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Oncogenic Potential and Clinical Implications of Giant Endometrial Polyps: A Case Report and Literature Review

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Endometrial polyps exceeding 4 centimeters in length are exceedingly rare and are termed “giant polyps.” We describe two patients that presented to our hospital with giant endometrial polyps. Clinical implications and oncologic potential of giant endometrial polyps are discussed. Risk factors of oncologic transformation include advanced age, menopausal status, obesity, diabetes, arterial hypertension, use of tamoxifen, and size greater than 1.0 centimeter. A literature review of all documented cases of giant endometrial polyps is presented and management strategies for counseling and polypectomy are reviewed.

1. Introduction

Endometrial polyps are localized overgrowths of the endometrial lining of the uterus. Microscopically, they are composed of varying amounts of glandular tissue, stroma, and blood vessels covered by an epithelium. Their size can range from a few millimeters to beyond 5 centimeters in length. Endometrial polyps larger than 1 cm are termed “large polyps,” and those that are greater than 4 cm, which are exceedingly rare, are called “giant polyps” [1].

The exact incidence of endometrial polyps is unknown; however, in women with dysfunctional uterine bleeding, the prevalence of endometrial polyps ranges from 10% to 24% [2], 10% to 25% of symptomatic polyps may contain hyperplastic foci and malignant transformation has been observed in about 0 to 12.9% [2]. Although evidence in the literature defining factors linked to malignant transformation is contradictory, advanced age, menopausal status, obesity, diabetes, arterial hypertension, and use of tamoxifen have reached statistical significance in varying reports [3–5]. Additionally, polyp size has been found to be a predictive factor. B. P. Lasmar and R. B. Lasmar [6] found that endometrial polyps larger than 1.5 cm were associated with hyperplasia, while a separate report by Wang et al. [3] identified that polyps measuring more than 1.0 cm were associated with malignancy.

We describe two patients that presented to our hospital with giant endometrial polyps and present a literature review of other similar cases. The oncogenic potential of large polyps is evaluated and evidence-based management strategies are discussed.

2. Case Series

2.1. Case #1. FM is a 70-year-old postmenopausal black female who presented with a chief complaint of intermittent vaginal spotting since the age of 50. She had not sought gynecologic care for several years. FM reported two episodes of vaginal spotting over the previous year, each lasting approximately one week in duration. Otherwise, she was asymptomatic and denied any recent intercourse or trauma to the vaginal area. Her past medical history was significant for poorly controlled hypertension, poorly controlled type 2 diabetes mellitus, osteoarthritis, angina, vitamin D deficiency, and glaucoma. She reported a long history of normal Pap smears over the course of her life and had one full-term normal spontaneous vaginal delivery. Family history
was significant for breast cancer in her mother at the age of 60 years. She denied any family history of uterine cancer, colon cancer, or ovarian cancer.

On initial evaluation, FM was alert and oriented and well nourished, with a body mass index (BMI) of 28 kg/m². On physical examination, her vaginal mucosa was atrophic. A 1 cm polyp that originated from the endometrial cavity was found to be protruding from the cervical os and was friable to the touch. On bimanual exam, the uterus was anteverted, smooth, and mobile without palpable adnexal masses. Transvaginal ultrasound confirmed an anteverted uterus measuring 9.1 × 5.2 × 7.1 cm with a thickened, heterogeneous endometrial echo measuring 12.1 mm with multiple cystic small spaces (Figure 1). A vascular signal was seen throughout the thickened endometrium and a partially calcified leiomyoma in the left uterine body was also noted. An endometrial biopsy was obtained and showed rare superficial fragments of inactive endometrial tissue. Due to postmenopausal bleeding, the patient was booked for operative hysteroscopy, dilation and curettage, and polypectomy. On hysteroscopy, a large polyp was seen arising from the anterior uterine wall. Using operative hysteroscopy and hysteroscopic scissors, this polyp, measuring 5.3 cm in greatest dimension, was removed in its entirety (Figure 2). Endometrial curettage was performed after complete removal of the polyp. Final pathology showed inactive endometrium without evidence of hyperplasia (Figure 3). At the two-week postoperative visit, FM reported complete resolution of her symptoms.

