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Removal of focal intracavitary lesions results in cessation of abnormal uterine bleeding in the vast majority of women

Endometrial polyps have mainly been reported in women with abnormal uterine bleeding. Recent studies, however, have demonstrated a high prevalence in asymptomatic women, especially after the menopause[1–3]. Dreisler *et al.* showed that polyps were more prevalent in asymptomatic premenopausal and postmenopausal women than in those with abnormal bleeding[4]. They challenged the generally accepted hypothesis that endometrial polyps cause abnormal bleeding.

We looked at the evolution of bleeding symptoms in 124 women referred for operative hysteroscopy because of focal intracavitary lesions diagnosed at ultrasound imaging with hydrosonography and/or office hysteroscopy at the 'one-stop bleeding clinic' of the University Hospital Leuven, Belgium, from November 2004 to March 2007[5]. Twelve patients did not undergo operative hysteroscopy: four had not returned for operative hysteroscopy, one patient had undergone a hysterectomy and one a myomectomy by laparotomy, one woman died, one developed ovarian cancer, one had breast cancer with metastasis in the uterus and three patients were lost to follow-up. The remaining 112 women were contacted by telephone or mail between September and October 2007, and interviewed about the evolution of their bleeding pattern since the operative hysteroscopy. Follow-up between the operative hysteroscopy and the questionnaire ranged from 7 to 34 (median, 21.3) months. In 27 cases (24.1%) additional treatment had been given after the operative hysteroscopy for contraception or bleeding control; this included medical treatment in 11.6%, a levonorgestrel intrauterine device in 9.8% and three women (2.7%) had since had a hysterectomy. These 27 patients were excluded from further analysis.

The mean ± SD age of the remaining 85 women at treatment was 53.6 ± 10.7 (range, 29–79) years and 50.6% ($n = 43$) were postmenopausal. The mean ± SD endometrial thickness at initial ultrasound examination was 11.0 ± 6.4 (range, 2.1–29.5) mm. Overall, 98.8% ($n = 84$) of women reported an improvement in their bleeding pattern (Table 1), 97% ($n = 32$) of the premenopausal women vs. 100% ($n = 43$) of the postmenopausal women ($P = 0.43$). For those in whom endometrial polyps had been confirmed at histology, 93% ($n = 14$) of the premenopausal patients and 100% ($n = 38$) of postmenopausal women declared the bleeding pattern improved after surgery (Table 2). There was a significant association between symptom relief and duration of follow-up (mean ± SD follow-up time 20.8 ± 6.6 months and 28.2 ± 5.7 months in the case of definitive and transient improvement respectively, $P = 0.01$), but not with endometrial thickness ($P = 0.61$), age ($P = 0.32$) or parity ($P = 0.68$). The fact that five polyps could not be confirmed at histology after operative hysteroscopy (Table 2) does not necessarily mean that those cases were false-positive diagnoses on ultrasound imaging or office hysteroscopy. In a previous series polyps could not be confirmed at histology in up to 38%[6]. This rather illustrates the lack of an infallible 'gold standard' in the evaluation of diagnostic accuracy for endometrial disease.

Although this is not a randomized controlled study, the present data support the hypothesis that hysteroscopic removal of focal intracavitary lesions is indicated in women with abnormal uterine bleeding; the bleeding symptoms improve or disappear in most cases, and the lesion can be sent for histological examination to exclude malignancy[7,8]. Our study shows that abnormal uterine bleeding tends to recur with time. Henriquez *et al.* reported that recurrence is especially common in premenopausal women[9]. Because we evaluated only symptomatic cases, our data do not allow any conclusions about the management of endometrial polyps diagnosed incidentally at ultrasound examination in women without abnormal uterine bleeding.

Table 1 Symptom relief with respect to menopausal status

	Symptom relief (n (%))			
Menopausal status	*Definitive*	*Transient*	*None*	*Total* (n)
Premenopausal	30 (90.9)	2 (6.1)	1 (3.0)	33
Perimenopausal	8 (88.9)	1 (11.1)	0 (0)	9
Postmenopausal	38 (88.4)	5 (11.6)	0 (0)	43
Total	76 (89.4)	8 (9.4)	1 (1.2)	85

Table 2 Symptom relief with respect to histology at operative hysteroscopy

	Symptom relief (n *(%))*			
Histology	*Definitive*	*Transient*	*None*	*Total* (n)
Premenopausal women				
Proliferative/secretory changes	3 (100)	0 (0)	0 (0)	3†
Endometrial hyperplasia	1 (100)	0 (0)	0 (0)	1
Endometrial polyp	12 (80.0)	2 (13.3)	1 (6.7)	15
Submucous myoma	11 (100)	0 (0)	0 (0)	11
Retained trophoblastic tissue	1 (100)	0 (0)	0 (0)	1
Other*	2 (100)	0 (0)	0 (0)	2
Total	30 (90.9)	2 (6.1)	1 (3.0)	33
Postmenopausal women				
Proliferative/secretory changes	2 (100)	0 (0)	0 (0)	2†
Endometrial hyperplasia	0 (0)	0 (0)	0 (0)	0
Endometrial polyp	33 (86.8)	5 (13.2)	0 (0)	38
Submucous myoma	3 (100)	0 (0)	0 (0)	3
Total	38 (88.4)	5 (11.6)	0 (0)	43

*Insufficient tissue in one and transection of adhesions only with no histology available in one. †In five cases the focal lesion could not be confirmed at operative hysteroscopy: in two cases a small polyp had been reported both at ultrasound imaging and diagnostic hysteroscopy, in two cases a small polyp had been reported only on ultrasound examination (in one hysteroscopy had not been performed and in the other an intracavitary clot as well as an endocervical polyp had been reported at hysteroscopy) and in one case a small polyp had been reported at hysteroscopy.

We acknowledge that only a randomized controlled trial comparing hysteroscopic removal with expectant management could prove the efficacy of the removal of focal intracavitary lesions in women with abnormal bleeding.

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