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Letter to the Editor

Spontaneous expulsion of a large infarcted endometrial polyp

Sir,

A 30-year-female presented to gynaecology OPD with history of polymenorrhea for two months. Cervical scrape smear was negative for intraepithelial lesion/malignancy. Ultrasonography revealed uterus normal in size, shape and echo texture. A central highly vascularised polyp measuring 38 x 25 x 33 mm. was seen in the endometrial cavity. Endometrial curettage and polypectomy was planned. However, three days later, the patient reported with spontaneous expulsion of tissue per vaginam. Examination revealed vaginal bleeding and bilateral fornix tenderness. Her haemoglobin was -11gm%, and blood counts were within normal limits. There was no evidence of galactorrhea or virilization. Urine pregnancy test was negative. Thyroid profile, liver and kidney function tests were within normal range. She was conservatively managed and discharged next day and was advised to return for follow up.

The expelled tissue was sent for histopathological examination. Gross examination showed an elongated, brown black, soft to firm tissue measuring 7.5 x 2.5 x 2 cm. Cut surface was hemorrhagic, with a grey white area at one end (Figure 1 A). Microscopy revealed an endometrial polyp covered by columnar lining showing altered gland to stroma ratio with hyperplastic endometrial glands showing stratification (Figure 1 B, C). Large areas of hemorrhagic infarction were seen in the polyp (Figure 1 D). There was no evidence of dysplasia or malignancy. A diagnosis of Infarcted endometrial polyp was given.

The patient reported normal menstrual periods after the expulsion of polyp. Follow-up ultrasonography after first menstruation revealed normal endometrial thickness.

Endometrial polyps are quite common in women of childbearing age with prevalence varying from 10% to 40% in women with abnormal uterine bleeding.¹ These are benign, localized overgrowths of endometrial tissue which are oestrogen dependent. They may be sessile or pedunculated, single or multiple and can arise in any part of the uterus, including the lower uterine segment.

Most common presentations are inter-menstrual bleeding in young patients and postmenopausal bleeding in older patients. Larger polyps can cause infertility. Uterine contractions can cause elongation of the pedicle of polyp, eventually leading to compromised blood supply and necrosis of the pedicle. This can rarely cause spontaneous expulsion of polyp.² Usually, polyps appear glistening

pale pink on gross examination; however, these may be brown, hemorrhagic in case of infarcted polyps. Glands within polyp fail to show normal response to cyclic hormones, showing either a weak secretory response or these may be inactive and dilated. Stroma appears more fibrous than in normal endometrium.

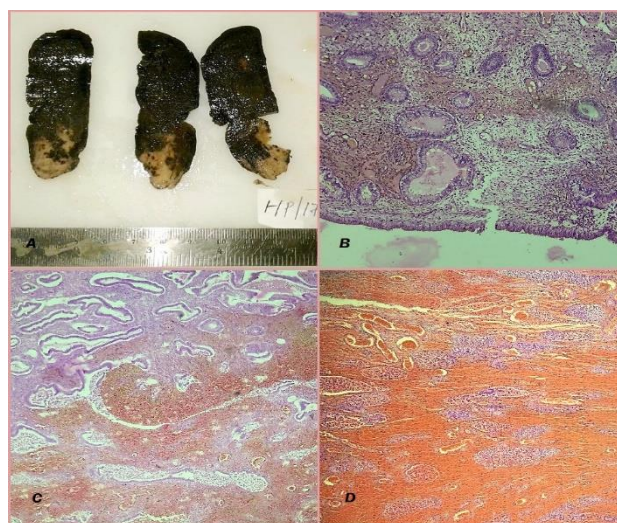


Figure 1: A) Large polyp showing black haemorrhagic discoloration due to infarction, B) Polyp covered by columnar lining, C) Polyp showing altered gland to stroma ratio and areas of haemorrhage, D) Polyp showing large areas of haemorrhage.

Differential diagnosis of polyps includes endometrial hyperplasia, polypoid adenocarcinoma, adenofibroma and adenosarcoma. Florid hyperplasia may assume a polypoid configuration; however, it usually involves entire endometrium in contrast to the localized polyp. Polypoid adenocarcinomas tend to show diagnostic features of malignancy. Adenosarcoma shows mitotic activity in stromal cells and adenofibroma shows significant fibrous component.

The risk of endometrial carcinoma in a polyp varies from 0.2% to 8%, being greater in older patients and with large sized polyps.^{3,4} Polyps containing atypical hyperplasia or carcinoma should be treated similar to comparable flat lesions. Recurrent polyps or polyps that continue to grow after menopause, should be removed.

Vaginal expulsion of submucous fibroid after red degeneration have been reported in literature.⁵ However, vaginal expulsion of endometrial polyp is still very rare.

Endometrial polyps should be removed due to the slight risk of malignancy. However, non-removal does not necessarily mean an added risk for spontaneous expulsion or malignancy. Very rarely, there can be infarction, necrosis and subsequent infection of large endometrial polyps. Simple polypectomy with or without endometrial ablation is the treatment. The importance of sending the tissue for histopathological examination cannot be undermined considering the fact that the differential diagnosis includes malignancy.

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