

- Common, usually benign growth on the cervix.  
 - Due to glandular epithelial hyperplasia.  
 - Ca in 0.2-1.5% (even less if asymptomatic).  
 - More common in parous women and 40-50y.

**Cervical polyp**

Disclaimer:  
 Read the disclaimer at [medimaps.co.uk/disclaimer](http://medimaps.co.uk/disclaimer)

References:  
 1. Scarborough NHS ,Oct 2019.

**Symptoms**

- Occasionally IMB, PCB, changes in vaginal discharge.

**Refer to 2o care**

- The base of the polyp is not visible (as could be a prolapsed endometrial polyp)  
 - >1cm wide.  
 - You do not remove polyps.  
 - Confirmed endometrial polyp.

**Investigations**

- USS.

- This is only needed if you suspect it is an endometrial polyp.  
 - Or if you have already removed a presumed cervical polyp, and the histology has come back showing it was in fact an endometrial polyp.

**Management**

asymptomatic

symptomatic

- Risk of malignant change is so small you can offer woman a choice of removal or monitoring.

- Remove due to the small risk of malignancy.  
 - Can be removed in primary care, and send off for histology.  
 - If not able refer to 2o care.

- Painless procedure apart from possible sting for 30 sec.  
 - Light bleeding and mild period cramps for up to 24hrs after removal.  
 - May get grey/brown discharge for few of days.

- If histology = NAD, nil needed.  
 - If histology = show it was 'endometrial polyp', USS to check for other endometrial polyps. If no more present nil needed. If more present refer to gynaecology.

- In referral letter include:  
 - Any current hormonal treatment.  
 - Smear history (including last smear result).

