

Giant Cervical Angiomyomatous Polyp Masquerading Third-Degree Uterine Prolapse: A Rare Case with Review of Literature

Abstract

Giant cervical polyps are rarely seen nowadays in routine day-to-day practice and are defined as a polyp with a size >4 cm. Giant cervical polyps protruding outside the vaginal canal causing diagnostic dilemma are rarely encountered in gynecologic practice. They masquerade as uterine inversion, prolapse, or cervical malignancy. Only a few cases have been reported in the literature. We hereby report a case of giant polyp of anterior lip of the cervix occurring in a multiparous woman and presented with something coming out per vagina. Histopathology of it came out to be angiomyomatous polyp (vascular leiomyoma) of the cervix that itself is a rare entity.

Keywords: Cervical polyp, giant, uterovaginal prolapse

Introduction

Giant cervical polyp rarely seen nowadays in day-to-day practice and are defined as polyps >4 cm in size. Only few cases are reported in the literature.^[1] Cervical polyps are a common pathology in adult females, but the size is mostly <2 cm and mostly diagnosed incidentally during the routine per-vaginal examination.^[2] Giant polyps commonly occur in multiparous women, mostly in the fifth decade of life and rarely found in children's. These giant cervical polyps frequently interpreted as malignant neoplasm at the time of presentation.^[3] We hereby report a case of giant polyp of anterior lip of the cervix occurring in multiparous woman and presented with something coming out per vagina. Histopathology of it came out to be angiomyomatous polyp (vascular leiomyoma) that itself is a rare entity.

Case Report

A 45-year-old multiparous woman came in Obstetrics and Gynaecology Outpatient Department of AIIMS, Jodhpur, with a complaint of something coming out per vagina from the past 3 years. The patient also complains of increasing frequency of micturition and incomplete evacuation of the bladder from the past 6 months. The patient has to reposit the mass back for complete evacuation of the bladder. There

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was no associated bowel dysfunction. The patient was amenorrhic from the past 10 months. She had three full-term normal vaginal deliveries and her last childbirth was 21 years back. The first delivery was institutional; rest two were home delivery. On examination, her vitals were normal. On per-abdomen examination, the abdomen was soft and nontender. On local examination, a mass of approximately 10 cm × 8 cm was protruding through the vagina. The mass was firm, keratinized, and nontender, with no decubitus ulcer. On the posterior aspect of mass, at the very high up position a dimple seen probably stenosed cervical os. Liquid-based cytology taken from opening that came out to be inflammatory, with no evidence of malignancy. There was no lymphadenopathy. On per-vaginal examination, the uterus was small and bilateral fornices were free. Routine hematological and biochemical investigation were within normal limits. The ultrasonography suggested of a bulky uterus with intramural fibroid of 1.9 cm × 3 cm and subserosal fibroid of 1.9 cm × 2 cm, bilateral ovaries normal, and with normal endometrial thickness. Still, the diagnosis was not clear. The probable diagnosis of ? third-degree uterine prolapse/uterine inversion was made. The patient has been planned for exploratory laparotomy and proceeded with surgery. During surgery, the uterus was found to be bulky and a boggy mass was seen below

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the bladder of approximately 4 cm × 3 cm. During surgery doubt of bladder diverticulum or any bladder, pathology came in mind. The uterovesical fold of peritoneum dissected and bladder was to push down. After pushing bladder down, a 4 cm × 3 cm of degenerated fibroid seen arising from the lower segment was seen. Cystoscopy was done to rule out any injury. Finally, hysterectomy was done. The gross specimen showed uterus with cervix without adnexa measuring 10.5 cm × 6 cm × 5 cm. Endomyometrium measured 0.8 + 3 cm. On serial slicing, intramural fibroids noted measuring 1 and 1.5 cm in diameter. Outer surface of lower uterine junction showed a polyp measuring 7 cm × 3.5 cm × 4 cm. The cervical os also showed a large polyp measuring 7.5 cm × 6 cm × 4 cm [Figure 1a and b]. Cut section of the polyp was solid, white. On microscopic examination, cervix showed features of chronic cervicitis with squamous metaplasia and endometrium showed disordered proliferation. Myometrium showed leiomyoma without necrosis, atypia, and mitotic activity.

