

ENDOMETRIAL PATHOLOGY: CLINICAL PICTURE, DIAGNOSIS AND TREATMENT

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Resume. Endometrial pathology, particularly polyps and hyperplasia, is a common reason for hospitalization in gynecological clinics. This article presents an analysis of clinical and demographic data from 10 patients. The average age of the patients was 39.4 years, and in 90% of cases, the pathology was diagnosed as an incidental finding during ultrasound examination. In 60% of patients, endometrial polyps were associated with uterine myoma, and in 30%, with adenomyosis. All patients underwent hysteroscopy with separate diagnostic curettage under intravenous anesthesia using propofol and fentanyl, without intraoperative complications. The data obtained highlight the high frequency of asymptomatic endometrial pathology and its frequent co-occurrence with other benign uterine diseases.

Keywords: endometrial polyp, hysteroscopy, endometrial hyperplasia, uterine fibroids, adenomyosis.

Relevance. Endometrial pathology, including polyps and hyperplasia, is a significant cause of gynecological morbidity in women of reproductive and perimenopausal age. 1,2. Despite its often-asymptomatic course, this pathology can cause menstrual irregularities, infertility, and also carry a potential risk of malignancy, which requires timely diagnosis and adequate treatment. 3. The gold standard for diagnosis and treatment is hysteroscopy, which allows visualization of the uterine cavity and removal of pathological formations. 1. Analysis of clinical and demographic characteristics of patients referred for this procedure allows us to optimize the treatment and diagnostic process.

Objective: to study the clinical, anamnestic, laboratory and instrumental diagnostic results of studies and the structure of concomitant gynecological pathology in patients referred for planned

hysteroscopy due to endometrial pathology.

Tasks:

1. Assess weight-height indicators (age, BMI) and the presence of clinical symptoms in patients.

2. Determine the frequency of combination of endometrial pathology with other benign diseases of the uterus (myoma, adenomyosis).

3. Describe the features of anesthetic care and course of the intraoperative period.

Materials and methods. A retrospective analysis of 10 patient records was conducted, including 10 consecutive patients admitted to the gynecology department from August to September 2025 for planned surgical treatment of endometrial pathology detected by ultrasound examination. Inclusion criteria: planned hospitalization for hysteroscopy (HS) and separate diagnostic curettage (SDC) of

the uterine cavity and cervical canal. Admission department data, ultrasound protocols, preoperative examination by an anesthesiologist-resuscitator, and surgical protocols were analyzed.

Results and discussion. The study group included 10 women with a mean age of 39.4 ± 5.9 years (range 29–48 years). The mean body mass index (BMI) was 27.8 ± 6.8 kg/m²; three patients (30%) were diagnosed with varying degrees of obesity (BMI >30).

The key finding was the absence of active complaints in 9 out of 10 patients (90%) at the time of hospitalization. Endometrial pathology was discovered incidentally during a routine pelvic ultrasound. Only one patient (10%) had a his-

tory of abnormal uterine bleeding (AUB), which required a more in-depth investigation.

During the analysis of gynecological pathology, according to ultrasound and hysteroscopy data, the following was revealed:

1. Endometrial polyp was confirmed in all 10 patients (100%).
2. Uterine fibroids were detected in 6 patients (60%).
3. Adenomyosis was diagnosed in 3 patients (30%).
4. Ovarian cyst was detected in 2 patients (20%).
5. Polycystic ovary syndrome (PCOS) was diagnosed in 1 patient (10%).

Tabl. 1. Structure of concomitant gynecological pathology in patients with endometrial polyps (n=10)

Pathology	Number of cases	Percent (%)
Endometrial polyp	10	100%
Uterine fibroids	6	60%
Adenomyosis	3	30%
Ovarian cyst	2	20%
Polycystic ovary syndrome (PCOS)	1	10%

Note: Some patients were diagnosed with more than one comorbidity

The average endometrial thickness measured by ultrasound was 11.7 mm (range, 2.2 to 22.5 mm) during the first phase of the menstrual cycle. All patients underwent hysteroscopy under intravenous anesthesia. The standard anesthesia protocol included premedication with midazolam, analgesia with fentanyl, and maintenance with propofol. Based on the preoperative assessment by the anesthesiologist, all patients were classified as ASA physical status I (7 patients) or II (3 patients). Preoperative airway assessment

(test Mallampati, thyromental distance, Wilson score) predicted a low likelihood of difficult intubation; however, endotracheal intubation was not required because the procedure was performed under intravenous anesthesia with sedation. The intra- and postoperative periods were stable and uneventful for all patients. Postoperative recovery was rapid, and consciousness was restored on the operating table.

