



# THE RESULTS OF THE STUDY OF CLINICAL AND ANAMNESTIC FEATURES IN WOMEN WITH INTERNAL GENITAL ENDOMETRIOSIS

Mukhammadjonova M. M.

Gafurova F. A.

Center for the Development of Professional Qualifications of Medical Workers,  
Department of Obstetrics, Gynecology and Perinatal Medicine, Tashkent

## Abstract

Adenomyosis is one of the most common gynecological diseases, ranking third after inflammatory processes and uterine fibroids. The urgency of the problem of adenomyosis is due to the severity and versatility of the clinical picture of the disease. At the present stage, it is very important to make a timely diagnosis of the disease. The study of the clinical and anamnestic features of genital endometriosis makes it possible to develop criteria for diagnosis and optimal management of patients with adenomyosis.

**Keywords:** Internal genital endometriosis, adenomyosis, menstrual disorders, miscarriage, infertility.

## Introduction

Internal genital endometriosis, or adenomyosis, is one of the most acute problems of modern gynecology, is one of the most common gynecological diseases, ranking third after inflammatory processes and uterine fibroids [2,3]. Despite some progress in the study of certain aspects of the pathogenesis, diagnosis and treatment of endometriosis of various localization, this problem has not lost its relevance. Endometriosis continues to attract more and more attention not only from obstetricians and gynecologists, but also from doctors of other specialties. In addition to the prevalence, the urgency of the problem of adenomyosis is due to the severity and versatility of the clinical picture of the disease [1, 4]. Patients suffer from persistent menstrual dysfunction, with the most common symptoms being menometrorrhagia and/or dysmenorrhea. Patients often have reproductive disorders such as infertility, miscarriage. Patients with adenomyosis make up the majority of women with pelvic pain, and they undergo repeated diagnostic, surgical, and prolonged medical and physiotherapy treatments, with varying degrees of effectiveness. All of the above determines the relevance of this work, as it allows us to develop criteria for diagnosis and optimal management of patients with adenomyosis [11, 14].

**The purpose of the study** – to study the anamnesis and clinical features of the course of internal genital endometriosis in the studied patients.





## Materials and Methods

A prospective study was conducted of 72 patients with adenomyosis who applied to the gynecological departments of the Tashkent branch of the Republican National Center for Maternal and Child Health and the city maternity hospital No. 3. The control groups were conditionally healthy women who applied for a preventive examination. The selection criterion was the established diagnosis of adenomyosis based on clinical, instrumental and histological data. The patients were divided into clinical groups according to the histological criteria of the degree of spread of adenomyosis.

The clinical study examined in detail complaints, gynecological history data, including information about the nature of menstrual function (menarche, regularity, duration and painfulness of menstruation, the presence of menstrual disorders), information about hormone therapy conducted earlier, the age of onset of sexual activity, the number of sexual partners. The patients' somatic anamnesis included information about hereditary pathology, data on general somatic diseases, and the presence of a burdened allergic anamnesis. Obstetric history data made it possible to assess reproductive and childbearing functions, the number and course of pregnancies, the presence of abortions, as well as the nature of the course of labor and the postpartum period. The data on previously performed therapeutic and diagnostic manipulations, surgical interventions, histological examination findings, and data on the therapy performed were analyzed.

Attention was also paid to the features of the physique, the presence of obesity, the distribution of hair, the condition of the thyroid and mammary glands.

During the gynecological examination, the external genitalia, cervix and vagina were examined in mirrors, and a bimanual examination of the vagina was performed. Bimanual examination determined the size of the uterus, its consistency, shape, soreness, mobility, size, soreness and mobility of appendages. Initially, all the examined patients underwent ultrasound examination using color Dopplerography. The echographic examination made it possible to assess the size and structural changes of the uterus (endometrium, "transition zone", myometrium), as well as to identify the features of vascularization with an assessment of qualitative and quantitative indicators of blood flow, including dynamic monitoring during the menstrual cycle. A month after the hysteroscopy, a developed functional stress test was additionally applied, designed to detect changes in vascular resistance of the uterine arteries and myometrial vessels in patients with adenomyosis.

The patients who participated in the study underwent a standard examination: enzyme immunoassay or radioimmune examination to diagnose sexually transmitted infections, examination of vaginal secretions to diagnose opportunistic urogenital flora, clinical and biochemical blood and urine tests.

Statistical data processing was performed on an individual computer using Microsoft Excel spreadsheets and the Statistica application software package for Windows version 6.1 from Stat Soft Inc. (USA).





