WOMEN’S HEALTH: CERVICAL POLYPS – UPDATE

Background
1. Definition: benign growth protruding from the cervix or endocervical canal
2. General Information:
   - Usually asymptomatic and found on pelvic exam.
   - Over 99% are benign growths,
   - Usually epithelial in origin.

Pathophysiology
1. Pathology of Disease:
   - Not completely known.
   - Possibly related to chronic inflammation or abnormal tissue response to hormonal factors.
2. Prevalence:
   - 2-10% of adult women.
   - Most common in ages 40s-50s.¹
3. Risk Factors:
   - Chronic inflammation
   - Multiparity
   - Post-menopausal state

Diagnostics
1. History: Usually asymptomatic, irregular vaginal bleeding, post-coital bleeding, heavy menses, postmenopausal bleeding, vaginal discharge or mass.
2. Physical Examination:
   - Shiny red, purple, or flesh-colored lobular structure,
   - usually protruding from cervical os;
   - may protrude from ectocervix.
   - Typically pedunculated with a long thin pedicle, but may be broad-based.
   - Usually less than 3 cm, although may be quite large.
   - Single or multiple.
3. Diagnostic Testing
   - Laboratory evaluation: If polyp removed, send to pathology for histology.
   - Diagnostic imaging: Not routinely used for diagnosis.

Differential Diagnosis
1. Key Differential Diagnosis: Prolapsed leiomyoma, endometrial polyp, malignancy
2. Extensive Differential Diagnosis: leiomyoma, endometrial polyp, primary malignancy, metastatic malignancy, products of conception, squamous papilloma, condyloma, Nabothian cyst.

Therapeutics
1. Acute Treatment: Removal of polyp generally recommended.² ³ (SOR:C)
   - If polyp is greater than 5mm and/or symptomatic, remove
   - If polyp is smaller than 5mm AND asymptomatic, removal not mandatory.⁴
If abnormal bleeding is present on history, consider hysteroscopy to look for coexisting endometrial polyp (SOR:C) (27% coexisting endometrial polyp)

2. Removal can usually be done with polypectomy in the office setting: grasp base with forceps and rotate to twist off;
   o Can also be done by D&C, electrosurgical excision, or hysteroscopy.
3. Can destroy base with cautery: decreases bleeding, decreases recurrence
4. Send polyp for histological examination.
5. Further management: Recheck for polyp growth (if not removed) or reoccurrence (if removed) every 6-12 months.

Follow-Up
1. Return to Office
   o If pathology benign, annually.
   o Sooner if pathology other than benign
2. Refer to Specialist
   o If hysteroscopy is indicated
   o If polyp does not appear to stem from the endocervical canal
   o If polyp is broad-based or too large to remove in the office

Prognosis:
1. 0.1% are malignant and 0.4-0.5% are premalignant \(^3,7\).
2. Perimenopausal and postmenopausal women are more likely to have malignant pathology than younger women.\(^7\)
3. Benign polyps unlikely to progress to malignancy.
4. Reoccurrence rate after removal is 6.2% \(^3\).

Prevention
1. No known prevention recommendations

Patient education
1. Medline Plus: Cervical Polyps

References

**Authors:** Jennifer Hanson, MD, & Gregory Brotzman, MD, *Medical College of Wisconsin*

**Editor:** Kara Cadwallader, MD, *Rural FMR of Idaho*