

Study Of Clinical And Morphological Features Of Different Forms Of Endometriosis

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ANNOTATION

Endometriosis is the spread of endometrial-like tissue into the uterus's target layer (adenomyosis) or beyond (external endometriosis). According to medical statistics, female endometriosis was considered the most common ailment in reproductive age, ranging from 12% to 50%.

In the structure of gynecological diseases, it ranked third after inflammatory processes and uterine fibroids. It was a common cause of reproductive disorders, up to the development of infertility, chronic pelvic pain syndrome, various mono and multiple organ pathologies (Strizhakov A.M., Davydov A.I., 1996; Adamyan L.V., Kulakov V.I., Andreeva E.N., 2006; Show R.W., 1995; Treloar S.A. et al., 2005). Despite numerous theories, endometriosis, which explained the etiopathogenesis and the essence of the pathological process, but not one of them could explain the diversity of forms and manifestations of this disease, and clinical and morphological varieties were giving little results. The statistics confirmed the prevalence of endometriosis worldwide. This disease affected more than 170 million women of reproductive age, on average every 8-10 women. In Russia, in the structure of gynecological diseases, endometriosis occupied a leading place among the most common diseases of the pelvic organs, infectious-inflammatory and uterine fibroids. The frequency of detection of endometriosis during diagnostic laparoscopy for infertility was on average 25-50%. External genital endometriosis was diagnosed in 35% of patients applying to centres of assisted reproductive technologies for in vitro fertilization (IVF) (Adamyan L. V. Burgova E. N., Mikoyan V. D. et al. 2006.; Adamyan L.V., Kulakov V.I., Andreeva E.N., 2006; Show R.W., 1995; Treloar S.A. et al., 2005). The American Society for Reproductive Medicine had issued recommendations on this issue 2 times, which once again confirmed this topic's relevance. A revolutionary method of treating this disease was surgical, although hormonal therapy had not lost its importance as an independent treatment, and as adjuvant therapy in the preoperative period (Makhmudova GM, 2004.; Adamyan L. V. Burgova E. N., Mikoyan V. D. et al. 2006.; Adamyan L.V., Kulakov V.I., Andreeva E.N., 2006; Show R.W., 1995).

Keywords: Ovarian endometriosis, Adenomyosis, Clinical and Morphological variants, Reproductive age.

THE AIM OF THE RESEARCH

Conduct a clinical and morphological analysis of ovarian endometriosis and adenomyosis, taking into account its various variants and morphofunctional forms.

MATERIALS AND METHODS

The morphological forms of adenomyosis and endometriosis of the ovaries were studied in 148 women of reproductive age in the Bukhara Patho-anatomical bureau sent from the Republican Emergency Center the Department of Gynecology of the Bukhara branch. The material for the study was operating materials. For general morphology, three pieces were excised from each endometrioid node, 1.5 × 1.5 cm from the centre, middle and peripheral parts, and solidified in 10% neutral formalin. After washing for 2–4 h in running water, it was dehydrated in concentrated alcohol and chloroform, then embedded in paraffin and prepared blocks. On paraffin blocks, sections of 5-8 μm were cut, stained with hematoxylin and eosin. Semi-thin 1 μm sections were obtained from Epon bricks on a Leykaultramicrotomy. Histological preparations were examined under 10, 20, 40 lenses of a light microscope, and the photographed crucial areas.

RESULTS AND DISCUSSION

Surgery materials of 148 female reproductive age patients without other gynecological diseases with various localizations of genital endometriosis, removed during surgical operations, were examined. The average age of patients was 36.8 ± 0.74 years, 40% of patients were under 35; 41% - from 36 to 45 years old; 22.2% - over 46 years old. Women were hospitalized on an emergency basis. Upon admission to the clinic, the examined women indicated complaints related to various manifestations of pain syndrome and menstrual irregularities. Periodic pain was indicated by 52.6% of patients, severe pain during the menstrual cycle was in 21.4% of patients, and pain before the menstrual cycle was noted by 5.7% of women. Indications for surgical treatment were: ovarian cystoma, uterine adenomyosis, a combination of adenomyosis with uterine myoma and menstrual irregularities by the type of hyperpolymenorrhea. Scope of surgical interventions - supravaginal amputation of the uterus without or with appendages, extirpation of the uterus without or with appendages and removal of endometriotic ovarian cysts. The removed preparations were carefully examined; the uterus's sizes, the thickness of the endometrium and ovaries, and the thickness of the endometrium and ovaries were measured. The presence of macroscopically visible pathological areas was determined. In the macroscopic examination, the uterus was enlarged in all cases. This is associated with both the growth of uterine fibroids and the shape and activity of foci of adenomyosis. In focal adenomyosis, thickening of one or several uterus walls was observed; in diffuse, the myometrium was thickened throughout. The nodular variant did not have a capsule, with indistinct boundaries of intramural nodules of various sizes. The incidence of different forms of endometriosis was also studied.

