Clinical case report: conservative treatment of nodular adenomyosis

Abstract

This article describes a clinical case report of nodular adenomyosis first diagnosed in an adolescent girl. It emphasizes the importance of early disease detection and correct choice of therapeutic approach factors, directly relating to the future reproductive health of an adolescent girl. This case describes an example of successful long-term conservative treatment of adenomyosis with dienogest (Visanne) treatment for over three years and subsequent realization of reproductive function by the patient.

Keywords: nodular adenomyosis, adolescence, visanne, deterioration, problem, endometriosis

Introduction

These days, the problem of endometriosis has become ever more relevant. Environmental deterioration, increased emotional stress load in the society contribute to the formation of tension in the neuro humoral regulatory systems predisposing to the emergence of various hyper proliferative pathologies, including endometriosis.

The problem of endometriosis has long ceased to be purely medical because it is associated with reduced quality of life of the women of reproductive age - the most socially important category. Currently, endometriosis is no longer associated with reproductive age only as there is an increasing incidence of this condition being diagnosed in adolescence and at that time it accounts for 70% cases of chronic pelvic pain. Numerous studies have proven that endometriosis may occur in adolescents girls. The average age of disease onset is 15.9 years. Therefore, timely diagnosis of endometriosis and choice of adequate therapeutic approach are of particular importance in this patient population since they predetermine the possibility of successful reproductive performance of such women in the future.

Hoping to the above, the case history of adenomyosis first diagnosed in adolescence deserves close attention. On June 6, 2013, patient M. aged 18 was admitted on an urgent basis to the gynecology department of Kyiv Municipal Hospital No.9. The patient presented with severe pain during menstruation, low-grade fever, nausea, vomiting. Referral diagnosis: nodular uterine leiomyoma with impaired nodular delivery. From the medical history of the patient: menstruation first started at the age of 13 and regular cycle was established within a year, periods were painful, sometimes leading to fainting. The patient also experienced loose stool during the first days of periods. The patient repeatedly applied to pediatric gynecology department where she was diagnosed with the following: Dysmenorrhea. Adenomyosis? In 2011, she was examined by the gynecologist of the “Okhmatdyt” National Children’s Specialized Hospital with subsequent pelvic ultrasound examination. Diagnosis: Nodular adenomyosis (72x68 mm; endometrial nodule was identified on the posterior uterine wall in the myometrium). The patient was prescribed 6 injections of Diphereline 3.62 mg. The reduction in the size of nodule to 31x29 mm has been observed under the course of the treatment. Diphereline was discontinued due to undesirable effects such as bone pain, hot flushes, fatigue, and tachycardia. Following withdrawal of Diphereline, the periods resumed in 3 months and in 6 months menstrual pain developed again.

The data of patient’s physical examination: the skin and visible mucous membranes are of pale pink color, the abdomen is soft, tender on palpation, particulates in the process of breathing. Peritoneal signs are weakly positive in the lower abdomen. Pasternatsky’s symptom is negative on both sides. Vaginal examination: uterus is enlarged as with 8-9 weeks pregnancy, round-shaped, dense, tender on palpation, cervical tractions are painless. Uterine appendages on both sides are not enlarged and painless on palpation. Ultrasound examination: uterus 69 x64x62mm. A hypoechoic mass is visible in the structure of myometrium on the posterior wall with hyperechoic dispersed particulate matter 50 x 46 x 43mm (Figure 1).

Figure 1 Patient M. Nodular adenomyosis (June 2013).

Diagnosis: adenomyosis, nodular form. Secondary dysmenorrhea. Continuous treatment with Visanne over the period of 9 months has been recommended. The patient was examined in 9 months, in March 2014. The general state of health was assessed by the patient as satisfactory. Pain disappeared in as little as 3 months of treatment with Visanne. Findings of pelvic ultrasound: uterus 56x52x48mm. A hypoechoic mass is present in the structure of myometrium on the posterior wall with hyperechoic particulate matter 41x36x28mm (Figure 2).
临床病例报告：保守治疗结节性腺肌症

推荐：继续服用Visanne一年。

在2015年3月，患者因随访检查。据患者所述，她决定在2015年3月因疼痛缓解期停止Visanne治疗。在2015年2月，患者报告月经疼痛。超声检查：子宫53×42.6×44mm。子宫肌层及宫腔后壁处存在低回声结节，大小为30×25.7×22.2mm，考虑为子宫腺肌瘤。患者被推荐继续Visanne治疗。

