PREGNANCY IN A CASE OF ADENOMYOSIS OF THE UTERUS AFTER OPERATIVE TREATMENT

A Case Report

by

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Adenomyosis of the uterus today is a well known pathological and clinical entity, capable of giving rise to characteristic symptoms by itself, in the absence of any associated uterine pathology. The following case has been reported as one of interest, as it is noted that the incidence of adenomyosis uteri as such is fairly low and rarer still is the incidence of pregnancy occurring in a case of adenomyosis of the uterus proved histologically.

Definition: The term "Adenomyosis of the Uterus" was first coined and preferred by Frankl (1925) to describe the entity of Uterine Endometriosis, which was also termed previously as "Adenomyoma" "Adenomyomatosis" "Endometriosis Interna" etc.

As Hunter (1947) puts it adenomyosis of the uterus means heterotopic endometrium found within the myometrium derived from the endometrium, but often times losing such a connection as the process advances. It may occur locally in a small area or diffusely throughout the hyperplastic musculature of one or both uterine walls. Novak defines the condition as an invasion of the endometrium into the myometrium, with a diffuse hyperplasia of the latter. In some cases the islands of mucosa may be found throughout the thickness of uterine wall extending to serosa itself.

Historical: The work of Cullen in 1897 appears to be the earliest and first major contribution on the subject of adenomyosis in the English literature. He described 3 cases and refers to earlier works of Von Recklinghausen and Dersterweig in the German literature, wherein is given an adequate pathologic description. In his detailed monograph (1908) Cullen mentioned Von Rakitanski, who first described adenomyosis as a clinical entity in 1860. In 1902 Baldy and Langscope reported 2 cases of adenomyosis uteri. In 1922 adenomyosis uteri was still considered to be a rarity enough to report even a single case as Abell and Frank did.

Incidence of adenomyosis of uterus amongst all cases of extirpated uteri shows good amount of variation as seen thus: (1) Cullen 5% (2) Mc carty 6.43% (3) Blackman 8% (4) Westman 4% (5) Light, Crossen and Crossen 5.6%. On the other hand

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Kanter, Klawans and Bauer show 52% incidence.

Incidence of adenomyosis of uterus amongst all types of endometriosis varies widely, Hill 15%, Councellor 69.9%, Payne 6.5%, Dreyfuss 76%, Fallas and Rosenbhum 49.6%, Hayden 55% and Masson 80%.

Case Report

Patient Mrs. G. D., aged 35 years, was first seen in the month of November 1960 with the following complaints:

(1) Primary sterility: married 6 years:
(2) Dysmenorrhoea of 2-3 years duration:
(3) Menorrhagia of 1 year duration: Present menstrual history: 7-10/30 days, regular, profuse. L.M.P.: 8 days ago.

On examination: General condition good. Build average. Circulatory and respiratory systems — nil abnormal. Abdominally — Nil abnormal felt.

Per Vaginam: Cervix downwards and forwards, firm in consistency and smooth to feel. A retroverted bulky uterus the size of 10 weeks, firm in consistency, mobile, but tender on movement. Fornices were clear. P.S.: Cervix was normal, no erosion or Nabothian follicles were seen.

A diagnosis of fibromyoma was made and an exploratory laparotomy was done on 8-12-60. However, on opening the abdomen, the uterus was seen to be bulky but there was no evidence of a fibroid. The uniform generalised enlargement of the uterus was more suggestive of adenomyosis uteri. There was a small ½" x ½" fibroid on the posterior aspect of the corpus just above the left utero-sacral ligament. This fibroid was enucleated.

A wedge resection of the fundus of the uterus was done, whereupon it was noticed that the entire myometrium was interspersed with multiple roundish areas of varying size, dark reddish blue in colour. The myometrium looked more whorlly in appearance and the cut edges seemed everted —a good enough evidence of adenomyosis uteri. The uterine walls were approximated with interrupted catgut sutures and the uterus was suspended ventrally. On inspection both the ovaries and fallopian tubes, were seen to be normal and patent and there was no other evidence of any endometriosis in the pelvis and abdomen.

The patient made an uneventful post-operative recovery and was discharged after ten days. She was being followed as an out-door patient every month for 3 months and then twice in six months. She was getting periods regularly and both menorrhagia and dysmenorrhoea had subsided considerably. Every time a vaginal examination showed a bulky anteverted uterus, having a firm consistency. There was no evidence of any pelvic pathology.

The specimen of the wedge of the uterus was subjected to histological examination and revealed presence of endometrial like glands along with the stroma in the myometrium.

(Micro-photograph of the slide)

The patient reported at the hospital on 9-4-1962 for vaginal bleeding after having missed her period, last period being on 22nd January 1962.

On examination: general condition good. Circulatory and respiratory systems— normal.

Per abdomen: Inspection: Swelling in the lower abdomen upto about 4 fingers below the umbilicus, more in the right iliac fossa; also extending in the hypogastric region.

Palpation: The swelling was firm in consistency, having a smooth surface and restricted mobility without any tenderness.

