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BMH Med. J. 2018;5(1):16-19 **Case Report**

An Unusual Case Of Adenomyosis In A 70 Year Old Female

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Abstract

Adenomyosis is an important clinical challenge in gynecology. It is defined as the benign invasion of endometrium into the myometrium producing a diffusely enlarged uterus. It is usually seen in women of reproductive age group or at least in the fourth or fifth decade where estrogen plays an important role. Here we present a case of a 70 year old lady who presented to us with postmenopausal bleeding and was found to have adenomyosis.

Keywords: adenomyosis, elderly

Case Report

A 70 year old lady presented with episodes of postmenopausal bleeding over a period of one and half months. She had attained menopause at the age of 45 years and had no similar history in the past. She was para 8 with all full term normal vaginal deliveries. She was diabetic and hypertensive on regular medications. On examination her vitals were normal, but she was bleeding per vagina. Bimanual pelvic examination revealed a bulky uterus. Laboratory investigations were unremarkable. Ultrasound of the pelvis and abdomen was performed and showed an enlarged uterus with markedly thickened endometrium (18mm). Pap smear showed chronic cervicitis with squamous metaplasia. Magnetic Resonance Imaging of the pelvis (MRI) showed small focal hyper enhancing endometrial lesion along the posterior wall in the region of body of uterus with no obvious serosal enhancement / peri serosal irregularity and no significant pelvic or para aortic lymphadenopathy.

A provisional diagnosis of Carcinoma Endometrium was made. Fractional curettage and biopsy cervix was performed. Plenty of endometrial curettings were obtained. Histopathology report came as endometrial polyp and chronic cervicitis. Since her bleeding continued, patient was taken for surgery. Uterus was uniformly enlarged to 8 weeks size, bilateral tubes and ovaries were normal. Total abdominal hysterectomy with bilateral salpingo oophorectomy was performed. Histological section from uterus showed atrophic endometrium and myometrium showed multiple foci of endometrial glands and stroma (**Figure 1** and **2**). A pathological diagnosis of adenomyosis was made. The patient was put on follow up and has been asymptomatic for the last 6 months.

