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IMPORTANCE OF PER SPECULUM EXAMINATION IN 1ST TRIMESTER BLEEDING TO DIAGNOSE RARE LOCAL CAUSE OF BLEEDING IN EARLY PREGNANCY- POLYP IN PREGNANCY- A CASE REPORT.

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ABSTRACT

Despite being a common occurrence, little has been studied about bleeding in early pregnancy. Its incidence ranges from 7-24% (1) and presentation can vary from per vaginum spotting to heavy bleeding associated with passage of clots. Bleeding in the first trimester has been implicated in both maternal and fetal morbidity like maternal anemia, maternal shock, abortion, intrauterine growth restriction, low birth weight, preterm delivery, increased incidence of manual removal of placenta and many others (2,3,4) Here we present an unusual case of a 23-year-old primigravida 13 weeks of gestation with bleeding in early pregnancy, the cause of which was found to be bifid polyp which was managed by transvaginal polypectomy without cervical cerclage leading to resolution of symptoms.

KEYWORDS

INTRODUCTION-

Early pregnancy bleeding occurs before 16 weeks of gestation. Incidence of it varies as; it may range from 7-24 % [1]. The amount of bleeding can vary from per vaginal spotting to massive hemorrhage. Common causes can be implantation bleeding, abortion, subchorionic hemorrhage, placenta previa, ectopic pregnancy, infection, cervical erosion, cervical polyps, gestational trophoblastic neoplasia, and ectopic pregnancy [5]. Bleeding in the first trimester has been implicated in both maternal and fetal morbidity like preterm labor, intrauterine growth restriction, low birth weight, abortions, manual removal of placenta, increased risk of antepartum hemorrhage, placenta accreta [2], anemia and wasting in mother [3,4]. Cervical polyp which is a rare local cause of early pregnancy bleeding has been reported in this case [6]. Although cervical polyps are commonly benign, malignant polyps can present in 0.2 to 1.5% of the cases [7].

Case Report

A 23-years-old, primigravida with 13 weeks gestation, spontaneous conception came to emergency with complaint of heavy vaginal bleeding for 7 days, associated with the passage of clots, with the complaint of generalized weakness. No other complaint of pain in abdomen, no history of recent sexual intercourse/ heavy weight lifting/ trauma/ passage of fleshy mass/ medical termination of pregnancy pills consumption. Her previous menstrual cycles were regular, she had no complaint of menorrhagia or irregular cycle, no history of inter-menstrual bleeding, and no complaint of spasmodic dysmenorrhea. On examination, she was conscious, and oriented to time, place, and person, severe pallor was present with no signs of decompensation like no dilated neck veins, no icterus, no cyanosis, no clubbing. Her general condition was moderate, was afebrile, pulse rate of 120 beats per minute regular, good volume, and blood pressure of 110/60 mm of Hg.

Systemic examination was normal. Per abdomen examination was soft, there was no guarding/tenderness/rigidity, uterus was 14-weeks in size. Per speculum findings was, a mass of approximately 3*2*2 cm with a thick stalk coming through os with a side lobe of 2*1 cm was seen, which was bleeding on touch and had an irregular surface, was soft in consistency, mobile mass, congested, friable and was vascular. On per vaginal examination uterus 12-14 weeks anteverted, bilateral fornices were free with no tenderness. A 3*2*2 cm mass of soft consistency was present suggestive of cervical polyp, protruding out of external os. Stalk was felt in the cervical canal and the internal os was closed. Outside ultrasonography was suggestive of 13 weeks intrauterine single live gestation. She was admitted and all serological and biochemical investigations were sent. She was transfused 2 units of packed cell volume at a hemoglobin level of 3 gm/dl. All other investigations were normal suggestive of anemia due to acute blood loss.

Repeat Ultrasonography (*Figure 1.*) was done at our center which was suggestive of 13-week single live intrauterine pregnancy with a cervical polyp of 3*2*2 cm with a feeder vessel in the cervical canal and internal os was closed.

