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 co-existing 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;
    - 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
    - If pathology benign, annually.
    - Sooner if pathology other than benign
2. Refer to Specialist
    - If hysteroscopy is indicated
    - If polyp does not appear to stem from the endocervical canal
    - 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
   http://www.nlm.nih.gov/medlineplus/ency/article/001494.htm

References

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