在2016年1月（11个月后），患者按时复查。患者自述身体状态良好。超声检查：子宫44×38×36mm。子宫肌层及宫腔后壁处存在低回声结节，大小为21×16.7×16.2mm（图3）。患者被推荐继续Visanne治疗。

在2017年4月，患者因结婚并开始无保护性生活而停止服用Visanne，并改用Epigalin（成分：200mg indol-3-carbinol-200, 82mg绿茶提取物）。患者未出现不适。超声检查：子宫46×39×38mm。子宫肌层及宫腔后壁处存在低回声结节，大小为29.0×20.7×18.9mm。患者被推荐继续服用Epigalin。

在2017年12月，患者因14天的月经过期而就诊。超声检查：子宫56.2×50.8×49.4mm。宫腔内见16.6×16.1mm妊娠囊。子宫肌层及宫腔后壁处存在低回声结节，大小为18.1×11.1mm（图4）。

医生陈述：怀孕4周。结节性腺肌症

患者于2018年2月2日进行常规复查。一般状态良好。妊娠进展正常。超声检查：子宫体139.0×74.0×103.0mm；妊娠囊113.0×44.0×57.0mm；宫颈37.0mm。子宫内口闭合；子宫壁及子宫内膜均无异常。宫颈管内无异常。超声报告：妊娠13周+05天。进展中（图5）。

在2018年3月9日，患者进行第二次复查。结论：妊娠18周。进展中（图6）。

图2 患者M. 结节性腺肌症（2014年3月）。
图3 患者M. 结节性腺肌症（2016年1月）。
图4 患者M. 孕4周。结节性腺肌症（2017年12月）。
图5 患者M. 孕13周。进展中。
图6 患者M. 孕18周。进展中。

引文：Zakharenko NF, Kovalenko NV, Manoliak IP. Clinical case report: conservative treatment of nodular adenomyosis. MOJ Womens Health. 2019;8(2):150–152. DOI: 10.15406/mojwh.2019.08.00227
Conclusion

Secondary dysmenorrhea with underlying endometriosis is a highly challenging issue in modern gynaecology. Unfortunately, statistical data demonstrate that this condition is often diagnosed in 6–7 years after the appearance of complaints. Considering the fact that endometriosis is diagnosed in 30%–40% of patients with primary infertility, the timely disease detection and correct choice of therapeutic approach are of vital importance since they are directly related to the future reproductive health of an adolescent girl. The nodular adenomyosis, even with large nodules, can be successfully treated conservatively with dienogest, and such long-term therapy (for over three years) is well-tolerated by the patients and contributes to the effective implementation of their reproductive function.

Acknowledgments

None.

Conflicts of interest

The author declares there no conflict of interest here.

References

1. Tatarchuk TF, Kalugina LV. On the issue of prevention and treatment of hormone-dependent hyper proliferative diseases in women. Women’s Health. 2013;7(1):51–57.

2. Guideline of the European Society of Human Reproduction and Embryology. Management of endometriosis. 2013. 97 p.

3. Dunselmear GA, Vermeulen N, Becker C, et al. ESHRE guideline: management of women with endometriosis. Hum Reprod. 2014;29(3):400–412.

4. Vovk IB, Zakharenko NF, Radysh TV. Status of activation of blood lymphocytes and serum levels of inflammatory mediators in different forms of endometriosis. Pediatrics, obstetrics and gynecology. 2013;76(1):77–81.

5. Zakharenko NF, Zadorozhaia TD, Kalugina LV. Indol-3-carbinol in the treatment of adenomyosis. F1000Res. 2013;2(15):22–24.

6. Zakharenko NF, Tatarchuk TF, Kovalenko NV. The role of oxidative stress in the genesis of endometriosis. Reproductive endocrinology. 2014;4(18):13–16.

7. Stilley JA. Cellular and molecular basis for endometriosis-associated infertility. Cell Tissue Res. 2012;349(3):849–862.

8. Johnson NP. Consensus on current management of endometriosis. Hum Reprod. 2013;28(6):1552–1568.

9. Zotova OA, Artymuk NV. Adenomyosis: clinic, risk factors and problems of diagnosis and treatment. Gynecology. 2013;5(6):31–34.