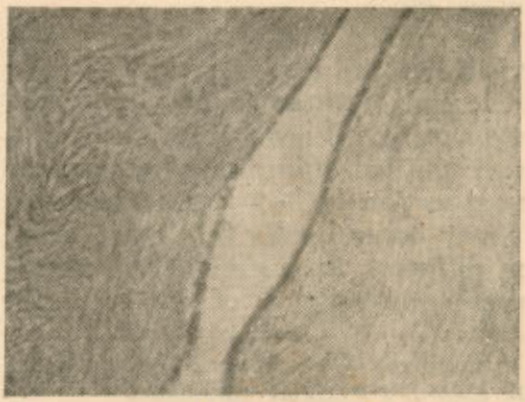

Fig. 1

The swelling was intra-abdominal and seemed to arise from the pelvis, as the upper border could be clearly demarcated but not so the lower.

Per Vaginam: The cervix was soft to feel and was deviated to the extreme right side; external os was closed. The uterus was deviated to the left side, soft in consistency and bulky, about 12 weeks' size. A firm mass was felt in the right fornix which seemed to be continuous with the uterus.

A diagnosis of pregnancy with either a fibroid or adenomyoma of the uterus was arrived at; pregnancy was confirmed when urine sent for A.Z. test was positive qualitatively and quantitatively (positive only upto 1 in 100 strength).

The patient was followed up regularly and registered in the A.N. Department, St. George's Hospital, at 5 months. A vaginal examination at this time revealed that the cervix, which was deviated to the extreme right, during the early part of pregnancy, was seen to assume a position more or less in the centre. The foetus was seen to grow normally, position remaining vertex throughout. At term it was noticed that the vertex was well in the brim and could be easily made to enter the pelvis. The patient gave birth to a healthy full-term male baby weighting 5 lbs. 4 ozs. on 21-10-1962. The placenta delivered normally. The uterus though involuted properly, still was bulky on the 15th puerperal day, palpable per abdomen and firm in consistency because of the fundal growth. The patient was discharged after 3 weeks.

In the second post-natal examination after 2 months, the uterine fundal growth was seen to have undergone a regression in size and no active line of treatment was undertaken as the patient did not desire any operation.

Discussion

Many of the reported cases of adenomyosis uteri associated with pregnancy represent incidental pathological findings in uteri extirpated for various reasons.

Adenomyosis uteri may cause an asymmetrical enlargement of the uterus, indistinguishable from a myoma or, a cornual pregnancy. In most of the cases a diagnosis of a myomatous change was the reason for laparotomy, Amos, in 1905, reported one case of adenomyoma of the uterus with decidual reaction. Robert Meyer (1905) described 3 such cases, and Samson, Cullen and Aschheim reported one, one, and three cases respectively.

Adenomyosis uteri, as reported in the literature, is probably the reason for uterine perforation on rare occasions, such as, at the time of therapeutic or criminal abortions, uterine rupture during pregnancy, uterine atony and post-partum haemorrhage.

However, to my knowledge, not a single case of pregnancy occurring in a case of adenomyosis of the uterus after operative treatment has been reported in the literature. In the present case pregnancy has occurred in a case of adenomyosis of the uterus after operative treatment and therefore possesses sufficient merit, as to have a place in the literature.

The disease is noted to demonstrate an apparant predelection for women in the late reproductive years. The greatest incidence is in the last half of fourth decade.

Adenomyosis is more common in multiparous women as seen from the study of Dreyfuss and is associated with a low sterility index. The present case stands out in contrast to the abovementioned facts about the disease, as it is a case of primary sterility and the condition is seen to occur in the third decade of the patient's life.

The pregnancy was seen to be associated with a growth in the fundus of the uterus. As, during laparo-

tomy there was no evidence whatsoever of a fundal uterine fibroid being present, the growth seen during pregnancy, could either be an adenomyoma of the uterus occurring in the fundus or a newly formed fundal fibroid. Though complicated by this growth, the pregnancy reached term successfully and ended in a normal delivery without any complications, as retained placenta, or postpartum haemorrhage.

Summary

(1) The case attended the hospital for treatment of sterility and was primarily diagnosed as one of fibromyoma. The diagnosis of adenomyosis was made at laparotomy only.

(2) As the patient was a case of sterility and in child-bearing age, a conservative approach was maintained and only wedge resection of the fundus was done.

(3) It is gratifying to note that after conservative treatment the patient conceived and reached her term uneventfully.

(4) A fundal growth, either a fibroid or an adenomyoma of the uterus was seen to complicate the pregnancy.

(5) The age of the patient, 35 years, is much less when compared to the usual average or common ages of the patients with adenomyosis.

(6) The sterility of the patient is not a common association with adenomyosis.

(7) Elective caeserean section at term was not done and she was allowed to go into labour and have a normal delivery, as clinically the baby was of average weight, about 5 to 6 lbs., and the maternal pelvis was quite adequate for the baby to go through. Patient was kept under observation for any maternal or feotal distress.

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