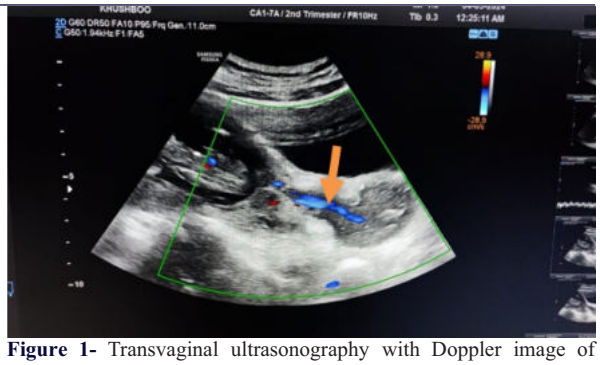
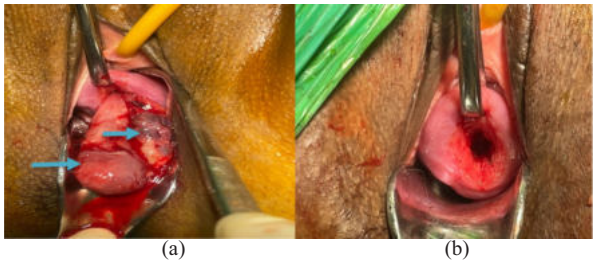


Figure 1- Transvaginal ultrasonography with Doppler image of cervical polyp with feeder vessel (orange arrow).

She was explained about her diagnosis, counseled regarding the plan of action and associated risks, and with informed consent was taken up for emergency transvaginal polypectomy, in which the stalk was clamped, cut, and ligated using absorbable sutures and removed (*Figure 2*). One unit packed cell volume was transfused peri-operatively. Postoperatively she was vitally stable and had no further complaints of bleeding. No remnant of polyp was felt per vaginally which was then confirmed by ultrasonography. She was discharged after three days in stable condition with advice to follow up in antenatal care –OPD regularly and serial cervical length monitoring. On follow up she had complete remission of symptoms with normal course of pregnancy with histopathology report suggestive of benign endocervical polyp.



(a) (b)

Figure 2-(a) Preoperative bilobed bleeding cervical polyp (pointed by blues arrows). (b) Post-Polypectomy picture of cervix showing no remnant of polyp.

DISCUSSION-

Polyp can have spectrum of symptoms varying from vaginal discharge which can be foul smelling, spasmodic pain in abdomen, something coming out per vaginum, to spotting or bleeding per vaginum, post coital bleeding, abortion, preterm delivery due to either funneling and shortening of the cervical length or infection or iatrogenic, chorioamnionitis or can be asymptomatic and an incidental finding.[8] Funneling and dilation may be due to weight of gaint polyp or

downward displacement has also been seen.[7] Polyp in postpartum period can cause severe post partum hemorrhage due its vascularity. Differential diagnosis can be low lying placenta, placenta previa, abruption, subchorionic hematoma, threatened abortion, complete hydatidiform mole, incomplete abortion, cervical ectropion, cervical cancer, Surface lesions of the genital tract. As there is no standard guideline or protocol for treatment of polyp in pregnancy, its treatment depends on surgeon expertise and severity of symptoms.

Transvaginal polypectomy under antibiotic cover can be done to control ongoing blood loss and improve maternal condition, in which the stalk is clamped near to its attachment and then ligated using an absorbable suture, and hemostasis is achieved. The other method of polypectomy can be holding the polyp and twisting its stalk, but as location of base of stalk can be high and can lead to premature placental separation, therefore may lead to avulsion in pregnancy[9] thus leading to torrential hemorrhage or abortion, therefore is avoided and the clamp and ligation method is used as in described case. Some studies suggests conservative management to avoid heavy bleeding, preterm delivery, abortion. In literature role of conservative management is with vaginal and oral probiotics with 17 alpha hydroxyprogesterone capsule has also been documented[10], or it can be through tocolysis, with intravenous fluids. It can be managed with dual approach as in this case that presented with preterm contraction with funneling and shortening of cervical length at 30 weeks was managed conservatively till 38 weeks followed by polypectomy at 38 weeks of gestation without any complications[7]. Some studies suggest removal of polyp with cryosurgery[11].

Polyp in pregnancy has to be managed as per the presentation of the patient or surgeon expertise or availability of resources.

If a speculum examination was not performed, a diagnosis of polyp would have been missed, leading to the non-resolution of her symptoms and worsening of her condition. This highlights the importance of speculum examination to rule out local causes of bleeding in pregnancy.

CONCLUSION

Polyp in pregnancy is rare but may present with heavy bleeding compromising maternal condition. Thus, when evaluating any patient with early pregnancy bleeding, clinical examination along with per speculum examination should never be missed even with the availability of modern diagnostic modalities. The literature emphasizes the importance of individualized care based on gestational age and symptomatology including expectant management, conservative interventions, and surgical excision when indicated.

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