DOI: 10.7860/JCDR/2022/55376.16559

Case Report

Obstetrics and Gynaecology Section

Giant Cervical Polyp in Primigravida: A Rare Case Report

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ABSTRACT

Cervical polyp is the most common benign lesion arising from the cervix. It is usually found incidentally unless it is symptomatic or gargantuan in size protruding from the introitus. The giant cervical polyp with size greater than 4 cm are rare in gravid women. Most of the obstetricians would prefer a conservative management for polyps in pregnancy. The present unusual case is of a 30-year-old primigravida, 19 weeks gestation with giant, symptomatic, significantly growing endocervical bifid appearing polyp. The case was managed with transvaginal polypectomy without any need of cervical cerclage. The giant polyp specimen measuring 7×3 cm though appeared clinically malignant, histopathology confirmed its benign aetiology. It is prudent to excise cervical polyp, when symptomatic and suspicious of malignancy. The gravid women undergoing cervical polypectomy may carry risk of premature delivery and hence pregnancy has to be carefully supervised.

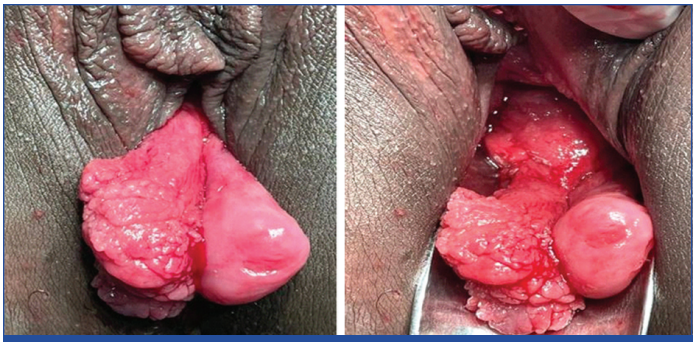
Keywords: Endocervical polyps, Polypectomy, Preterm labour

CASE REPORT

A 30-year-old primigravida at 19 weeks gestation presented to the department with complains of something coming out of vagina with sensation of dragging discomfort and spotting per vaginum. It was first noticed just at the introitus at 2nd month of pregnancy. It was pea sized initially and increased to present size over the span of 3 months. There was no urinary complains.

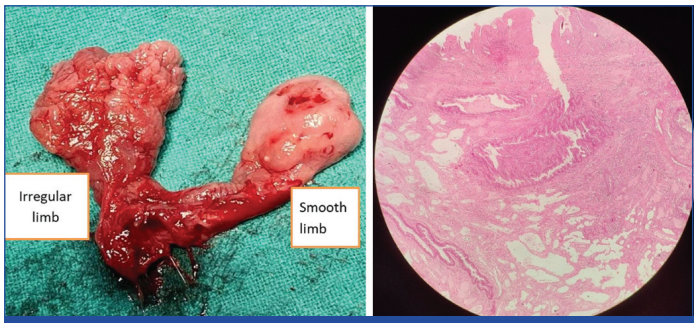
On examination, her vitals were stable. On per abdomen examination uterus was 20 weeks, and relaxed. Local genital examination showed a polypoidal fleshy mass hanging out of introitus [Table/Fig-1]. On per speculum examination, a bifid polypoidal growth 7×3 cm with stalk arising from anterior lip of cervix extending into the endocervical canal was noted [Table/Fig-2]. One limb was smooth and firm and other limb was irregular, congested and friable [Table/Fig-3]. On per vaginal examination, polyp was arising from endocervical canal. External os patulous and internal os was closed.

Her biochemical investigations were normal. Ultrasound suggestive of single live intrauterine foetus of 20 weeks gestation with no gross congenital anomalies with multiple small fibroids in uterus. Cervix was bulky and internal os closed. Her Papanicolaou (PAP) smear was normal. Under Saddle block, surgical excision of the polyp was done ligating upto its base with polyglactin No. 1. A single shot of antibiotic was given peroperatively. She was managed with polypectomy alone without any need for cervical circlage procedure as there was no cervical effacement or dilatation. Patient had uneventful postoperative recovery and was discharged on third day.



[Table/Fig-1]: Bifid endocervical polyp on local examination. **[Table/Fig-2]:** Bifid endocervical polyp on per speculum examination. (Images from left to right)

Histopathology revealed an inflamed endocervical polyp with squamous metaplasia [Table/Fig-4]. She was under regular follow-up and had no vaginal complaints throughout. At 2 weeks follow-up, per speculum examination of cervix was normal. The cervical length on ultrasound was 2.7 cm and internal os closed. At 30 weeks, she had preterm labour and delivered a live female baby weighing 1.45 kg. She is under postnatal follow-up and doing well.