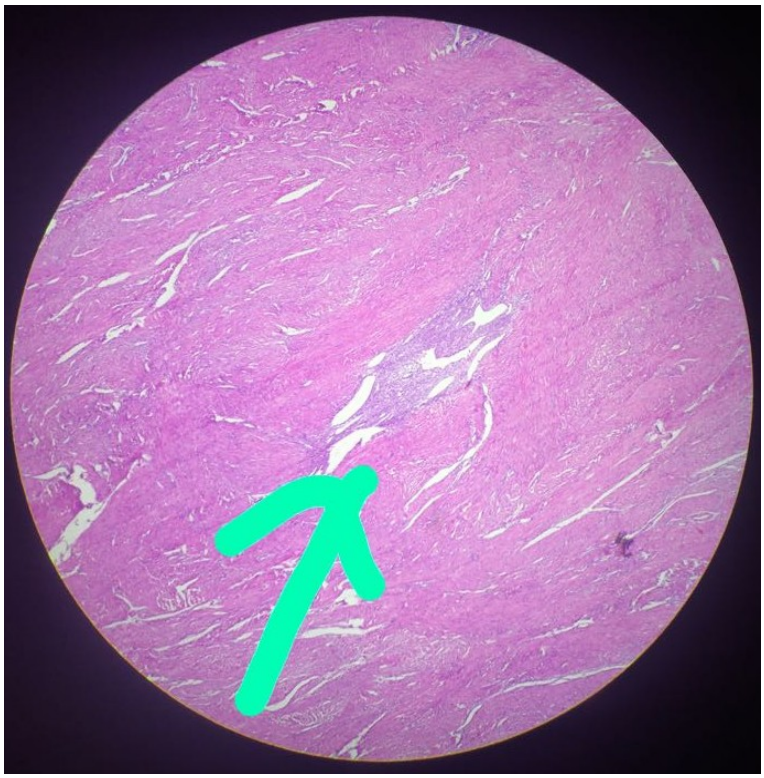

Figure 1: Endometrial stroma seen deep in the myometrium

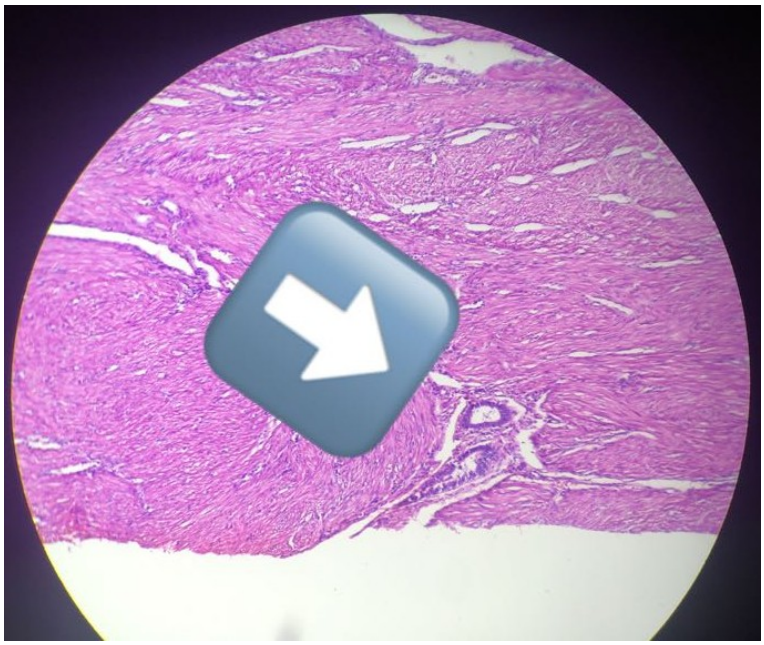

Figure 2: Myometrium show foci of endometrial glands and stroma

Discussion

The modern definition of adenomyosis was provided in 1972 by Bird who stated "Adenomyosis may be defined as the benign invasion of endometrium into the myometrium producing a diffusely enlarged uterus which microscopically exhibits ectopic non neoplastic endometrial glands and stroma surrounded by the hypertrophic and hyperplastic myometrium" [1]. Adenomyosis typically affects women of reproductive age. In general, affected women are multiparous, seen in higher frequency in women with a history of uterine surgical procedures (eg: Caesarean sections, dilatation and curettage). It has a reported incidence that ranges widely from 5 to 70 % depending on histological definition or imaging modality used, with the mean frequency of adenomyosis at hysterectomy given as approximately 20 to 30 % [2]. Adenomyosis is rare in postmenopausal

women (except for tamoxifen associated cases). Risk factors for adenomyosis include increasing age up to menopause, multi parity, smoking, increased estrogen levels, previous uterine surgery and tamoxifen treatment.

Clinical symptoms are non specific: dysmenorrhoea, menorrhagia, abnormal uterine bleeding, dyspareunia and chronic pelvic pain. It is basically a non neoplastic condition presenting with palpably enlarged uterus. It tends to regress after menopause. When extensive, it confers a potential risk of infarction and thrombosis and exacerbates menorrhagia via activation of coagulation and fibrinolysis during menstruation.

Presence of adenomyosis in post menopausal female is very rare, documented only in old literature. No recent studies are available. Lewinski (1931) reported adenomyosis in 26 cases among 49 women more than 50 years and in 3 women out of 5 cases more than 70 years undergoing autopsy [3]. In series reported by Dreyfuss (1940), 13 (8.5%) out of a total of 152 cases with adenomyosis were more than 50 years of age [4]. Dreyfuss stated that the adenomyotic structures were of the resting type in women who were not menstruating any more [4]. There were 55/115 (46%) postmenopausal females in study by Reinhold et al (1996) and 23 % postmenopausal women in the study by Kepkep et al (2007) [5]. Lister et al(1988) described a case of postmenopausal adenomyosis who had an apparent thickening of endometrium mimicking a carcinoma [6]. Ozkan et al (2012) compared women who underwent hysterectomy for fibroids (n=98) with those who had adenomyosis (n=106); overall 40% were postmenopausal [7].

Transvaginal ultrasound (TVS) and MRI are the only two practical means available to establish a pre surgical diagnosis of adenomyosis [8]. TVS is cheap and readily available with a sensitivity of 79% and specificity of 85% for diagnosis of adenomyosis [8]. Doppler Ultrasound can be used during TVS to differentiate adenomyosis from uterine fibroids. This is because uterine fibroids typically have blood vessels circling the fibroid capsule. In contrast adenomyomas are characterized by widespread blood vessels within the lesion [8]. The junctional zone at the endometrial-myometrial interface may be assessed by three dimensional TVS and MRI [9]. Features of adenomyosis are disruption, thickening, enlargement or invasion of the junctional zone. MRI provides slightly better diagnostic capability with a sensitivity of 74% and specificity of 91% for detection of adenomyosis [10].

Histopathology is the gold standard method to definitely diagnose adenomyosis. The diagnosis is established when the pathologist can find invading clusters of endometrial tissue within the myometrium.

Several diagnostic criteria can be used, but typically require either the endometrial tissue to have invaded greater than 2% of the myometrium or a minimum depth of invasion such as 1-4 mm [11].

Adenomyosis can cured definitively only with surgical removal of the uterus. As adenomyosis is responsive to reproductive hormones, it usually abates following menopause when these hormones decrease. In women in their reproductive years, adenomyosis can typically be managed with the goals to provide pain relief, to restrict progression of the process and to reduce significant menstrual bleeding. But in postmenopausal women diagnosed with adenomyosis presurgically, hysterectomy with bilateral salpingo oophorectomy is the definitive management.

In conclusion, adenomyosis is a benign but often progressive condition. It is very very rare in postmenopausal women. It is advocated that adenomyosis poses no increased risk for cancer development. However, both entities could co exist and the endometrial tissue within the myometrium could harbor endometrioid adenocarcinoma, with potentially deep myometrial invasion [20]. As the condition is estrogen dependent, menopause presents a natural cure. Still very rarely as

seen here, adenomyosis can present in the seventies or beyond.

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