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CASE STUDY

PAIN IN ABDOMEN : NEED OF WIDENING THE SPECTRUM

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ABSTRACT

Adenomyoma is circumscribed nodular aggregate of benign endometrial glands surrounding endometrial stroma with leiomyomatous smooth muscle. The presenting complaint being abdominal pain, dysmenorrhea and abnormal uterine bleeding. The aim of reporting this case is to highlight adenomyoma as the cause of chronic /acute pelvic pain and to distinguish it from it's sinister causes and to establish laparoscopic diagnosis and resection as the earliest method of intervention. Here we report a case of lady presenting with severe pain in abdomen for 2.5 yrs. Her laboratory investigations were normal. Ultrasound showed a fibroid of 2*2 cm on left side of uterus. Patient had undergone upper and lower GI endoscopy which was normal. Laparoscopy revealed a myoma of 3*3 cm and an adenomyoma of 1*2cm on the fundus near the left cornua which were resected. Post surgery her symptoms abated dramatically and 5 months later the patient is still pain free for the first time in almost 3 yrs. On conclusion though adenomyoma is rare, we should be vigilant for its diagnosis and treatment in case of severe pain in abdomen, and the use of laparoscopy in the diagnosis and treatment of adenomyoma can help many a lady suffering from pain.

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INTRODUCTION

Adenomyoma of the uterus is a circumscribed nodular aggregate of benign endometrial glands surrounded by endometrial stroma and leiomyomatous smooth muscle bordering the endometrial stroma component. (Tahlan *et al*., 2006) It is a focal region of adenomyosis resulting in a mass which is difficult to distinguish from uterine fibroid although in general the degree to which the contour of the uterus distorted is less marked in adenomyosis. (Hamm *et al*., 2007) The main symptoms include pain in abdomen, dysmenorrhea and abnormal uterine bleeding. A patient of adenomyoma presenting as pain in abdomen may pose diagnostic difficulties. Transvaginal ultrasound is an effective, noninvasive and relatively inexpensive procedure for differential diagnosis of adenomyoma. (UIgi Fedele *et al*., 2003) MRI may also be used but it is an expensive tool for diagnosis. The promptness and accuracy of diagnosis is important. Laparoscopy has been recognized as the gold standard for diagnosis of endometriosis and its surgical treatment. Mettle *et al*. 2003, suggested laparoscopic inspection of pelvis with resection followed by histological biopsy confirmation for the diagnosis of endometriosis/ adenomyosis/ adenomyoma.

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Case report

A 31 yr old P1L1A1 lady, was referred to our outpatient department by the treating gastroenterologist for the complaints of pain in abdomen. She had undergone upper gastrointestinal endoscopy and lower gastrointestinal endoscopy which revealed a caecal diverticulum, rest was normal. Her previous cycles were regular for 5-6 days every 30 days with average flow associated with passage of clots and pain in abdomen. She had a prevoius uneventful vaginal delivery. Her blood investigations were normal. Ultrasound pelvis showed normal sized uterus with a fibroid of 2*2 cm in the left cornua of the uterus. Bilateral adnexa were normal. On laparoscopy she had a myoma of 3*3cm near left cornua with features of adenomyosis. A adenomyoma of 1*2 cm was present on the left cornua. Both of them were resected. Endometriotic patches on the left tube, pouch of douglas and left broad ligament were present all fulgurated. Her post operative period was uneventful and she is pain free since last 5 months the first time in three years.

DISCUSSION

Adenomyosis/myoma has been characterized as the disease of the parous pre- and peri-menopausal woman with the highest incidence during the fourth and fifth decade of life (Bird *et al.,*

1972). Adenomyosis/myoma is also present in young infertile women with endometriosis (kunz *et al*., 2000) and in particular in those with severe dysmenorrhoea. The treatment of adenomyosis has been limited by the difficulty and delay associated with the diagnosis, often not until after hysterectomy. Magnetic resonance imaging, high resolution vaginal ultrasound and uterine biopsy have improved early detection of adenomyosis Conservative surgery involving endomyometrial ablation, laparoscopic myometrial electrocoagulation or excision has proven to be effective in >50% of patients. In endovaginal sonography (EVS) and magnetic resonance imaging (MRI), women with endometriosis exhibit a significant expansion of the archimyometrium (`halo' in EVS or `junctional zone' in MRI respectively) over controls, which is similar or identical to the images obtained in adenomyosis (Leyaender *et al*., 1998; Kunz *et al*., 2006). Many studies have clearly shown that there is a substantial delay in endometriosis diagnosis which inevitably has negative effect on quality of life of endometriosis patients (Matsuzaki *et al*,) The aim of surgical management is to remove visible areas of endometriosis and restore anatomy by division of adhesions. Few principles have to be considered regarding the surgical management of adenomyosis:

- Severe disease must be treated differently from mild to moderate disease.
- Patients with pain symptoms associated with endometriosis must be approached differently from patients seeking fertility. (Maomer Al Jefout, 2007)

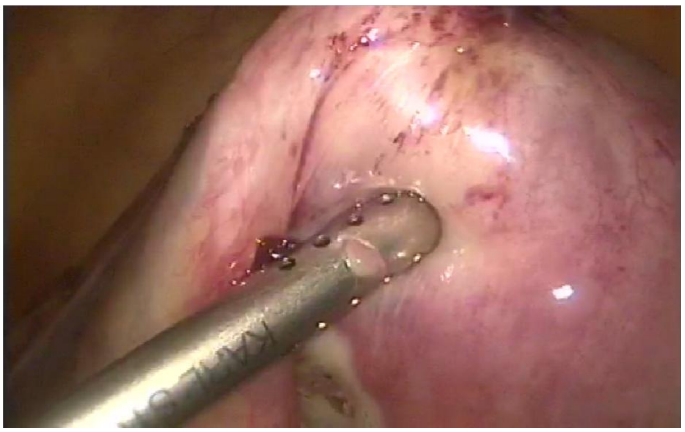

Image 1.

