HYSTEROSCOPY IN ABNORMAL UTERINE BLEEDING

SARITA SARAIYA ● NOZER SHERIAR ● V.R. WALVEKAR

SUMMARY

Abnormal uterine bleeding is a common Gynaecologic disorder. Dilatation and curettage has long been the diagnostic gold standard in these cases.

This study was done to compare hysteroscopy with histopathology in the diagnosis of the aetiology of abnormal uterine bleeding, 85 patients were included in the study.

Hysteroscopy was found to have a sensitivity of 94.3% and a specificity of 81.2%. Hysteroscopy is not a substitute for tissue diagnosis. However, hysteroscopy findings will increase the information available to the Gynaecologist.

INTRODUCTION

Abnormal uterine bleeding is a common gynaecologic disorder. Dilatation and curettage has long been the diagnostic standard for abnormal uterine bleeding. However, even the most thorough curettage, curettes and assesses at best 70-80% of the endometrium. Failure rates in making a tissue diagnosis may occur in 36-50% cases.

Hysteroscopy is not a substitute for tissue diagnosis. According to Loffer (1989) hysteroscope or not, a tissue diagnosis is essential, especially on this litigious world. However, one is likely to be more precise by using a hysteroscopic examination with tissue sampling as opposed to tissue sampling - a D & C alone. The aim of this study was to correlate hysteroscopic findings with histopathology.

MATERIALS AND METHODS

Eighty five patients of abnormal uterine bleeding were included in the study. All

Dept. Obst. & Gyn., Nowrosjee Wadia Maternity Hospital, Parel, Bombay.

Accepted for Publication on 2.12.94

the patients were in the age group 20 - 80 years. Menorrhagia was the commonest presenting complaint, followed by polymennorhagia, polymenorrhoea, post menopausal bleeding and menometrorrhagia.

Hysteroscopy was performed under general anaesthaesia or a local paracervical block, after which curettage was done and the material sent for histopathology.

Hysteroscopy findings were then compared to the histopathology reports.

RESULTS

Table I
Hysteroscopy Findings

Findings	Number of Cases	Percentage
NORMAL	29	34.1
ABNORMAL	56	65.8
Hyperplastic Endometrium	37	
Submucous fibroid	11	
Intrauterine Adhesions	4	
Subseptate uterus	2	
Placental polyp	1	
Trabeculations/alveoli	1	
Forgotten IUCD	1	

Normal hysteroscopy findings were recorded in 34.1% of cases. In 65.8% cases, one or more abnormal findings were seen.

The commonest abnormal findings were hyperplastic endometrium in 37 cases, submucous fibroids in 11 cases and endometrial polyps in 8 cases.

Table II
Histopathology Findings

Findings	Number of Cases	Percentage
NORMAL	60	70.5
ABNORMAL	25	29.4
Hyperplasia	13	
Polyp	9	
Tuberculosis	1	
Products of conception	2	

Normal Histopathology reports were documented in 70.5% cases. 29.4% were abnormal, showing one or more abnormalities.

Thirteen cases had endometrial hyperplasia, 9 cases had polyps. 1 case was reported to have endometrial tuberculosis and evidence of products of conception were seen in 2 cases.

ANALYSIS

In 26 cases, both hysteroscopy and histopathology were normal. In 22 cases, both hysteroscopy and histopathology were abnormal. Therefore, in 48/85 cases, i.e. 56.5% cases hysteroscopy and histopathology findings showed a high correlation.

In 3 cases, hysteroscopy was normal, but histopathology abnormal. One was a case of Koch's endometritis, another was a case of cystic glandular hyperplasia and in the third, a mucous polyp was found on histopathology which was not found on hysteroscopy.