Sections from endocervical polyp and polyp at the lower uterine junction showed similar morphology, with many variable calibered thickened blood vessels which were admixed with spindle-shaped cells arranged in short fascicles and around the vessels [Figure 2a]. There was no significant atypia, mitosis, or necrosis noted. The features were suggestive of angioleiomyoma. On immunohistochemistry, the luminal structures were positive for CD34 [Figure 2b] and spindle cells for smooth muscle actin [Figure 2c and d] and negative for human melanoma black-45. Postoperative period was uneventful, and the patient discharged on the 8th-postoperative day.

Discussion

Cervical polyps are relatively common pathology seen in the fourth and fifth decades of life, with incidence of 4%–10% of all cervical pathology.^[4] They occur due to the reactive changes from long-standing chronic

inflammation. Other factors include multiparity and foreign bodies.^[5] We reported the case of a giant cervical polyp arising from the anterior lip of ectocervix in a multiparous woman that masquerade as a uterine prolapse/inversion. The histology of our case was reported as vascular leiomyoma with no malignant changes. Khalil *et al.* in their study reported 17 cm × 10 cm × 5 cm polyp arising from the anterior lip of cervix. Histopathology came out to be fibrovascular tissue with endocervical glands.^[6] Another case reported cervical fibroid polyp measuring 18 cm × 15 cm × 12 cm. Histopathological finding confirmed vascular leiomyoma with no malignant change.^[2] In reported literature, the most common presenting symptoms were mass protruding outside the vagina with foul-smelling discharge and bleeding in few cases.^[7] Yadav *et al.* in his study reported the most common location was ectocervix and with benign pathology.^[4] The incidence of malignant changes in cervical polyps is only 1.7%.^[8] Even though the giant polyps are reported as benign, their clinical presentation, size, and appearance can mimic as malignant tumor. Hence, proper clinical examination and investigation must be done to rule out any malignant pathology. The definitive treatment is surgery, and the final diagnosis is given after histopathological examination.

Conclusion

Giant cervical polyps are rare entity. Only a few cases are reported in literature; all the reported cases are of benign pathology. It masquerades as uterine inversion or prolapse and cervical malignancy. Hence, proper evaluation is required to make accurate diagnosis and surgical management.

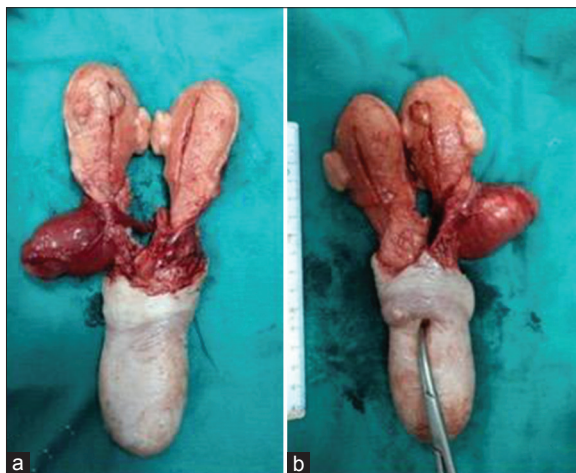


Figure 1: (a) Anterior view of gross specimen (b) posterior view of gross specimen

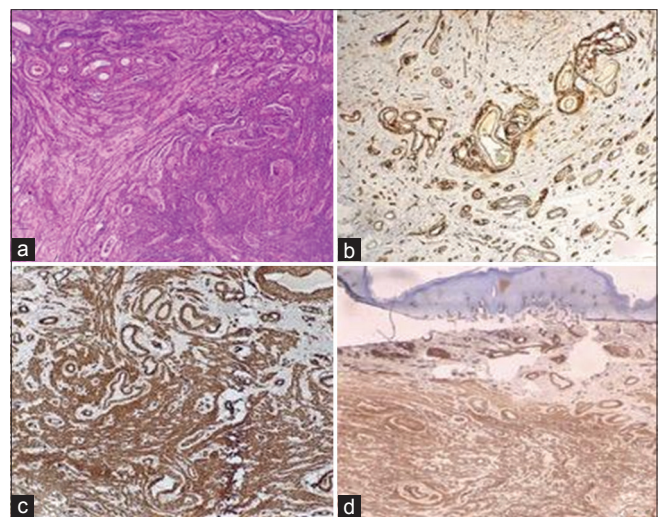


Figure 2: (a) Spindle-shaped cells admixed with small-calibered vessels (H and E, ×40) (b) CD34-positive immunorexpression in blood vessels (immunohistochemistry, ×40) (c) smooth muscle actin-positive immunorexpression in lower uterine junction polyp (immunohistochemistry, ×40) (d) smooth muscle actin-positive immunorexpression in ectocervical polyp (immunohistochemistry, ×10)

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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