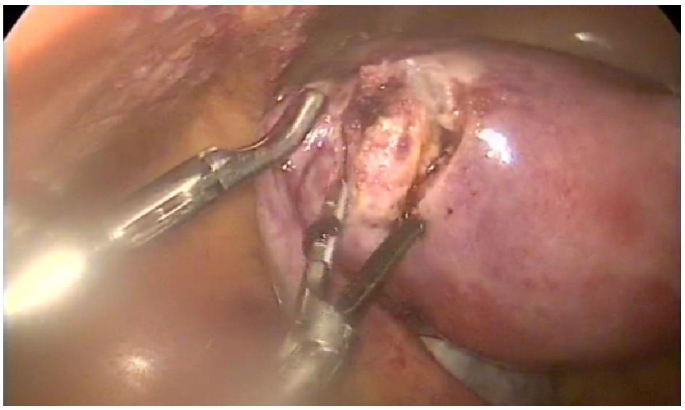

Image 2.

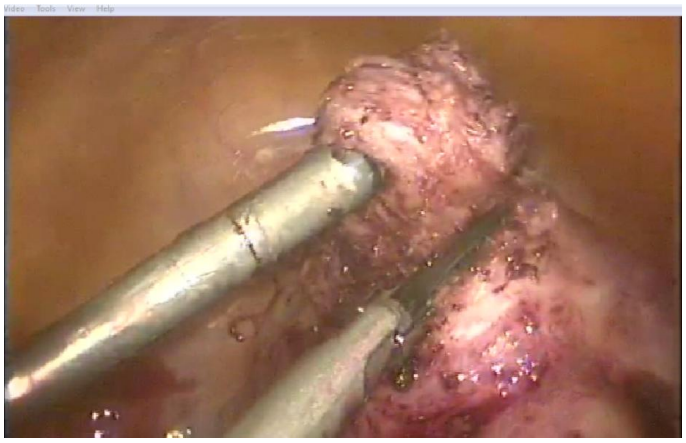

Image 3.

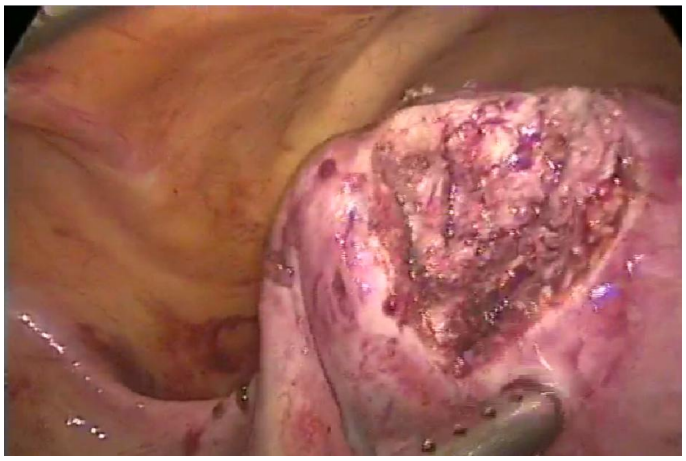

Image 4.

Laparoscopy in endometriosis is based on the visualization of superficial implants, endometriomas, adhesion distribution, bowel disease and ureteric disease. In doubtful cases, biopsies showing glands and stroma have been the basis of the diagnosis. Laparoscopic conscious pain mapping was first described when it was used for laparoscopic evaluation of the appendix (Almeida *et al*., 1998). Pelvic pain mapping during laparoscopy performed under conscious sedation can provide useful information about visceral and somatic sources of chronic pelvic pain. Conscious laparoscopic pain mapping has been proposed as a way to improve information derived from laparoscopic evaluations in gynaecology even in an office set up (Howard 2000,Almeida and Val Gallas 1998, Howard 2003). Conscious pain mapping can be done with reasonable success in women with prior surgical evaluations and treatments for chronic pelvic pain. Chronic visceral pain syndrome, adhesions, and endometriosis were the most common diagnoses (Howard *et al*., 2000).

A clinicopathological review of 26 cases done in Department of pathology Government Medical College Chandigarh, India highlights the importance of identifying this fairly common pathological entity and its distinction from a number of other lesions like adenomyosis, leiomyoma, endometrial polyps and adenofibroma (Tahlan *et al*., 2006).

Conclusion

Although adenomyoma is a rare form of adenomyosis but its early diagnosis and treatment would lead to rise in the quality of life of patients suffering from pain in abdomen. A careful history focusing on pain characteristics, review of systems and thorough gynecological history and examination in addition to physical examination are of utmost importance. The early use of laparoscopy would help in the early diagnosis and direct access to adenomyoma. It also allows the resection and fulguration of the adenomyoma depending on size simultaneously. The above case is used as moot point to highlight that in women with chronic pelvic pain one must widen the spectrum of diagnosis from just bowel pathologies only and think of unusual and less common gynaecological conditions too ,where might lie the answer to her problem and hence its treatment and cure.

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