In 34 cases, abnormal hysteroscopy

Table III
Correlation between Hysteroscopy and Histopathology

Histopathology Report	Hysteroscopy Findings Normal	Abnormal	Total
Normal	26	34	60
Abnormal	3	22	25
Total :	29	56	85

Table IV
Sensitivity and Specificity of Hysteroscopy

Hysteroscopy Finding	Disease Actually Present	Absent	Total
Disease indentified	50	6	56
Disease not identified	3	26	29
Total :	53	32	85

Sensitivity of Hysteroscopy = 94.3%
Specificity of Hysteroscopy = 81.2%

was accompanied by normal histopathology. In one case a 'forgotten' IUCD was found. The patient had been through multiple curettages, but was not relieved of menorrhagia till hysteroscopy was done and the IUCD identified and removed.

Intrauterine adhesions were seen in 4 cases and a subseptate uterus in 2 cases. These are lesions which cannot be picked up on histopathology.

Taking histopathology as the diagnostic gold standard for tissue diagnosis, the sensitivity of hysteroscopy is 94.3%. Thus, hysteroscopy alone cannot replace histopathology. However, hysteroscopy along with curettage improves the accuracy of diagnosis.

DISCUSSION

Dysfunctional uterine bleeding is a diagnosis made by exclusion. The patient is given symptomatic reief, empirical hormonal therapy given and often a hysterectomy done when the condition

persists.

Today, with the advent of hysteroscopy, many more lesions are being picked up, the diagnosis of dysfunctional uterine bleeding less frequently made, and fewer hysterectomies performed, there being an additional therapeutic option of hysteroscopic surgery.

The proficient hysteroscopist can accurately anticipate the microscopic pattern by microphysteroscopy but the last word in histopathological diagnosis is always reserved for the pathologist.

The advantages of supplementing every blind curettage with hysteroscopy is evident from the current study.

According to Barbot (1989) blind curettage removes polyps in fragments together with strips of endometrium, making detection difficult for the pathologist. The ability to recover the entire polyp under visual control will result in a more reliable histologic examination.

The presence of a submucous myoma can occasionally be suspected by the 'feel' of the curette, but in most cases the diagnosis will be missed and the abnormal bleeding will persist because the myoma has been eroded by the scraping.

In the diagnosis of benign endometrial hyperplasia, random tissue sampling provides only limited information. The curette blindly destroys endometrial organisation and collects small fragments for the pathologist. Direct visualisation of the uterine cavity prior to trauma provides a classification and mapping of hyperplasia, whether plain or polypoid, diffuse or focal. Hysteroscopy is also invaluable in the assessment of response to therapy. According to Hamou and Lewis (1990) outpatient hysteroscopic assessment of patients with abnormal uterine bleeding can be used as a screening procedure, to decide whether primary medical treatment may be given or whether a pathological lession is present which requires removal.

Abnormal bleeding following IUD insertion will benefit by hysteroscopy. According to Baggish and Valle (1989), blind techniques for removal of a misplaced IUCD may eventuate in uterine perforation and the danger of bleeding or infection. The comfort of visualising the uterine cavity directly permits detection of embedment or fragmentation of the device and adds enormously to the safe evaluation of these patients.

CONCLUSION

Hysteroscopy along with curettage improves the accuracy of clinical diagnosis, the procedures being complimentary.

Hysteroscopy is not a substitute for tissue diagnosis. Lesions seen on hysteroscopy should be biopsied and subjected to histopathological examination whenever possible.

With the value of a visual diagnosis of intrauterine abnormalities now well established it may be time to mandate hysteroscopy every time traditional curettage is indicated.

REFERENCES

1. *Loffer F.D. : Obstet. Gynec. : 73, 16, 1989.*
2. *Hamou J; Lewis V; Recent Advances in obstetrics & Gynaecology Number 16: 1990: 185: Churchill Living Stone*
3. *Barbot J : Diagnostic and Operative Hysteroscopy : a text and atlas :1989: 147 : Chicago Year Book Medical Publishers*
4. *Baggish M and Valle R.F. : Diagnostic and Operative Hysteroscopy: a text and atlas, 1989 : 226: Chicago Year Book Medical Publishers.*