Table 1 The incidence of different forms of endometriosis

Forms	Number of women
Endometrioid ovarian cyst	49(68 %)
Retrocervical endometriosis	24(24%)
Adenomyosis of the uterus	15(26%)
Combination of different localization of endometriotic lesions	60(74%)

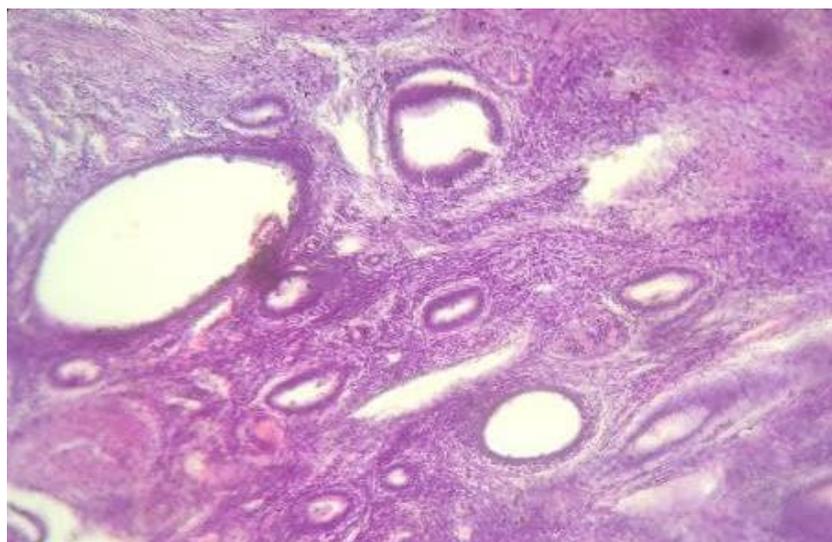


Figure 1. Iron structures of various shapes and sizes, from small with a narrow lumen to larger ones

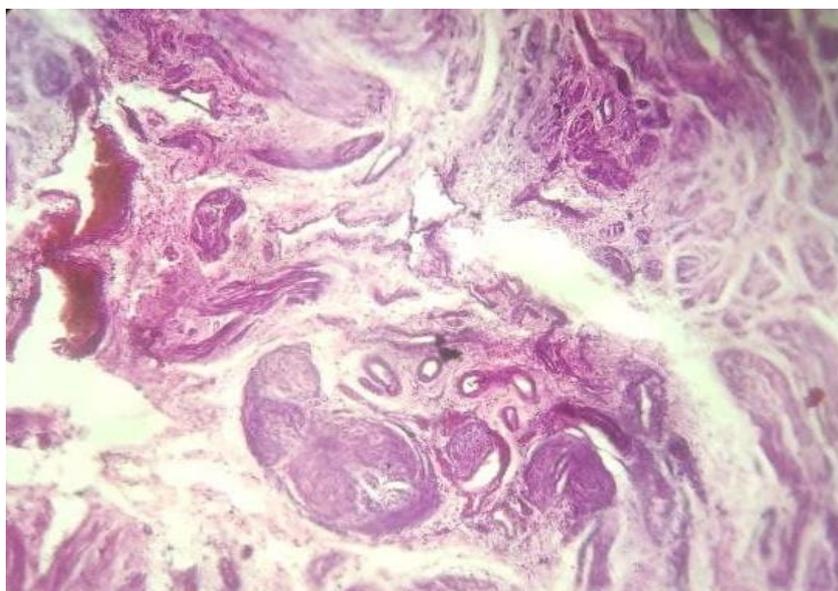


Figure 2. Penetration of the basal layer of the endometrium into the myometrium. Stained with hematoxylin and eosin. 10x10