## Results and Discussion

A detailed examination of patients with adenomyosis ( $n = 72$ ) showed that the majority of patients had clinical and anamnestic features. The age of patients with adenomyosis ranged from 25 to 54 years.

Among the examined patients, patients of reproductive age prevailed – 40 women (55.6%) and late reproductive age – 29 patients (40.3%). These data probably indicate that adenomyosis, as a chronic disease, develops with few symptoms in patients of early reproductive age and gradually progresses, manifested by a pronounced clinic of common stages already in the fourth decade of life.

The main reasons for contacting a doctor were: dysmenorrhea (complaints of aching pains in the lower abdomen 2-5 days before the onset of menstruation and painful menstruation), unstable menstrual cycle prone to hyperpolymenorrhea (long, more than 7 days of menstruation, combined with a short menstrual cycle of 23-25 days), bleeding before and after menstruation, as well as in days of expected ovulation, uterine bleeding of varying intensity, infertility lasting from 2 to 6 years.

According to our study, dysmenorrhea was the most common symptom of the disease. The incidence of dysmenorrhea in the examined patients was 100%. Moreover, the severity of dysmenorrhea was assessed by patients as average in 50.7% and severe in 22.5%. The second most common symptom in the studied groups was bleeding before and after menstruation, and with early, grade I spread of adenomyosis, this symptom was detected in 55 patients (76.4%), the frequency of this syndrome was statistically significantly increased in the second stage of adenomyosis ( $p < 0.05$ ). Bleeding in the middle of the menstrual cycle was significantly more common ( $p < 0.05$ ) in isolated form in patients of the main clinical group – 22 (30.6%), as well as hypermenorrhea, which occurs in 100% of women of the second group.

The symptom of hyperpolymenorrhea – heavy and prolonged menstruation – was detected in 47 patients (65.3%). Infertility was the most common (43.4%) reason for outpatient treatment in patients who were subsequently suspected and confirmed to have grade I adenomyosis, and 5 of them had a history of unsuccessful attempts at in vitro fertilization.

The family history of almost half of the examined patients (34 patients (47.2%)) was characterized by the presence of benign (hormone-dependent) tumorous and tumor-like diseases of the uterus and appendages in close relatives. In addition, patients with adenomyosis showed a high incidence of various endocrine and metabolic disorders in their immediate family: 21 women (29.1%) had a family history of obesity, 6 cases (8.3%) had type II diabetes, and 8 cases (11.4%) had pathology of the thyroid gland. 47 patients (33.1%) had a family history of adenomyosis, which may indicate a genetic predisposition to this disease.

The somatic anamnesis in patients with adenomyosis was carried out taking into account the childhood and adolescence, which forms the reproductive health of the patients. A fairly high frequency (58 patients (80.5%)) of childhood infections (measles, rubella, chickenpox in various combinations), frequent diseases of the ENT organs (chronic tonsillitis, adenoiditis, sinusitis, etc.), as well as a higher susceptibility (49 patients (68.1%)) to acute respiratory diseases of patients with adenomyosis. There was also a significantly significant incidence of vegetative vascular dystonia in the prepubescent and post-pubertal periods in patients with adenomyosis compared





with the control group (53.5% versus 1.6%). Increased body weight in childhood was found in 39 (54%) patients. Iron deficiency anemia (IDA) prevailed in the first place among somatic diseases in patients of clinical groups (55 patients – 76.4%). Moreover, patients with advanced adenomyosis had IDA in 100% of cases. The pathology of the gastrointestinal tract (GIT) and hepatobiliary complex took the second place, which occurred in 43 patients (59.8%) with adenomyosis; chronic gastritis - in 32 patients (45.1%); chronic, including calculous cholecystitis – in 23 (31.6%); peptic ulcer stomach and duodenum - in 6 (8.4%). At the same time, diseases of the hepatobiliary system in 28 patients (38.8%) were often combined with increased body weight: grade 2 obesity in 29 (40.2%) patients. Grade 3 obesity occurred in 4 (5.6%) patients of the main group. Thyroid diseases in patients with adenomyosis occurred in 12 patients (16.9%). The results obtained confirm the high incidence of endocrine metabolic diseases in patients with adenomyosis. It was noteworthy that the patients of the main groups had a statistically significant increase in the incidence of all of the above diseases compared with the control group.

