21.9
Missing Cu-T		4	12.5
Infertility (primary/secondary)		2	6.25

Table 2 shows that abnormal uterine bleeding in its various clinical manifestations was the predominant indication for hysteroscopy, collectively accounting for 81.28% of all procedures, with postmenopausal bleeding constituting the single most frequent individual indication (34.38%), followed by irregular menstruation (25.0%) and menorrhagia (21.9%). Missing intrauterine contraceptive device (Cu-T) accounted for 12.5% of procedures, infertility evaluation represented 6.25% of indications.

Table 3: preoperative ultrasonographic findings among study population (n=32).

Ultrasonographic finding	Frequency	Percentage
Thickened endometrium	9	28.125
Endometrial polyp	8	25.0
Thickened endometrium with cystic hyperplasia	4	12.5
Cu-T in situ	4	12.5
Cervical polyp	3	9.375
Fibroid (submucosal/ intracavitary)	2	6.25
Normal ultrasound	2	6.25

Table 3 shows that, present either as isolated thickened endometrium (28.125%) or in combination with cystic hyperplastic changes (12.5%), collectively representing 40.625% of all ultrasonographic findings. Endometrial polyp was the second most common ultrasonographic diagnosis (25.0%). Cu-T visualization was documented in 12.5% of patients, correlating with the missing Cu-T indication group, while cervical polyp (9.375%) and fibroid (6.25%) were also identified, Importantly, 6.25% of patients demonstrated a normal preoperative ultrasound despite a clinical indication for hysteroscopy.

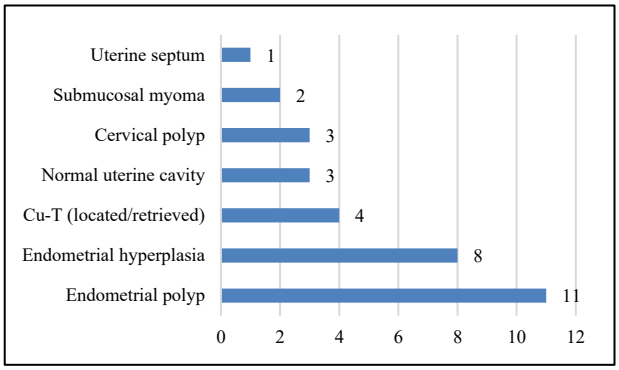


Figure 1: Hysteroscopic findings distribution (n=32).

Figure 1 shows that endometrial polyp was the most frequently identified hysteroscopic pathology, accounting for 34.38% of all procedures (n=11). Endometrial hyperplasia was the second most prevalent finding (25.0%, n=8). Confirming 100% retrieval success and validating hysteroscopy as the definitive management modality for missing contraceptive devices. Normal uterine cavity and cervical polyp were each identified in 9.375% of cases, while submucosal myoma (6.25%) and uterine septum (3.125%).

Table 4: Correlation between clinical indication and hysteroscopic finding (n=32).

Clinical indications	Most frequent hysteroscopic finding	N	%
Postmenopausal bleeding (n=11)	Endometrial hyperplasia	5	45.5
	Endometrial polyp	4	36.4
	Normal cavity	2	18.2
Irregular menstruation (n=8)	Endometrial polyp	5	62.5
	Endometrial hyperplasia	2	25.0
	Cervical polyp	1	12.5
Menorrhagia (n=7)	Endometrial polyp	2	28.6
	Submucosal myoma	2	28.6
	Cervical polyp	2	28.6
	Normal cavity	1	14.3
Missing Cu-T (n=4)	Cu-T located	4	100.0
Infertility (n=2)	Uterine septum	1	50.0
	Endometrial polyp	1	50.0

Table 4 presents the most frequent hysteroscopic findings according to clinical indication. Among 11 patients with postmenopausal bleeding, endometrial hyperplasia was the most common finding (5, 45.5%), followed by endometrial polyp (4, 36.4%) and a normal cavity (2, 18.2%). Among 8 patients with irregular menstruation, endometrial polyp was predominant (5, 62.5%), followed by endometrial hyperplasia (2, 25.0%) and cervical polyp (1, 12.5%). In 7 patients with menorrhagia, endometrial polyp, submucosal myoma, and cervical polyp each occurred in 2 patients (28.6%).