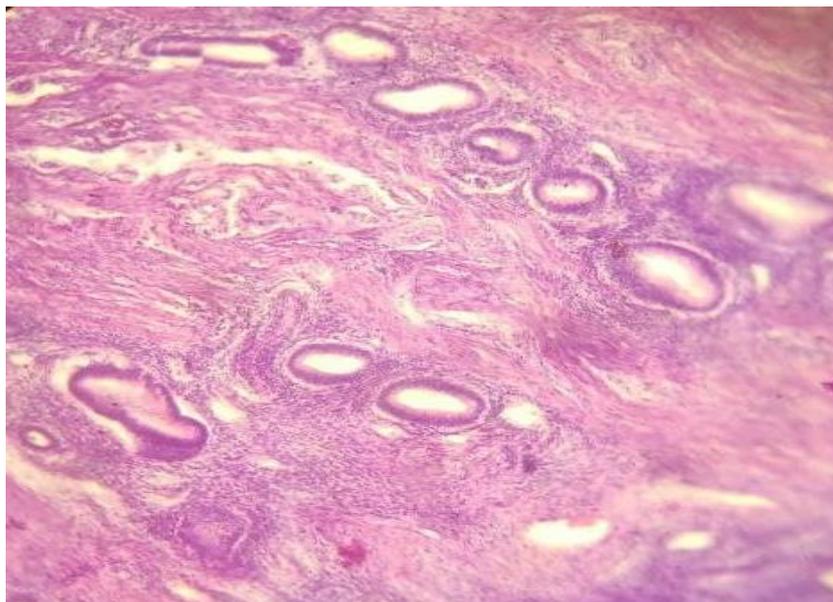


Figure 3. Adenomyosis of the uterus, endometrial glands with the surrounding cytotogenic stroma is located in the myometrium and stained with hematoxylin and eosin. 10x10.

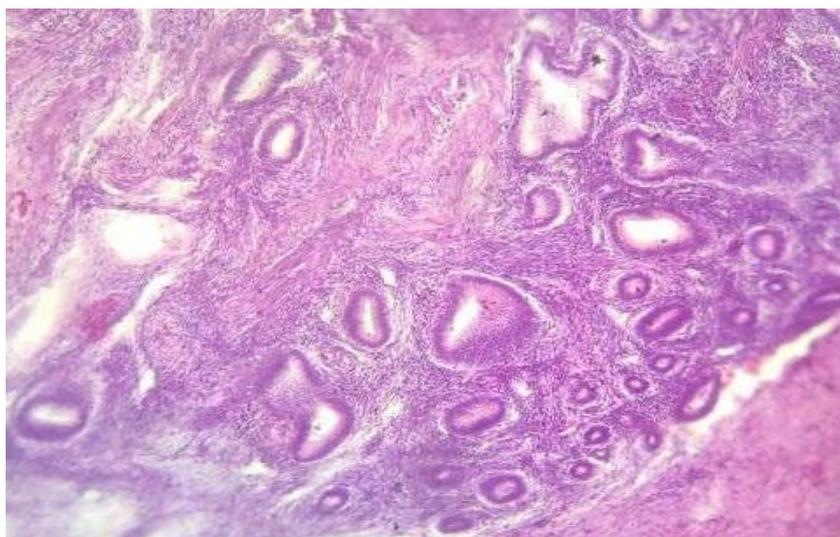


Figure 4. Adenomyosis of the uterus, endometrial glands with the surrounding cytotogenic stroma located in the myometrium. Stained with hematoxylin and eosin. 10x10.

Histologically, both in the myometrium and in the ovaries, endometrioid foci were determined, penetrating to different depths. The lesions had two components, both stromal and glandular structures: the ratio of these components varied depending on these nodes' types. Inactive adenomyosis, the glandular component was $33.4 \pm 17.4\%$, the share of the stromal was $66.5 \pm 16.4\%$, not significantly differing from inactive foci - the proportion of the glandular component and the stromal, respectively ($36.5 \pm 11.4\%$ and $63.4 \pm 11.4\%$ at $p = 0.14$ and 0.32).

Thus, morphological studies showed that endometriosis in women was one of the most common pathologies. Various forms of ovarian endometriosis and adenomyosis should be considered when choosing rational tactics for managing patients in the postoperative period to prevent relapse.

CONCLUSION

In patients with endometriosis against the background of inflammatory processes, the syndrome of chronic pelvic pain, various mono and multiple organ pathologies were most often observed. Endometriosis of the uterus and ovary was characterized by a long-term asymptomatic or low-symptom course, followed by the rapid development of the clinical picture and the appearance of indications for surgical treatment. In this case, the main indications were: pain syndrome (100%) combined with the hyper menstrual syndrome (55.7%), accompanied by every second patient overgrows, every third had anaemia.

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