The obtained data on the high frequency of asymptomatic endometrial pathology (90%) are consistent with the lit-

erature data indicating that endometrial polyps are often an incidental finding [1,3]. The identified high frequency of combination with uterine myoma (60%) and adenomyosis (30%) indicates common pathogenetic mechanisms, probably associated with hyperestrogenism [22]. The successful use of a standardized intravenous anesthesia protocol confirms its safety and efficacy in short-term gynecological operations.

Conclusions:

1. The typical patient referred for a routine hysteroscopy for endometrial pathology is a woman of reproductive or perimenopausal age (mean age 39.4 years), often overweight, without active complaints (90% of cases).

2. Endometrial pathology (polyp) in most cases (60–90%) is combined with other benign diseases of the uterus, such as myoma and adenomyosis, which requires a comprehensive approach to diagnosis and treatment.

3. In our small cohort, a trend toward an association between endometrial pathology and obesity was observed in 30% of patients, consistent with the known role of adipose tissue in estrogen production. However, given the limited sample size (n=10), this association should be interpreted with caution and requires further study in larger studies.

4. Hysteroscopy under combined intravenous anesthesia using propofol and fentanyl was well tolerated in our study, with no intra- or postoperative complications reported, and rapid recovery from anesthesia (as evidenced by recovery of consciousness on the operating table and an Aldrete 20/20 score in documented cases). Although these results indicate the safety and efficacy of the method, a more detailed evaluation, including continuous hemodynamic monitoring and assessment of postoperative cognitive dysfunction, is required to fully confirm its effectiveness.

Literature

1. Salim, S., Vaughan, H., Nesbitt-Howes, E., et al. Diagnosis and treatment of endometrial polyps: a critical review of the literature. *Journal of Minimally Invasive Gynecology*. 2011.
2. American Association of Gynecologic Laparoscopists (AAGL). AAGL Practice Report: Practice Guidelines for the Diagnosis and Treatment of Endometrial Polyps. *Journal of Minimally Invasive Gynecology*. 2012.
3. Clarke, T. J., Stevenson, H. and Gupta, J. K. Management of endometrial polyps in the 21st century. *Obstetrician and Gynecologist*. 2002.
4. Dewaay, DJ, Tanyi, JL, & Watts, KA (2016). Asymptomatic endometrial polyps and the risk of endometrial cancer. *Journal of gynecological surgery*, 32(3), 149-153.
5. Van Dijk, L. J., Breuer, M. K. & Timmermans, A. (2015). Diagnostic accuracy of endometrial thickness and features for the detection of endometrial pathology in women with postmenopausal bleeding: a meta-analysis. *Human Reproduction Update*, 21(6), 745–757.
6. Perez-Medina, T., Bajo-Arenas, J., Salazar, F., et al. (2016). Endometrial polyps and their impact on pregnancy rates in patients undergoing intrauterine insemination: a prospective randomized study. *Reproduction human*, 20(6), 1632-1635.
7. Yoo, K. Y., Jeon, C. W., and Lee, J. (2016). Anesthetic aspects of hysteroscopic surgery. *Korean Journal of Anesthesiology*, 69(3), 226–232.
8. Al Chami, A. and Saridogan, E. (2017). Endometrial polyps and subfertility. *Journal of Obstetrics and Gynecology*, 37(1), 1-5.

9. Lee, S.K., Kaunitz, A.M., & Sanchez-Ramos, L. (2017). Oncogenic potential of endometrial polyps: a systematic review and meta-analysis. *Obstetrics & Gynecology*, 116(5), 1197-1205.
10. Tosti, K., Pinzauti, S. and Ferrini, C. (2015). Pathophysiological mechanisms of uterine fibroids and adenomyosis: the role of estrogen and progesterone. *Gynecological endocrinology*, 31(8), 587-591.

ПАТОЛОГИЯ ЭНДОМЕТРИЯ: КЛИНИКА, ДИАГНОСТИКА И ЛЕЧЕНИЕ

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Резюме. Патология эндометрия, в частности полипы и гиперплазия, является частой причиной госпитализации в гинекологические стационары. В статье представлен анализ клинико-лабораторных данных 10 пациенток. Средний возраст пациенток составил 39,4 года, в 90% случаев патология была диагностирована случайно при ультразвуковом исследовании. У 60% пациенток полипы эндометрия были связаны с миомой матки, а у 30% – с аденомиозом. Всем пациенткам была проведена гистероскопия (ГС) с отдельным диагностическим выскабливанием (РДВ) под внутривенным наркозом с использованием пропофола и фентанила, без интра- и послеоперационных осложнений. Полученные данные свидетельствуют о высокой частоте бессимптомной эндометриальной патологии и ее частой ассоциации с другими доброкачественными заболеваниями матки.

Ключевые слова: полип эндометрия, гистероскопия, гиперплазия эндометрия, миома матки, аденомиоз.