2.2. Case #2. HA is a 66-year-old obese postmenopausal Hispanic female who presented with a chief complaint of intermittent vaginal spotting of a duration of eight months. Past medical history was significant for poorly controlled hypertension, aortic stenosis, hypercholesterolemia, and glaucoma. She reported a history of normal Pap smears throughout her life, the last one being one month prior to presentation. She had two full-term vaginal deliveries and one cesarean delivery. HA denied any significant family history of malignancy. On initial examination, she was noted to be alert and oriented and was obese with a BMI of 39.5 kg/m². The external genitalia appeared normal and without lesions. A polyp was seen protruding 2 cm from the cervical os. On bimanual exam, the uterus was noted to be mobile, anteverted, and smooth, with no palpable adnexal masses. Transvaginal ultrasound revealed a 9.6 × 5.9 × 5.7 cm uterus with endometrial lining measuring 20 mm with small cystic appearing areas (Figure 4). Due to the large polyp protruding from the cervical os, the patient was booked for operative hysteroscopy, dilation and curettage, and polypectomy. The polyp was grasped with forceps and removed from its base prior to the hysteroscope being introduced to the uterine cavity. The polyp measured 8 cm in its greatest dimension. Hysteroscopy revealed areas of polypoid tissue which were removed under direct visualization (Figure 5). Endometrial
curettage was then performed. Final pathology revealed inactive endometrium with no hyperplasia or atypia (Figure 6). At her two-week postoperative visit, she reported a resolution of her symptoms.

3. Discussion

Endometrial polyps are found in both premenopausal and postmenopausal women. Patients may either be asymptomatic at the time of diagnosis or present with abnormal bleeding patterns, including intermenstrual bleeding, menorrhagia, or postmenopausal bleeding [1]. The exact cause of endometrial polyps is unknown, but estrogenic activity appears to play a crucial role in their pathogenesis and growth [2]. Several molecular mechanisms have been proposed to play a role in the development of endometrial polyps. These include overexpression of endometrial aromatase, unbalanced activity between estrogen and progestin, inhibition of apoptosis, certain gene mutations that favor endometrial proliferation, and cellular mechanisms linked with inflammation [3, 4].

Previous case series indicate that malignancy occurs within 0% to 12.9% of endometrial polyps [4]. Although there is no consensus in the literature on the exact risk factors that are associated with malignant transformation of polyps, most authors agree that the risk of malignancy is increased with age and menopausal status and with the presence of symptomatic bleeding [1, 2]. Larger endometrial polyps also have been shown to be a risk factor for premalignant or malignant pathology, with authors advocating a cut-off point of 1.0 to 1.8 cm diameter as a risk factor [3–6].

Wang et al. retrospectively reviewed consecutive cases of patients that underwent hysteroscopic removal of an
endometrial polyp and correlated malignant and prema-
alignant lesions to clinical risk factors [3]. Of the 766
patients, polyps were histologically benign (no atypia) in
96.21% of patients, hyperplasia with atypia was identified
in 3.26% of cases, and invasive endometrial carcinoma
was present in only 0.52% of patients. Independent vari-
ables that were significantly related to premalignant and
malignant polyps included polyp diameter greater than
1.0 cm, menopausal status, and abnormal uterine bleed-
ing. In this report, hypertension, diabetes mellitus, body
mass index, and use of tamoxifen were not found to be
associated with the malignant transformation of polyps
[3].

Ferrazzi et al. compared the prevalence of hyperplasia
and malignancy in endometrial polyps among a cohort of
1,552 asymptomatic postmenopausal patients in comparison
to a similar cohort of 770 postmenopausal patients that
presented with abnormal uterine bleeding [15]. The prev-
ance of atypical hyperplastic polyps was 1.2% in asymptomatic
versus 2.2% in symptomatic patients ($P < .005$). One single
case of stage 1 grade 1 endometrial carcinoma was recorded
within a polyp with a mean diameter 4 cm in an asympto-
tomatic patient. After multivariate analysis, diameter of the
polys was the only variable significantly associated with an
abnormal histology (malignancy and atypical hyperplasia) in
asymptomatic women with an odds ratio of 6.9 (confidence
interval: 2.2–21.4) for polyps with mean diameter $> 1.8$ cm
[15].

