A case of huge symptomatic endocervical polyp

Hamadeh S, Addas B, Hamadeh N, Rahman J, Rahman MS
King Fahd hospital of the univeristy, Khobar, Saudi Arabia

Objective

Cervical polyp is a rare finding in pregnancy and in most cases is small and asymptomatic. The objective is to report a case of a huge symptomatic endocervical polyp.

Methods

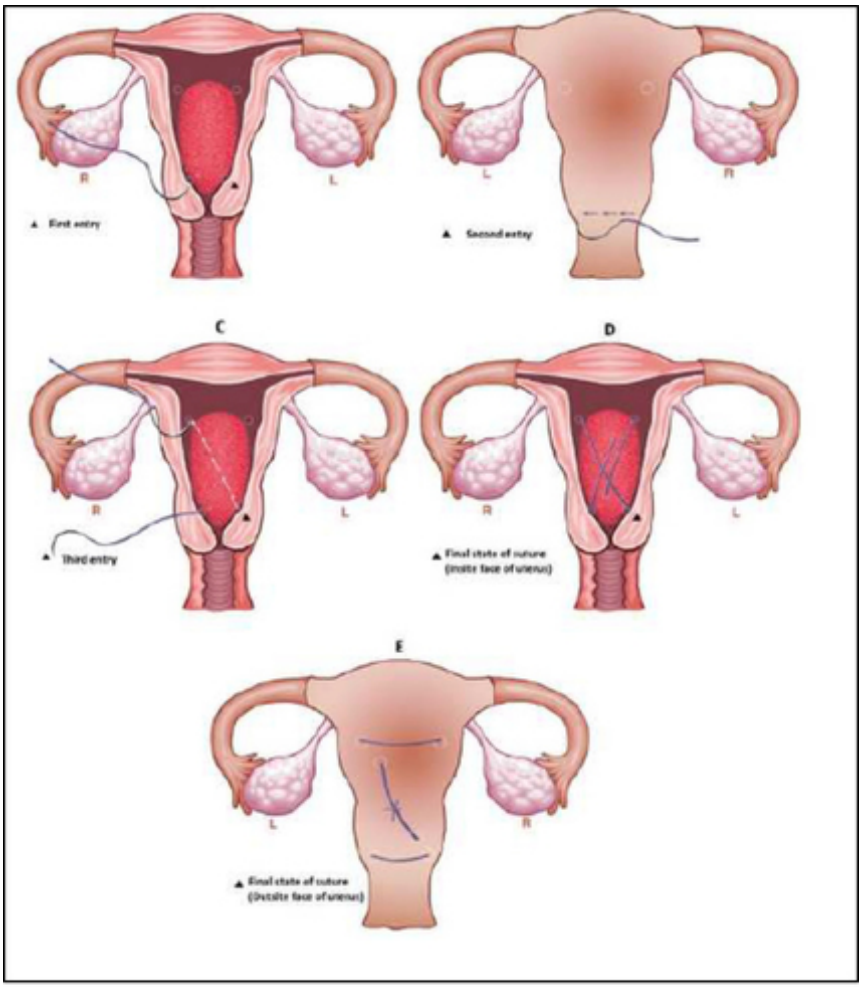
This is a case report.

Results

A 35-year-old, G2 P1, presented to our emergency department at 32 weeks' gestation with mild vaginal bleeding and period like pain. She had an uneventful antenatal care in primary health care centre. Routine first and second trimester ultrasound scans were normal. No pathology was detected. Obstetric palpation revealed a soft, abdomen, fundal height of 30 cm and regular fetal beat. Obstetric ultrasound confirmed a single, viable fetus, measuring compatible with dates and cervical funnelling. Placenta previa was ruled out. Speculum examination revealed the presence of a huge, endocervical polyp, approximately 4 cm in diameter, protruding from the anterior lip of the cervix, with signs of bleeding. Vaginal examination confirmed the findings of speculum inspection and revealed a dilatation of the external cervical with closed internal os. The cervical length on transvaginal ultrasound was 21 mm. Few mild uterine contractions per 10 minutes were demonstrated on CTG. The patient was admitted to our labor and delivery ward for observation, tocolytics and steroids. The pain and contractions subsided. Colposcopy showed no suspicion of malignancy. She was counselled for conservative management and cervical polypectomy at 38 weeks gestation. Vaginal delivery was recommended. The option of cesarean section at 38 weeks, or earlier in case of active vaginal bleeding , followed by cervical polypectomy after 6 was discussed. She was discharged home with a plan of regular follow up appointments in the outpatient clinic. No further problems occured in the pregnancy. Serial transvaginal ultrasound scans showed no changes in cervical length. At 38 weeks, cervical polypectomy was performed under spinal anesthesia. The pedicle was ligated and the mass excised by electrosurgery. Histopathology evaluation confirmed the diagnosis. Two days later, the patient was spontaneously into labor and delivered a female baby.