Table 5 shows among the 32 patients, ultrasonography most frequently identified endometrial hyperplasia/ thickened endometrium (13, 40.625%), followed by endometrial polyp (8, 25.0%), Cu-T (4, 12.5%), cervical

polyp (3, 9.375%), submucosal myoma/fibroid (2, 6.25%), and normal findings (2, 6.25%). In comparison, hysteroscopy detected 11 (34.38%) endometrial polyps, 8 (25.0%) cases of endometrial hyperplasia/thickened endometrium, 4 (12.5%) Cu-T, 3 (9.375%) cervical polyps, 2 (6.25%) submucosal myomas/fibroids, and 3 (9.375%) normal cavities. Hysteroscopy identified 3 additional endometrial polyps compared with ultrasonography.

Table 5: Comparison of ultrasonographic and hysteroscopic findings (n=32).

Pathology	Ultrasonography N (%)	Hysteroscopy N (%)	Concordance
Endometrial polyp	8 (25.0)	11 (34.38)	Hysteroscopy detected 3 additional cases
Endometrial hyperplasia/ thickened endometrium	13 (40.625)	8 (25.0)	5 cases reclassified on hysteroscopy
Cervical polyp	3 (9.375)	3 (9.375)	Complete concordance
Submucosal myoma/fibroid	2 (6.25)	2 (6.25)	Complete concordance
Cu-T	4 (12.5)	4 (12.5)	Complete concordance
Normal	2 (6.25)	3 (9.375)	1 additional normal on hysteroscopy

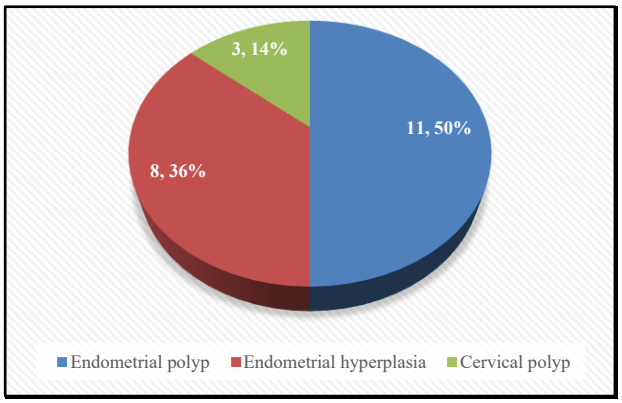


Figure 2: Histopathological findings of biopsied specimens (n=22 biopsied cases).

The histopathological examination of 22 biopsied specimens showed that endometrial polyp was the most frequent diagnosis, accounting for 11 cases (50.0%), followed by endometrial hyperplasia in 8 cases (36.4%). Cervical polyp was identified in 3 cases (13.6%).

