Quantitative study of uterine curettage in the menstrual cycle

B. BISWAS AND J. A. H. FINBOW

From the Department of Pathology, Doncaster Royal Infirmary, Doncaster

SYNOPSIS  The histological appearances in 114 endometrial curettings from cases of dysfunctional bleeding have been analysed quantitatively by the method of Dunnill and Whitehead (1972) and Risdon and Keeling (1974).

As applied to this type of specimen, the technique provides indices of both tubular volume and tubular surface to volume ratio.

The histological diagnosis of endometrial hyperplasia is made from the increase in stromal and epithelial elements and the change in the pattern of the glands. These changes, on some occasions, can be difficult to detect.

Quantitative analysis can be used to distinguish minor degrees of abnormal endometrial hyperplasia, in comparing serial endometrial changes in a given patient, and in comparing different menstrual cycles in dysfunctional uterine bleeding.

Endometrial biopsies were collected and put in categories according to the clinical diagnosis. These biopsies were then examined morphometrically to find the volume/glandular surface and glandular/volume ratio. A significant change in these ratios was found.

Endometrial curettage is an essential procedure in the investigation of all forms of disorders of the menstrual cycle.

On light microscopy most forms of menstrual disorders present little difficulty in interpretation but minor degrees of abnormal menstrual cycle can be difficult to assess. This study considers a method of quantitative examination in which minor degrees of abnormal endometrial hyperplasia can be accurately recorded.

Several morphometric methods other than direct linear measurement are available for the measurement of tissue components in histological sections (Dunnill, 1968). All these methods depend on (1) adequate sampling, and (2) random distribution of the structures to be measured.

Materials and Methods

Routine diagnostic endometrial curettings were used. The curettings were fixed in 10% formol saline, dehydrated, cleared, and embedded in paraffin wax.

Sections were cut at 5 μ and stained with haematoxylin and eosin.

An eyepiece graticule (Graticules Ltd) containing a template (according to Weibel (1963)) with 15 lines of equal length connecting the vertices of a regular hexagonal point network was used and gave a constant 150 magnification throughout the study. At this magnification the length (l) of each line cast on the section was 1.4 × 10^{-2} cm. The section was orientated so that it lay centrally in the vertical axis of the microscopic field, and the most lateral of the lines on the graticule were superimposed on the stroma. The other lines then fell at random. The lines cutting the mucosal surface were cuts (c) and where the ends of the lines fell over the epithelium of the gland counted as hits (h). The number of cuts and of hits were recorded. The slide was moved, with the aid of mechanical stage, until the adjacent field was in view and this was then counted. This procedure was repeated until the biopsy material containing whole glands and stroma had been covered. The non-endometrial elements in the curettage were excluded. The index c:lh was calculated for each biopsy and the mean value was obtained to indicate the significance of the irregular distribution of fragments containing crowded glands within stroma.

It was not possible to calculate the absolute ratio of surface length to volume described by Chalkley et al. (1949) because of the type of material.
The mean number of hits per microscopic field examined was determined and this was proportional to the glandular volume.

Results

The results are set out in figs 1 to 4 and tables I to III.

Statistically significant results were found between group II (premenstrual endometrium) categories, mean $\bar{h}$ 4·01 (SD 1·76), and group III categories (abnormal endometrial hyperplasia), mean $\bar{h}$ 2·66 (SD 1·51) ($t = 2·97; p < 0·01$) but no significant difference between the mean $\bar{h}$ value of group III and the other categories.

The mean c:lh ratio for groups III and II was significant ($t = 260; p < 0·02$) but there was no significant difference between the mean c:lh ratio for group III and the other categories.

Discussion

Abnormal endometrial hyperplasia can be due to persistent Graafian follicles of the ovary. The changes in the endometrium and the symptoms are due to low oestrogen levels following abnormal interrelationship between the ovaries and the pituitary.

The gross histological pattern of abnormal endometrial hyperplasia can be categorized into four groups:

1. Proliferative Epithelial proliferation, tall elongated glands, and stromal cell proliferation with hyperchromic nuclei and the absence of mitoses
2. Adenomatous Epithelial proliferation, convoluted tubular glands with back-to-back distribution and stromal cell proliferation with hyperchromic nuclei and the absence of mitoses
3. Cystic Epithelial proliferation of the surface mucosa, dilated cystic glands, some containing pink amorphous material and stromal cell proliferation without mitoses
4. Mixed Containing all or two of the groups above.

In the cases of abnormal endometrial hyperplasia examined by us all the above groups were represented. Three of the patients with curettings showing abnormal endometrial hyperplasia had a subsequent hysterectomy and the histology was constant.

This study confirms that abnormal endometrial

Fig 1  A template of 15 lines of equal length arranged according to the specifications of Weibel (1963). They are superimposed on a curettage of an abnormal adenomatous hyperplasia with endometrial carcinoma. ‘Hits’ are counted where the end points of the lines lie over the mucosal surface; ‘cuts’ are counted where the lines cross the surface epithelium of the gland. Haematoxylin and eosin $\times$ 105.
Quantitative study of uterine curettage in the menstrual cycle

Fig 2 Abnormal proliferative endometrial hyperplasia. H and E × 105.

