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A GIANT (MAMMOTH) INFLAMMATORY ENDOMETRIAL POLYP IN A YOUNG LADY NECESSITATING HYSTERECTOMY - CASE REPORT

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ABSTRACT Endometrial polyps are overgrowth of localized endometrial tissue consist of glands, stroma and blood vessels with epithelium. Endometrial polyps have been the major cause of bleeding per vaginum in pre and post-menopausal women. The size usually being <2 cms. Polyps >4 cm are called giant polyps.Mostly seen in women in the 5th decade. Ambulatory hysteroscopic polypectomy is what is usually performed for poly removal. **Case Description:** In this case report, we present a giant/ mammoth size endometrial polyp measuring 25 x 20cms, which rapidly reached the size of about 28-30 weeks gravid uterus in a span of 3-4 days, in a young lady, 29yrs of age, necessitating hysterectomy. **Conclusion:** A huge endometrial polyp is a rare entitiy in young age mimicking various other entity lead to hysterectomy. **Clinical Significance:** The clinical, radiographic and histopathological picture of this entity is discussed according to the literature.

KEYWORDS : Large endometrial polyp, Abnormal uterine bleeding, Endometrial hyperplasia, Dilation and curettage

CASE REPORT:

A 29 year old, Para2 Live2, previous normal vaginal deliveries, LCB 8 years back, presented with complaints of pain lower abdomen and back pain for 15 days, associated with vomiting and fever for 3 days. She had not menstruated for past 2 months. She had undergone Dilatation and Curettage (D&C) 45 days before this procedure for AUB- E (endometrial hyperplasia, ET- 68mm, histopathological examination revealed Polypoidal endometrial hyperplasia). She was started on oral tab regestrone 5mg 2 TDS for 1 week and then tapered taking till she presented to us with above complaints. She was not a known case of Diabetes mellitus or Systemic hypertension, On general physical examination, patient was febrile (temp- 100-degree F), toxic, mildly dehydrated with normal vitals. BMI 35 Kg/m ^{2} tenderness and guarding over suprapubic region. Uterus~ 14 weeks. 0n Per speculum examination hypertrophied cervix and minimal bleeding through os noted. In the bimanual examination uterus was 14-16 weeks size with bilateral forniceal tenderness. Acute Pelvic inflammatory disease with Abnormal uterine bleeding.

INVESTIGATIONS

Hb : 12 g/dL; TLC: 44,000; ESR :130 mm; RFT and LFT : Normal; bhcg : 3.21 mIU/mlp; USG

Abdomen- Bulky uterus measuring 12.1 x 6.5 x4.8 cm, ET- 86mm; Endometrium was hetero-echoic with few cystic areas.

A provisional diagnosis of AUB with Acute PID was made. Pending High Vaginal swab report, broad spectrum I.V antibiotics and anti-inflammatory medications were started. Temperature continued to be high. Plan was to take her up for a repeat diagnostic and therapeutic dilatation and curettage after antibiotic cover. The size of the uterus meanwhile increased rapidly, and by day 3 it reached up to 28-30 weeks gravid uterus. Patient was greatly distressed (pain and pressure effects) by the size.

Day 3 Reports:

Figure 1 - *MRI picture of patient shows well defined heterogenously hyperintense lesion of size 20.5 x 12.9 x 16.7 cm noted in endometrial cavity with possibility of endometrial polyp/ hematometra/ pyometra*

TLC : 58,500; CA 125 : 7345 mu/mL, CEA: 2.73 mg/dL; Procalcitonin : positive (0.6mg/ml); RFT, LFT and coagulation profile within normal limits.Blood and urine culture indicated no microbial growth. Vaginal swab culture (on Day 1) revealed E.Coli moderate growth.

In (**figure 1**)-MRI Abdomen and pelvis of patient showed uterus 20.5 x 12.9 x 16.7 cm with a well defined heterogenous enhancing lesion of thickness 11.2 cm in endometrial cavity (?Endometrial polyp).Adnexa were normal,no ascites /lymphadenopathy.

Decision taken to proceed with laparotomy and hysterectomy in view of acute PID is not responding to higher broad spectrum anti-biotics including Inj.Colistin. Possibility of endometrial malignancy was also considered.

INTRA-OP FINDINGS (LAPAROTOMY):

Abdomen opened by vertical paramedian incision, Uterus of 26-28 weeks seen. Right ovary appeared inflamed, Total Abdominal Hysterectomy with Right Salphingo Oopherectomy with left salpingectomy was done. Left ovary was normal and hence preserved (Frozen section : Inflamed endometrial polyp).No evidence of collection of purulent material. On **Cut section in (figure-2**) - Polypoidal mass of 25 x 20 cm (as shown in picture),Frozen section- Inflamed endometrial polyp.

