The
Journal of Obstetrics & Gynaecology of India

Vol. 43 No. 1 February 1993

## EDITORIAL

# ADENOMYOSIS OF THE UTERUS : STILL AN ENIGMA !

It was almost a century ago that in 1896 von Rechlinghausan established Adenomyosis of the uterus as a separate pathological entity. He believed that it developed from Wolffian remnants. Cullen in 1908 showed direct continuity between endometrium and these ectopic glands and maintained that the glands were of Mullerian origin. However the controversy of their mode of origin still remains as nowhere in the human body can the benign epithelium invade adjacent tissue in this manner.

In spite of the fact that Adenomyosis and pelvic endometriosis co-exist only in 12% of the cases the two conditions are clubed together in the text books. In reality adenomyosis forms a distinct clinical entity, occuring decade later in life and presenting with painful menorrhagia and a bulky uterus. Even the text books of operative Gynaecology consider the differential diagnosis between Fibromyoma and Adenomyosis purely academic "since they both require abdominal hysterectomy". All this leads to considerable clinical confusion, under-diagnosis and emperical treatment.

The ancillary methods of diagnosis are equally unsatisfactory. The diagnostic curettage and endosocopy do not give any help, while imaging technology like abdominal ultrasonography is of doubtful value. Only with the Trans-Vaginal ultrasound if carried out just prior to or during the menstrual period, the area of adenomyosis can be identified as a suspicious area. M. R. I. can also be helpful but since

these are not easily available only the clinical judgment remains the best mode of its diagnosis.

The question may be asked as to why now should we be worried about its diagnosis ? The reason for this is, that more and more the women in the later age group are trying for pregnancy even in the third world countries. The pregnancy failures which cannot be explained, the disappointment at the intended operation of "myomectomy" which has to end up either as Hysterectomy or Closure without treatment are all devastating to the patient. The established practice of the abdominal route of hysterectomy for adenomyosis because pelvic endometriosis may co-exist is based on just one in ten possibility. Vaginal hysterectomy should be the route of choice since uterus is very rarely bigger than twice the normal size and a co-existing small ovarian endometriosis does not contraindicate the route. Even a bigger size uterus can be removed by coring out the fundus by the method of Lash or by wedge resection of the fundus. Since majority of these cases are of secondary infertility and have previous vaginal deliveries, the vaginal route of hysterectomy remains suitable for them. The one operation which however is definitely contraindicated is that of endometrial resection. It is this condition of unrecognised adenomyosis which leads to recurrent bleeding, dysmenorrhea and haematometra formation. Expect in very early cases adenomyosis remains an important contraindication to endometrial resection.

In summary more attention than before is required in cases of adenomyosis of uterus to prevent a diagnostic jumble and a therapeutic bangle.

**Vithal N. Purandare**