

Adenomyosis with Tuberculosis of Uterus

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Introduction

Adenomyosis refers to the presence of islands of endometrial glands and stroma within the myometrium. The glands may even reach the serosal surface of the uterus. Benson Smeeden established the criterion for adenomyosis that the endometrial glands should extend at least two low power fields into the myometrium¹. It occurs in 8% to 27% of patients and is usually encountered in women over 35 years age. Adenomyosis results in an enlarged and globular uterus because of myometrial hypertrophy. The diagnosis may be suspected on cut sections in the presence of depressed small cystic lesions in obvious but ill defined zones of muscle hypertrophy². Microscopically the endometrium of adenomyosis usually has a proliferative appearance, consistent with its basal derivation. When the endometrium is in the secretory phase, this is true only in one quarter of foci of adenomyosis³. These foci can be involved by any of the diseases affecting the orthotopic endometrium, including hyperplasia and adenocarcinoma⁴. Tuberculosis of female genital tract is common amongst all communities where pulmonary or other forms of extra genital tuberculosis is prevalent. It follows that genital tract tuberculosis is nearly always secondary to a focus elsewhere in the body but the spread takes place at a very early stage of disease.

Case Report

A 35 years old married female with history of primary infertility presented in the Gynaecology Ward, Jinnah Postgraduate Medical Center, Karachi. The patient was suspected as a case of Fibroid Uterus and hysterectomy was done.

Pathological Findings

Macroscopic Features

The uterus on gross examination revealed a mass measuring 8 x 5 cm in the wall which was obliterating the uterine cavity.

