Practice Tips

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Endometrial biopsy

Hormone replacement therapy (HRT) should be discussed with all perimenopausal women[1] and is, therefore, a frequent intervention in primary care. One of the most common difficulties with HRT is unexpected vaginal bleeding. A recent guideline on this subject estimated the risk of irregular bleeding after 1 year of continuous combined HRT to be 5%.[2] Assessing the endometrium is recommended when there is unexpected bleeding after 6 months' therapy.[2,3]

Biopsy or transvaginal ultrasound?

Initial assessment of bleeding can include either or both of endometrial biopsy and transvaginal ultrasound (TVUS) examination. Some guidelines advocate use of biopsy initially, with TVUS only if biopsy is not accepted or impossible,[2] while others recommend TVUS first.[3] Endometrial thickness of 5 mm or more on TVUS had a sensitivity of 90%, but a specificity of only 48%, for predicting endometrial disease[4]; in other words, about half of all women will still require biopsy after TVUS. The negative predictive value for endometrial thickness less than 5 mm was 99%, so these women could be managed with observation only.

Because of the current uncertainty as to the best initial intervention, I offer and discuss both options with women. Most of my patients seem to prefer biopsy, perhaps because a definitive diagnosis can be made more quickly. I use the Pipelle endometrial suction curette for office assessment of the endometrium. The Pipelle's sensitivity for detecting endometrial cancer has been reported at 97.5%.[5] For thicknesses greater than 5 mm on TVUS, the Pipelle's sensitivity and specificity were 92% and 96%, respectively, for predicting combined cancer and hyperplasia.[6]

Procedure

The Pipelle endometrial suction curette is a thin, hollow, plastic tube, 3.1 mm in diameter, with a suction piston inside its lumen. Before biopsy, I obtain informed consent. Patients are given a brief handout on the subject and verbal explanations. They are asked to take 600 mg of ibuprofen 1 hour before the procedure to minimize discomfort.

I perform a bimanual examination first, then insert the speculum. I clean the cervix with povidone. If the uterus is not overly curved and the cervix not very mobile, I often do not use a tenaculum; otherwise, a tenaculum is useful for straightening and stabilizing the uterus.

The Pipelle is then gently inserted into the uterine cavity. Rotating the probe and using a small amount of lubricant on the tip are often useful for overcoming resistance at the cervical os. Once inside the endometrial cavity, I pull back on the piston, which creates suction within the Pipelle, and move the instrument back and forth several times, while rotating it. After withdrawing the Pipelle, I cut off the tip and express the endometrial specimen into a formalin solution.

After the procedure

The procedure causes some cramping and some vaginal bleeding. There is a small risk of perforation if excessive force is used. I have sometimes been unable to insert the Pipelle into the endometrium due to cervical stenosis, especially with

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nulliparous postmenopausal women. If this happens, I offer the patient TVUS if she has not already had it. If TVUS demonstrates an endometrial lining of 5 mm or thicker, I refer the patient to a gynecologist. Most of these patients will then go on to hysteroscopy and dilation and curettage.

Endometrial biopsy using the Pipelle curette is a well tolerated office procedure. It is relatively easy for family physicians to learn. Its main advantages are rapid and accurate diagnosis of the reason for postmenopausal vaginal bleeding and avoidance of more invasive surgical procedures. It is a valuable tool for those of us looking after women taking HRT.

References

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