Fig 3 Abnormal cystic endometrial hyperplasia. H and E × 40.
Fig 4 Endometrial carcinoma. H and E × 105.

<table>
<thead>
<tr>
<th>Group</th>
<th>Age Range</th>
<th>Indication for Biopsy</th>
<th>No. of Biopsies</th>
<th>Histological Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>17-42</td>
<td>Dysmenorrhagia, infertility</td>
<td>15</td>
<td>Proliferative</td>
</tr>
<tr>
<td>II</td>
<td>15-54</td>
<td>Irregular menstrual period, menorrhagia, infertility</td>
<td>37</td>
<td>Premenstrual</td>
</tr>
<tr>
<td>III</td>
<td>16-50</td>
<td>Frequent menorrhagia with prolonged menstrual periods</td>
<td>21</td>
<td>Abnormal endometrial hyperplasia</td>
</tr>
<tr>
<td>IV</td>
<td>16-50</td>
<td>Menorrhagia, infertility</td>
<td>18</td>
<td>Secretory</td>
</tr>
<tr>
<td>V</td>
<td>49-60</td>
<td>Continuous vaginal bleeding</td>
<td>3</td>
<td>Endometrial carcinoma</td>
</tr>
<tr>
<td>VII</td>
<td>35-48</td>
<td>Irregular bleeding</td>
<td>3</td>
<td>Progesterone effect</td>
</tr>
<tr>
<td>VIII</td>
<td>22-52</td>
<td>Menorrhagia, infertility</td>
<td>17</td>
<td>Non-secretory</td>
</tr>
</tbody>
</table>

Table I Main clinical and histopathological findings in the patients studied

<table>
<thead>
<tr>
<th>Group (See table I)</th>
<th>Endometrial Biopsy Specimen</th>
<th>Histology</th>
<th>No.</th>
<th>c:h Ratios</th>
<th>h</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Range Mean SD</td>
<td>Range Mean SD</td>
</tr>
<tr>
<td>I</td>
<td>Proliferative</td>
<td>15</td>
<td>3-92</td>
<td>3-16 1-33</td>
<td>3-48 2-88 1-16</td>
</tr>
<tr>
<td>II</td>
<td>Premenstrual</td>
<td>37</td>
<td>4-95</td>
<td>2-88 1-32</td>
<td>8-11 4-01 1-76</td>
</tr>
<tr>
<td>III</td>
<td>Abnormal endometrial hyperplasia</td>
<td>21</td>
<td>6-52</td>
<td>3-94 1-79</td>
<td>5-54 2-66 1-51</td>
</tr>
<tr>
<td>IV</td>
<td>Secretary</td>
<td>18</td>
<td>8-19</td>
<td>3-08 2-15</td>
<td>11-82 4-34 2-44</td>
</tr>
<tr>
<td>V</td>
<td>Endometrial carcinoma</td>
<td>3</td>
<td>2-7</td>
<td>3-60 1-48</td>
<td>2-35 3-32 1-19</td>
</tr>
<tr>
<td>VII</td>
<td>Progesterone effect</td>
<td>3</td>
<td>4-12</td>
<td>4-29 2-08</td>
<td>2-05 1-65 1-17</td>
</tr>
<tr>
<td>VIII</td>
<td>Non-secretory</td>
<td>17</td>
<td>3-39</td>
<td>2-58 1-03</td>
<td>4-01 2-89 1-08</td>
</tr>
</tbody>
</table>

Table II Results in each set of cases
hyperplasia is found through the menstrual cycle (Beer, 1970), and that the cystic glandular hyperplastic type (Fraser and Baird, 1972) is found in 2% of cases of polycystic ovarian disease (Goldzieher, 1973). Three biopsies showed endometrial carcinoma, one of which also showed abnormal endometrial hyperplasia, an association found by Southam and Richart (1966). One of these cases occurred in the menarche and was stage I and the other two occurred postmenopausally and were stages II and IV (Gusberg, 1973).

A greater degree of the combination of abnormal adenomatous hyperplasia and cystic hyperplasia was found in curettage taken towards the end of the cycle in cases of dysfunctional bleeding. Wedge resection of the ovaries in three cases, taken at the time of curettage, showed haemorrhagic corpora lutei and multiple follicular cysts.

The utilization of quantitative methods to the examination of endometrial curettage to give the value of the ratio c:h and h takes about 10 minutes for each section. As the diagnosis of abnormal endometrial hyperplasia is not difficult on the majority of occasions, this procedure to provide accurate diagnosis in borderline cases would not make a marked increase in workload.

We are grateful to Dr D. N. Shanbhag and his staff, Department of Probability and Statistics, The University, Sheffield, for the statistical analysis, and to Mrs Lyn Boon for secretarial assistance.

References