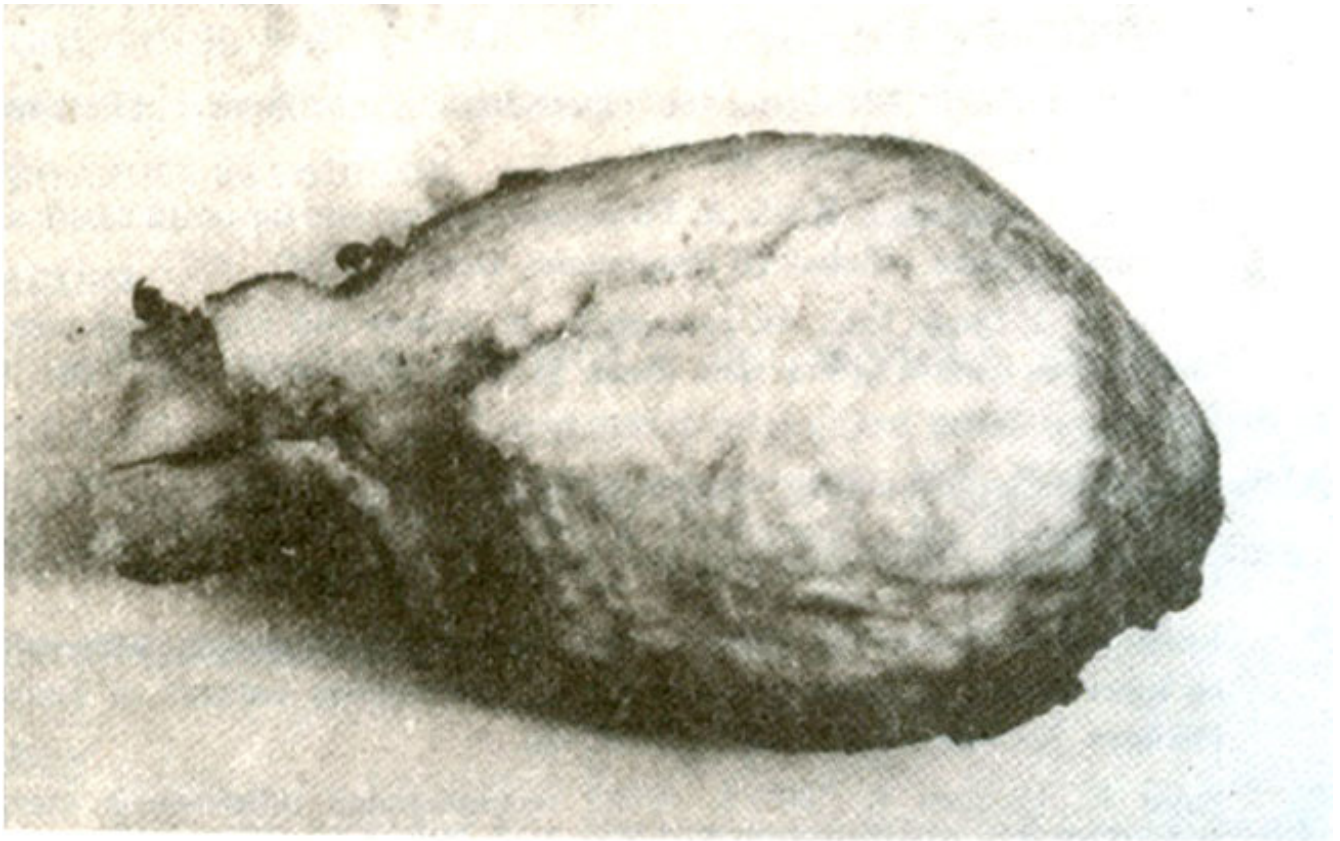


Figure 1. Gross examination of uterus revealing a mass measuring 8 X 5 cm in the wall obliterating the uterine cavity



Figure 2 Photomicrograph of uterus revealing adenomyosis with scattered epithelial cell granulomas (HE X 40).