POST OPERATIVE :

Post-operative period uneventful and hence patient got discharged on post operative day 5. Patient followed up with histopathological examination on Day 14. The histopathological examination revealed Inflamed endometrial polyp with areas of necrosis and progesterone induced changes -PILL endometrium. Cervix- ulceration with chronic cervicitis, cystic follicle in right ovary. Left side tube- acute salpingitis

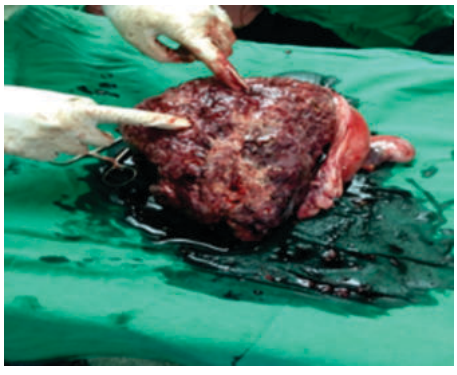

Figure 2 - Shows Cut-section Of Endometrial Poly

A polypoidal mass of 25 x 20 cm seen arising from the endometrial cavity.

DISCUSSION:

Polyps in endometrium are localized overgrowths of endometrial tissue with variable -components being present. Its prevalence range is from 10-24% in women presenting with dysfunctional uterine bleeding. These polyps can be seen at any age, but most commonly seen in menopause. In the reproductive age, epithelium of polyp may be active and pseudostratified while it may become inactive and flat after menopause. Polyps in endometrium are of 3 groups: Mature functioning polyps, Immature non functioning polyps and Non functioning adenomatous polyps, based on their response to ovarian hormones. HPE in this case appears to be belonging to the first group.

There are number of mechanisms such as monoclonal endometrial hyperplasia, over-expression of endometrial aromatase and gene mutatation that hasve been responsible for development of polyps. But the exact pathogenesis is unclear. Indraccolo U et al., demonstrated a causative mechanism in the pathogenesis of polyps: Ageing, bcl-2 expression, Obesity& tamoxifen therapy. The most common symptom being bleeding per vaginum and few may present with an introital mass(1). Transvaginal ultrasound is been the first line of investigation when compared to other modality.

Interestingly in our case report, the lady was obese BMI 35kg/m² only 29 years old, but not on tamoxifen therapy, nor was she hypertensive or diabetic. Histopathological examination had shown severe polypoidal endometrial hyperplasia. Subsequently after Dilatation and Curettage , patient was on progestins for two months before presenting to us. So the cause for the recurrence and rapidly increasing size of the polyp, in this case is not clear. May be superadded infection was only partially responsible,as the microbial growth was not very heavy as would have been expected in this case.

Contrary to our case, endometrial giant polyps occur with increased frequency secondary to unbalanced oestrogen levels or exposure to tamoxifen after breast CA . The possibility of malignancy in polyps from endometrium is 1– 3% . The malignancy risk with polyps increases with age, obesity, hypertension, postmenopausal period, tamoxifen etc. Hysterectomy for our patient was deemed necessary in view of the rapidly increasing size ,severe pain abdomen, suspicion of malignancy and to remove the focus of infection. The mainstay of evaluation and management of endometrial polyps is Hysteroscopic polypectomy . Many articles have indicated that removal of polyps by blind curettage is found to be not effective and incomplete in >50% of attempts.Hence blind curettage must not be considered as diagnostic or therapeutic intervention.

The literature is still unclear about clinical presentation and malignant potential of giant endometrial polyps. The pathogenesis of endometrial polyps as well as factors leading to oncogenesis is still being elucidated. Therefore, with these limitations in knowledge, caution should be taken when counseling patients that present with large or giant endometrial polyps. In our case the patient is of reproductive age group with bizarre presentation needs hysterectomy found to have endometrial polyp with here histopathological examination revealed diagnosis differ from other case reports. Information ,presently are obtained from case reports,case series,or small studies.

Table 1: Summary Of Reported Cases Of Giant Endometrial Polyps.

Report	Patient age	Polyp size (cm)	Associated drugs	Management	Pathology
Narin et a l.(2) Adana, Turkey	66	12 × 6 × 5	No	Total abdominal hysterectomy, BSO	No hyperplasia, atypia, or malignancy
Çil et al. (3) Malatya, Turkey	73	8 × 4 × 3	No	Hysteroscopic polypectomy	No hyperplasia, atypia, or malignancy
Meena et al(4) Delhi, India 658.5 × 1.5 No Hysteroscopic polypectomyCystic hyperplasia without atypia8 × 4 × 3NoHysteroscopic polypectomyNo hyperplasia, atypia, or malignancy					

CONCLUSION:

To summarize, Endometrial polyps, its pathogenesis, origin have not been completely understood and evaluated. Giant polyps in endometrium are rare which can develop spontaneously and can mimic endometrial cancer. The gold standard has been Hysteroscopy for diagnostic and therapeutic management of endometrial polyps, whereas blind dilatation and curettage is not to be preferred.

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