[Table/Fig-3]: Excised gross specimen which shows a bifid polyp which has irregular limb and a smooth limb. **[Table/Fig-4]:** Histopathology suggesting inflammation and squamous metaplasia (H&E,40X). (Images from left to right)

DISCUSSION

Cervical polyp is the focal hyperplasia of endocervical epithelium. They are often asymptomatic and usually seen in 4th and 5th decade of life. It occurs in 2-5% of women and is uncommon to see in pregnancy [1]. It is usually small in size of less than 2 cm [2]. The prevalence of cervical polyps in pregnancy is not known and very limited reports are available in the literature. Giant cervical polyps with more than 4 cm are uncommon variants and around 23 cases of this are reported as per literature [3]. Although literature suggests its common occurence in nulliparous women, but our case is in primigravida. Similar cases in primigravida have been reported by Kirbas A et al., and Robertson M et al., [2,4].

The women with polyp can present with complaints of spotting or bleeding per vagina, excessive vaginal discharge, foul smelling discharge, postcoital bleeding, mass per vagina, preterm delivery and chorioamnionitis [5]. Bleeding cervical polyp during early pregnancy can often be confused with abortion and it may be a cause for antepartum haemorrhage in late pregnancy. Hence,

a proper per speculum examination is a must to rule out cervical pathologies. We should be cautious in cases of extremely giant polyps as it may cause torrential bleeding and rarely can be a cause for obstruction during delivery [6].

Most of the obstetricians prefer conservative method for small sized polyps in pregnancy. The management is always a dilemma due to rarity of this condition and non availability of standard guidelines. However, the removal of polyp is warranted when it is symptomatic and suspicious of malignancy. A cervical smear examination prior to polypectomy is essential. Radiological exploration with ultrasound or Magnetic Resonance Imaging (MRI) is an important tool for assessing the extent of giant cervical polyp. While some studies suggest removing cervical polyp from gravid women is not warranted, we should keep in mind that they are prone for infection, ulceration due to friction and malignancy potential of 0.2 to 1.7% [7].

Both our case and review of literature suggest that endocervical polyp is usually benign in nature. In present case report, the patient was managed with surgical excision. Similar management has been reported by Kirbas A et al., and Sameer Hamadeh S et al., [2,5]. As per Kirbas report, 22 week primigravida with symptomatic giant cervical polyp causing funnelling and shortening of cervix was managed with simple polypectomy alone without any cervical circlage. Post operatively, the funnelling of cervix disappeared and cervical length returned to normal with continuation of pregnancy to 34 weeks. Hamadeh S et al., has reported similar case of giant polyp with funnelling and shortening of cervix at 38 week gestation managed with polypectomy and patient delivered vaginally two days after the procedure [5]. The choice of combining cervical cerclage procedure can be decided on individual case basis considering cervical changes and other high risk factors.

Fukuta K et al., in their study were able to conclude that patients who underwent polypectomy have high risk of premature delivery [8]. Tokunaka M et al., in their study reported higher risk of miscarriage and spontaneous preterm birth with decidual polyp, than endocervical polyps in pregnant women. They concluded, it is safer to avoid cervical polypectomy during pregnancy except those suspected to be malignant [9].

In the study conducted by Gopalan U et al., on clinicopathological diagnosis of cervical polyps, endocervical mucous polyp (common in age group 20-29 years) was found to be the most common comprising 50.5% and endocervical glandular polyp comprising 9.3% [10]. Most common age group was 40-49 years where all types of cervical polyp was found. Radiological exploration including ultrasound or MRI may be necessary to assess the extension of the polyp and also colour doppler to rule out other causes of bleeding in pregnancy like vasa previa [4].

Since preterm delivery is multifactorial in aetiology, it may be difficult to conclude if preterm delivery occurred due to ongoing inflammation even after polypectomy or due to any other underlying or emergent causes. However, cervical changes may be followed clinically and by ultrasound as there may be a high risk for premature delivery.

CONCLUSION(S)

Giant cervical polyps seen in pregnancy are of rare occurrence. The removal of polyp is warranted when it is symptomatic and suspicious of malignancy. The giant cervical polypectomy may carry risk of preterm delivery. The patient need to be followed-up for early warning signs of preterm delivery and careful supervision of pregnancy should be carried out.

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PLAGIARISM CHECKING METHODS: [Jain H et al.]
- Plagiarism X-checker: Feb 05, 2022
- Manual Googling: Apr 11, 2022
- iThenticate Software: Apr 13, 2022 (8%)

ETYMOLOGY: Author Origin

AUTHOR DECLARATION:
- Financial or Other Competing Interests: None
- Was informed consent obtained from the subjects involved in the study? Yes
- For any images presented appropriate consent has been obtained from the subjects. Yes

Date of Submission: **Jan 31, 2022**
Date of Peer Review: **Mar 04, 2022**
Date of Acceptance: **Apr 14, 2022**
Date of Publishing: **Jul 01, 2022**