Conclusion

Cervical polyp in pregnancy occurs mainly in multiparous women but the exact incidence in pregnancy is unknown. They are usually small in size. Giant cervical polyps > 4 cm x 4cm have been reported in 17 cases in the literature, three of them in pregnancy. Among these cases only one case presented with funneling and shorting of cervical length and none of them presented with preterm contraction and APH. The usual complaint in patients of reproductive age group are intermittent vaginal bleeding, postcoital bleeding or vaginal discharge. If it occurs in pregnancy it should be differentiated from other obstetrics conditions that can have similar presentation. Although cervical polyps are mostly benign, malignancy should be ruled out in any abnormal looking or large polyps more than 4cm diameter in size. The incidence of malignant transformation in pregnancy is 1.7 % and 5% of symptomatic cervical polyp were precancerous or cancerous ones. There are no guidelines available for the management of cervical polyp in pregnancy but, it was agreed on that symptomatic cervical polyp should be managed by polypectomy. We decided to manage the patient conservatively after excluding malignancy till 38 weeks of gestation with serial follow up of transvaginal ultrasound assessment of cervical length due to the possibility of uncontrolled bleeding during polypectomy, associated risk of preterm labor and anesthesia. Our conservative approach in this patient demonstrates that instant surgical intervention is not the solo management for cervical polyp encountered in pregnancy. A large cervical polyp in pregnancy can be an underlying cause of preterm labor. Although it is agreed that symptomatic cervical polyp in pregnancy should be managed by polypectomy, conservative management in this patient, after excluding malignancy, proves it still has a place in such situations, thus avoiding any surgical intervention and complications at an earlier period of gestation.



Modified intracavitary suture illustration. (A) First entry, (B) Second entry, (C) Third entry, (D) Final state of suture (cavity of the uterus), (E) Final state of suture (serosal surface of the uterus).

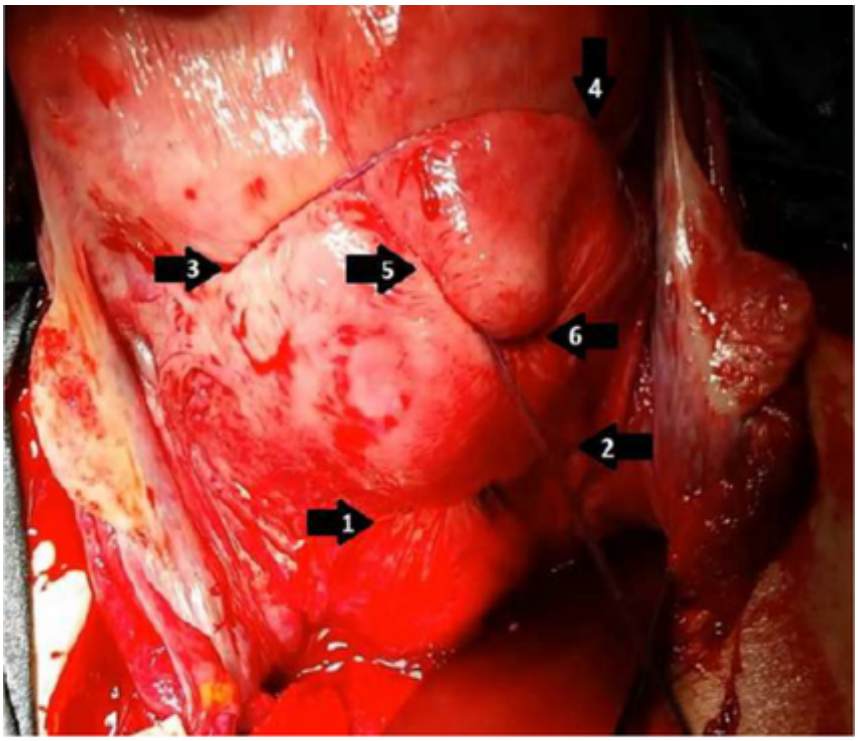


Figure 2. Final state of suture (serosal surface of the uterus) (1) First exit, (2) Second entry, (3) Third exit, (4) Fourth entry, (5) Fifth exit, (6) Sixth exit (with the other needle).