DISCUSSION

In the present study, abnormal intrauterine pathology was identified in 90.6% of all hysteroscopic procedures, with endometrial polyp representing the most common single finding (34.38%), followed by endometrial hyperplasia (25.0%) and Cu-T (12.5%). A prospective institutional audit of diagnostic hysteroscopy findings at a South Asian tertiary gynaecology unit similarly reported an abnormal pathology detection rate of 85-92% in patients undergoing hysteroscopy for defined clinical indications including AUB and postmenopausal bleeding, with endometrial polyp identified as the most prevalent single intrauterine pathology across all age groups, confirming the consistency of polyps as the leading hysteroscopic finding in symptomatic women referred for uterine cavity evaluation.[16] The 41-50-year age group was the most frequently represented in the current study (31.3%), followed by 51-60 years (25.0%), confirming the predominance of middle-aged to postmenopausal women among hysteroscopy recipients. A demographic analysis of hysteroscopy patients at a tertiary gynaecology center similarly documented the highest procedural frequency in the 40-55-year age range, attributing this to the peak incidence of endometrial polyps in the perimenopausal transition and the clinical urgency of evaluating postmenopausal bleeding the most prevalent indication in this age group- to exclude endometrial carcinoma.[17] Postmenopausal bleeding was the single most frequent clinical indication in the current study (34.38%), consistent with the established guideline-recommended practice of expedited hysteroscopic evaluation for all cases of postmenopausal bleeding given the 5-10% risk of underlying endometrial malignancy. A retrospective hysteroscopy outcome study from a comparable institutional setting similarly identified postmenopausal bleeding as the predominant referral indication, and demonstrated that hysteroscopic-directed biopsy provided superior diagnostic accuracy over blind endometrial sampling for characterizing the endometrial etiology of postmenopausal bleeding, particularly in cases with focal lesions.[18] Hysteroscopy identified three additional endometrial polyps compared to preoperative ultrasonography (n=11 versus n=8), confirming the superior sensitivity of direct endoscopic visualization over ultrasound for focal intrauterine lesions. A prospective diagnostic accuracy study comparing transvaginal ultrasonography with hysteroscopy for intrauterine pathology detection similarly documented significantly higher sensitivity of hysteroscopy for endometrial polyps particularly those below 10 mm in diameter compared to ultrasound, recommending hysteroscopy as the definitive diagnostic gold standard when ultrasound reveals an indeterminate endometrial appearance or unexplained abnormal bleeding persists despite a reportedly normal ultrasound.[19] All four missing Cu-T cases were successfully located and retrieved by hysteroscopy in the

current study, confirming a 100% procedural success rate for intrauterine device visualization and retrieval. A clinical case series of hysteroscopic management of missing intrauterine devices similarly reported visualization success rates of 95-100% for Cu-T retrieval by hysteroscopy, advocating for hysteroscopy as the preferred primary intervention for missing contraceptive devices following failed outpatient string retrieval, given its simultaneous diagnostic and therapeutic capability without requiring laparoscopic or laparotomy-level intervention.[20] Endometrial hyperplasia was confirmed histopathologically in all eight cases where hysteroscopy raised this diagnosis (36.4% of biopsied specimens), demonstrating the high positive predictive value of experienced hysteroscopic impression for endometrial hyperplasia based on macroscopic cavity appearance including surface irregularity, polypoid areas, and abnormal vascular patterns. A hysteroscopy-histopathology correlation study similarly documented positive predictive values of 85-92% for hysteroscopic diagnosis of endometrial hyperplasia when confirmed against formal histological classification, while noting that final histological subclassification into simple, complex, or atypical categories, which governs the distinction between conservative hormonal management and surgical intervention, requires definitive tissue diagnosis.[21]

The retrospective design may have limited the completeness and uniformity of the available clinical and procedural data. The study included only 32 patients from a single institutional unit, which limits the generalizability of the findings. In addition, follow-up data regarding symptom improvement and longer-term outcomes after hysteroscopic treatment were not available.

CONCLUSION

In this institutional series, hysteroscopy provided direct assessment of the uterine cavity and identified intrauterine abnormalities in 90.6% of patients. Endometrial polyp was the most common hysteroscopic finding (34.38%), followed by endometrial hyperplasia (25.0%) and Cu-T-related findings (12.5%). Postmenopausal bleeding was the most frequent indication for hysteroscopy (34.38%). No procedure-related complications were documented. These findings highlight the usefulness of hysteroscopy for evaluating selected patients with suspected intrauterine pathology in routine gynaecological practice.

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Ethical approval: The study was approved by the Institutional Ethics Committee

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