Similarly, another retrospective review of 1,136 asympto-
tomatic women that underwent hysteroscopic resection of an
endometrial polyp found that polyps with diameters greater
than 1.5 cm had hyperplasia rates of 14.8% compared with
7.7% in the group with smaller polyps ($P < 0.5$) [6]. Com-
parable to the above findings, Ben-Aire et al. assessed 430
women with endometrial polyps undergoing hysteroscopic
resection and found hyperplasia without atypia in 11.4% of
cases, hyperplasia with atypia in 3.3% of cases, and malignant
conditions in 3.0% of cases [5]. Older age, menopause status,
and polyps larger than 1.5 cm were associated with significant
premalignant or malignant changes [8]. Interestingly, the
presence of postmenopausal or irregular vaginal bleeding was
not a predictor of malignancy in this study [8].

Giant endometrial polyps larger than 4 cm in diameter are
exceedingly rare. Table 1 summarizes the management and
outcomes of reported cases of giant endometrial polyps in the
literature. The mean age of patients with giant endometrial
polyps was 66.6 years (range: 55–70). All of the reported
patients were postmenopausal. The most common presenting
symptom was vaginal bleeding. Of the reported cases, 58%
(7/12) were in association with use of a phytoestrogen or
selective estrogen receptor modulators such as tamoxifen or
raloxifene. In the report by Unal et al., the authors state that
the patient consumed a large amount of thyme, a known
phytoestrogen [13]. The six highest estrogen binding herbs are
soy, licorice, red clover, thyme, turmeric hops, and Verbena
[13].

Although not on exogenous drugs, the patient described
by Narin et al. had several risk factors similar to our patients,
including obesity, older age, and hypertension [10]. The
patient described by Meena et al. did not present with post-
menopausal bleeding and did not use hormones. However,
she had several risk factors including postmenopausal status,
obesity, diabetes mellitus, and hypertension. Similarly, the
patient in the case by Unal et al. did not report vaginal
bleeding; her polyp was discovered by an incidental CT
scan for complaints of lower back pain. Demographic details
were not provided in the report by Cil et al.; however, the
patient was of older age [1]. In addition to their menopausal
status, both of our patients have medical comorbidities that
may be risk factors for malignant transformation of polyps
including hypertension, obesity, and type 2 diabetes mellitus.
It is interesting to note that 8 of the 12 patients described
were of Turkish or Mediterranean origin. It is possible that
there are genetic, dietary, or ethnic factors related to the
development of large polyps; however, with such a small
incidence and limited reporting, no conclusions can be
inferred.

The rationale for removing polyps is to exclude mali-
nancy and to relieve symptomatic vaginal bleeding. Man-
agement of small asymptomatic polyps may be conservative
with follow-up. However, conservative management should
be undertaken with caution in postmenopausal patients,
patients with any risk factors, or those with polyps measuring
greater than 1.0–1.5 cm in size, as there is increased risk for
atypical hyperplasia or malignancy [7, 15]. Risk factors for
malignancy differ among reports and populations; however,
larger size, advanced age, menopausal status, obesity, dia-
betes, arterial hypertension, and tamoxifen use have been
associated with malignancy.

Hysteroscopic polypectomy remains the mainstay of
evaluation and operative management of endometrial polyps
as the associated morbidity is minimal when compared to
a hysterectomy. Operative hysteroscopy allows for visu-
alization of the entire uterine cavity. There are a variety
of methods practiced to remove polyps at hysteroscopy
(sharp scissors, electrosurgical techniques); however, there
are no comparative studies for these methods with regard
to efficacy. Therefore, the method of choice should be one
that is most familiar to the surgeon. Regardless of which
method is employed, removal of the entire polyp, including
complete excision of the polyp stalk, should be achieved.
Studies have indicated that removal of endometrial polyps
by blind curettage is unsuccessful in more than 50% of
attempts, and, in many cases, the removal is incomplete
[4]. Therefore, blind curettage should not be used as a
diagnostic or therapeutic intervention [4]. If malignancy is
found within the polyp, the patient should be referred to
a gynecological oncology specialist for further staging and
management.