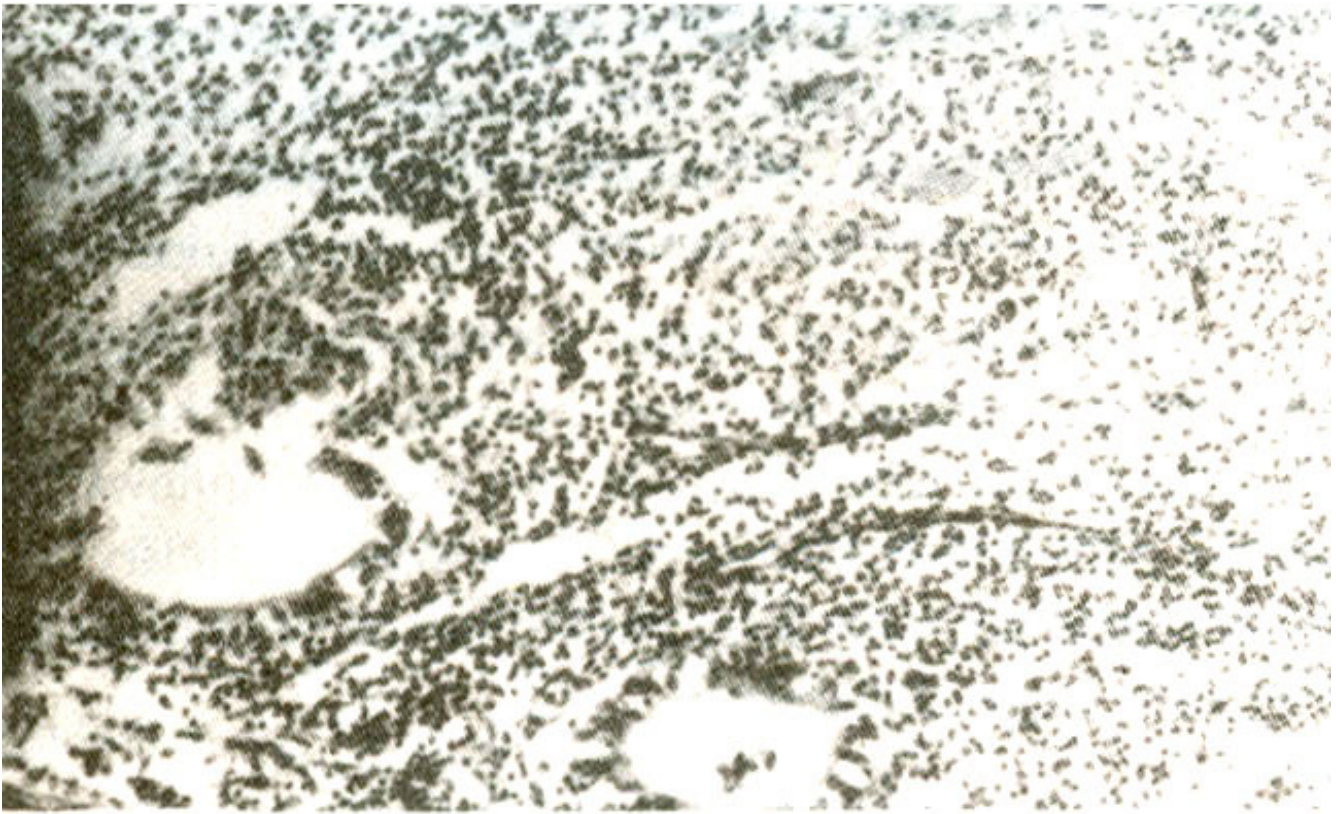


Figure 3 Photomicrograph of endometrial glands within the myometrium. epithelial cell granulomas and scattered mono inflammatory infiltrate (HE X 40)

Microscopic Features

Microscopically the mass revealed adenomyosis with scattered caseating epithelioid cell granulomas.

Discussion

Adenomyosis is frequently found coincidentally during histologic examination of a uterus and can be asymptomatic, the main symptoms of more extensive disease are abnormal bleeding and dysmenorrhoea.

An accurate preoperative diagnosis of adenomyosis often can not be made. However, the presence of abnormal uterine bleeding, progressive dysmenorrhoea and a symmetric enlargement of uterus in women over 35 years age are suggestive. The abnormality is associated with uterine leiomyomas in 46% cases and with endometrial polyps in 12%. The size of the uterus in women in this condition is variable. In one study, it was normal in 20%, weighed 80 to 150 gm in 52% and exceeding 200 gm in 6%⁵.

Pelvic tuberculosis in majority of cases is caused by mycobacterium tuberculosis (H man type). The bovine bacillus is likely to be involved when the primary focus is in the lymph node or bowel. Incidence is 0.7% in gynaecological admission but is higher (9.3%) in infertility clinics. Any part of genital tract can be affected but the common sites, as observed by Scheafer in descending order of frequency are:-Fallopian tubes 90%. Endometrium Myornetrium 25%, Cervix 5-15%, Vagina 1%.50-60%,

The uterus may look normal to the naked eye and ordinarily tuberculosis endometritis is recognized only by histological and bacteriological examination of the tissues. Occasionally an ulcer may be seen

in the endometrium. Extensive involvement can result in collections of caseous material to form a type of pyometra or to cause abscesses in the myometrium. Adhesions and partial obstruction of uterine cavity are also seen.

The association of adenomyosis and tuberculosis of the uterus appears to be very rare. In our experience this is the first case of adenomyosis associated with tuberculosis of the uterus.

References

1. Benson RC, Sueden ED. Adenomyosis: A reappraisal of symptomatology. *Am. J. Obstet Gynaecol.*, 1958;76:1044-45.
2. Mathur BBL, Shah US, Bhande YM. Adenomyosis uteri. *Ant, J. Obstet. Gynaecol.*, 1962;84:1820-29.
3. Malitar JJ. Adenomyosis: A clinical and pathological appraisal. *Am. J. Obstet Gynaecol.*, 1971;110:275-84.
4. Winkelman J, Rabunson R. Adenocarcinoma of endometrium involving adenomyosis. Report of an unusual case and review of the literature. *Cancer*, 1966;19:901-8.
5. Bird CC, McElin TW. Adenomyosis and other benign diffuse enlargements of the uterus, in Sciarra JJ (ed) *Gynecology and obstetrics* New York. Harper and Row. 1982.