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Adenomyosis Uteri: A Study of 416 Cases

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EDITORIAL COMMENT: *This essay on adenomyosis confirms that the patient is usually a multipara with menorrhagia and uterine enlargement, often with associated fibromyomas — this sentence also describes the type of patient coming to hysterectomy whose uterus does not show the histological features of adenomyosis. It would be interesting to see these clinical features documented in a prospective series to test the strength of the correlation between adenomyosis and menorrhagia with regular uterine enlargement. The editor was interested to note the absence of uterine tenderness and low incidence (10%) of dyspareunia in this series, since his clinical impression is that the multipara with menorrhagia and uterine enlargement often has a tender uterus which in the hands of the pathologist shows evidence of adenomyosis. Perhaps an interested reader will examine this impression scientifically!*

Summary: Adenomyosis was noted in 16% of 2,616 consecutive hysterectomy specimens examined during a 7-year period. Multiparas between the ages of 30 and 50 years were most commonly affected. Abnormal uterine bleeding was the common symptom. Myohyperplasia and leiomyomas were the usual associated lesions. Adenomyosis uteri was seen equally in women of African, Indian and mixed races in this West Indian population.

Adenomyosis uteri is described in textbooks as a benign invasion of the myometrium by the endometrium and is a common, poorly understood disease; in fact, it has been considered as an elusive condition, the diagnosis of which is often missed (1). More often, adenomyosis is an incidental pathological finding in a uterus extirpated for a more obvious diagnosis. The preoperative diagnosis of this entity is rare, since this disease is not usually taken into account. The present communication describes the cases of adenomyosis uteri diagnosed at the Port-of-Spain General Hospital, Trinidad which caters to a predominantly non-white West Indian population of different racial origins, 43% Negro, 41% Indian and 16% mixed with less than 1% whites.

MATERIALS AND METHODS

The charts of all women treated by hysterectomy between January, 1976 and December, 1982 were reviewed and those in which the histological diagnosis of adenomyosis was recorded formed the basis of this study. The relevant clinical details were noted and all the histological material was reexamined. The histological criterion used to diagnose adenomyosis was the presence of endometrial glands and stroma within the myometrium beyond one microscopic high-power field from the basal endometrium.

RESULTS

During the 7-year period, 2,616 hysterectomies were performed. Adenomyosis was found in 416 patients, an incidence of 16%. The racial composition of 416 patients with adenomyosis uteri reflected the population served by this institution and was equally seen in African, Indian and mixed races.

Clinical Data

The age distribution showed the peak incidence of adenomyosis in the 30-49 age group. The youngest patient was aged 24 years and the oldest 82 years; 95% of the patients were parous and the incidence of adenomyosis was directly related to parity — only 5% with adenomyosis were nulligravidas. Abnormal uterine bleeding was the common symptom (80%). Dysmenorrhoea preceding and/or during the menstrual flow was recorded in 30% of the patients. Dyspareunia and nonmenstrual pelvic pain were less common (10% and 5% respectively). Clinical enlargement of the uterus was described in 63% of patients and uterine tenderness was not recorded in any. A preoperative diagnosis of adenomyosis was suspected in 8% of patients.

Pathology

Myometrial involvement with adenomyotic foci was extensive in 44% of cases and mild to moderate in the rest. There was a good correlation between the activity of the basal endometrium and that of adenomyotic foci. There was myometrial hyperplasia in 392 (94%) cases. Single or multiple leiomyomas vary-

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ing in size from 1-12 cm, were present in 89 (21%) cases. Pelvic inflammatory disease was an associated finding in 21 cases. Seven cases of cervical cancer (5 in situ and 2 invasive squamous carcinomas) were seen independent of adenomyosis; 70% of the patients had oophorectomy and the associated lesions in the ovaries were benign cystadenomas (6 cases), apart from the common follicular cysts which were seen in 65%. Extrauterine endometriotic foci were seen in the ovary in 4 patients in association with adenomyosis uteri.

DISCUSSION

The reported incidence of adenomyosis uteri in surgical hysterectomy specimens has varied from 8-40% in different studies (2-10). Although, many reasons for this marked variation have been advanced no really satisfactory answer has been found. However, Bird et al (6) demonstrated that the diagnosis of adenomyosis could be made more frequently by extensive sampling of the myometrium.

The high incidence of adenomyosis in multiparas aged 30-50 years in our study is in agreement with studies elsewhere (6-9). The common clinical manifestation of the disease is abnormal uterine bleeding and uterine enlargement. It is sometimes difficult to establish whether the symptoms were due to adenomyosis or to the associated pathology. A constant finding was the lack of specific symptomatology and the accurate preoperative diagnosis was made in less than 10% in most studies.

It has been suggested that adenomyosis results by direct penetration of the basal endometrial glands into the myometrium and this could be confirmed by proper orientation of the tissue selected and by serial sectioning (11). But the cause for its development is not clear. Grading of adenomyosis as to the depth of penetration and degree of involvement of myometrium has been attempted by some authors (5,6,8) with a view to correlate structural with functional changes. There are limitations to this type of study, since all grades of adenomyosis can be asymptomatic irrespective of depth of penetration of endometrial glands into the myometrium (4).

Adenomyosis and extrauterine endometriosis are 2 separate and distinct entities with different mechanisms of origin. Endometriosis in extrauterine sites observed in 4 of our patients was seen in the ovaries. Mathur et al (5) noted only 2 cases of extrauterine endometriosis in a study of 290 cases of adenomyosis. However, Molitor (7) found this association in 14% of patients.

A study of adenomyosis uteri in the Negro population of Jamaica (9) suggested that this condition was not as uncommon as is generally believed. The present study establishes that adenomyosis is not uncommon in the West Indian Negro and it is also seen with equal frequency in East Indian and mixed racial groups in this population. On the basis of our findings, we conclude that adenomyosis is a frequent entity and it should be considered when examining middle aged multiparas for abnormal uterine bleeding and dysmenorrhoea, where bimanual examination reveals a normal or slightly enlarged uterus.

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