It should be emphasized that the clinical implications
and oncogenic potential of large and giant endometrial polyps
are still unclear in the literature. Information is currently
derived from small studies, case series, and case reports.
The pathogenesis of endometrial polyps as well as factors
leading to oncogenesis is still being elucidated. Therefore,
with these limitations in knowledge, caution should be taken
when counseling patients that present with large or giant
endometrial polyps.
## Table 1: Summary of reported cases of giant endometrial polyps.

<table>
<thead>
<tr>
<th>Report</th>
<th>Patient age</th>
<th>Polyp size (cm)</th>
<th>Associated drugs</th>
<th>Management</th>
<th>Pathology</th>
</tr>
</thead>
<tbody>
<tr>
<td>C¸iletal. [1]</td>
<td>73</td>
<td>8 × 4 × 3</td>
<td>No</td>
<td>Hysteroscopic polypectomy</td>
<td>No hyperplasia, atypia, or malignancy</td>
</tr>
<tr>
<td>Moon et al. [2]</td>
<td>58</td>
<td>7.5 × 5.5 × 2.6</td>
<td>Tamoxifen</td>
<td>Total abdominal hysterectomy</td>
<td>No hyperplasia, atypia, or malignancy</td>
</tr>
<tr>
<td>Nomikos et al. [3]</td>
<td>74</td>
<td>Diameter 8 cm</td>
<td>Tamoxifen</td>
<td>Total abdominal hysterectomy</td>
<td>Complex hyperplasia with atypia</td>
</tr>
<tr>
<td>Kutuk and Goksedef [4]</td>
<td>63</td>
<td>4.5 × 4 × 5.2</td>
<td>Raloxifene</td>
<td>Polypectomy under ultrasound guidance</td>
<td>No hyperplasia, atypia, or malignancy</td>
</tr>
<tr>
<td>Narin et al. [5]</td>
<td>66</td>
<td>12 × 6 × 5</td>
<td>No</td>
<td>Total abdominal hysterectomy, BSO</td>
<td>No hyperplasia, atypia, or malignancy</td>
</tr>
<tr>
<td>Erdemoglu et al. [6]</td>
<td>55</td>
<td>10 × 6 × 3</td>
<td>Tamoxifen</td>
<td>Extraction of mass under general anesthesia</td>
<td>No hyperplasia, atypia, or malignancy</td>
</tr>
<tr>
<td>Caschetto et al. [7]</td>
<td>64</td>
<td>9 × 7 × 4.5</td>
<td>Tamoxifen</td>
<td>Total abdominal hysterectomy, BSO</td>
<td>Complex hyperplasia with atypia</td>
</tr>
<tr>
<td>Catania, Italy</td>
<td>67</td>
<td>8 × 6 × 3</td>
<td>Tamoxifen</td>
<td>Total abdominal hysterectomy, BSO</td>
<td>Simple hyperplasia, no atypia</td>
</tr>
<tr>
<td>¨Unaletal. [8]</td>
<td>78</td>
<td>10 × 9</td>
<td>Phytoestrogens</td>
<td>Total abdominal hysterectomy</td>
<td>No hyperplasia, atypia, or malignancy</td>
</tr>
<tr>
<td>Meena et al. [9]</td>
<td>65</td>
<td>8.5 × 1.5</td>
<td>No</td>
<td>Hysteroscopic polypectomy</td>
<td>Cystic hyperplasia without atypia</td>
</tr>
<tr>
<td>van Staalduinen et al.</td>
<td>70</td>
<td>9.1 × 5.2 × 7.1</td>
<td>No</td>
<td>Hysteroscopic polypectomy</td>
<td>No hyperplasia, atypia, or malignancy</td>
</tr>
<tr>
<td>New York, USA (index cases)</td>
<td>66</td>
<td>8 × 6 × 5</td>
<td>Polypectomy/hysteroscopy</td>
<td>No hyperplasia, atypia, or malignancy</td>
<td>No hyperplasia, atypia, or malignancy</td>
</tr>
</tbody>
</table>
Data Availability
The data presented in article is available from the corresponding author upon request.

Consent
Consent was obtained for publication of case and images from both patients and can be provided on request.

Conflicts of Interest
The authors declare that they have no conflicts of interest.

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