The gynecological history of patients with adenomyosis shows a high incidence of chronic inflammatory diseases of the female genital organs (chronic metroendometritis and/or salpingoophoritis) – in 68 patients (94%). He repeatedly underwent antibacterial and anti-inflammatory therapy, the effect of which was short-lived. Cervical diathermocoagulation was performed in 17 patients with adenomyosis (23.6%) for cervical erosion, 13 (18.1%) for cryodestruction, and 3 (4.2%) for laser vaporization. Juvenile uterine bleeding requiring therapeutic measures (hormone therapy, vitamin therapy, physiotherapy) was noted in the anamnesis in 15 patients (20.8%).

A history of bacterial vaginosis and colpitis was treated in 70 patients (97%). Colpitis was associated with opportunistic flora in 18 patients (25%). Chlamydia, trichomoniasis, ureaplasmosis and mycoplasmosis were treated in 68 (94.4%) patients with mandatory control of cure by PCR and bacterial studies. We did not find any statistical differences between the groups. 8 patients (12.5%) had previously undergone surgery (laparoscopic access) for tubal pregnancy. Appendage surgery (ovarian suturing or coagulation for ovarian apoplexy or removal of an ovarian follicular cyst) was performed in 14 patients (19.4%). Due to a history of infertility, 15 patients (11.1%) underwent diagnostic laparoscopy to exclude tubo-peritoneal infertility and peritoneal endometriosis. Tubal-peritoneal infertility factor and peritoneal endometriosis were not confirmed in these patients. During the gynecological examination, special attention was paid to assessing the size, shape and consistency of the uterus in the dynamics of the menstrual cycle, and pain during palpation. The shape of the uterus approached spherical in almost all patients, the consistency was more often assessed as dense and moderately painful on palpation. The size of the uterus in adenomyosis increased as much as possible on the eve of menstruation and decreased after it. However, at an early stage of adenomyosis, no significant changes in the size of the uterus were detected. The dynamics of uterine enlargement was especially pronounced in patients with grade II adenomyosis.

### Conclusion

Thus, almost all patients had a factor of burdened heredity, more often on the maternal side, mainly benign tumors of the genital organs and endocrine pathology. In patients with stage I adenomyosis,





the clinical picture of the disease is dominated by dysmenorrhea, pre- and postmenstrual bleeding, hypermenorrhea, unstable menstrual cycle and infertility. In addition to dysmenorrhea, patients with grade II and III adenomyosis are characterized by menometrorrhagia and uterine bleeding of varying intensity. The data we have obtained confirm the generally accepted opinion that the clinical symptoms of the initial degree of adenomyosis are nonspecific and do not allow us to verify the disease, which leads to its progression to severe, conservatively intractable degrees.

## References

1. Green I.C., Burnett T., Famuyide A. Persistent pelvic pain in patients with endometriosis. *Clin. Obstet. Gynecol.* 2022;65(4):775–85. DOI: 10.1097/GRF.0000000000000712
2. Moura A.P.C., Ribeiro H.S.A.A., Bernardo W.M., Simões R. et al. Accuracy of transvaginal sonography versus magnetic resonance imaging in the diagnosis of rectosigmoid endometriosis: systematic review and meta-analysis [published correction appears in *PLoS One.* 2019;14(8):e0221499]. *PLoS One.* 2019;14(4): e0214842. DOI: 10.1371/journal.pone.0214842
3. Chowdary P., Stone K., Ma T., Readman E. et al. Multicentre retrospective study to assess diagnostic accuracy of ultrasound for superficial endometriosis — are we any closer? *Aust. N. Z. J. Obstet. Gynaecol.* 2019;59(2):279–84. DOI: 10.1111/ajo.12911
4. Guo C., Zhang C. Platelet-to-lymphocyte ratio and CA125 level as a combined biomarker for diagnosing endometriosis and predicting pelvic adhesion severity. *Front. Oncol.* 2022;12:896152. DOI: 10.3389/fonc.2022.896152
5. Xue Y.H., You L.T., Ting H.F., Chen Y.W. et al. Increased risk of rheumatoid arthritis among patients with endometriosis: a nationwide population-based cohort study. *Rheumatology (Oxford).* 2021;60(7):3326–33. DOI: 10.1093/rheumatology/keaa784
6. Kusunoki M., Fujiwara Y., Komohara Y., Imamura Y. et al. Hemoglobin-induced continuous activation of macrophages in endometriotic cysts: a potential mechanism of endometriosis development and carcinogenesis. *Med. Mol. Morphol.* 2021;54(2):122–32. DOI: 10.1007/s00795-020-00272-4
7. Chapron C., Marcellin L., Borghese B., Santulli P. Rethinking mechanisms, diagnosis and management of endometriosis. *Nat. Rev. Endocrinol.* 2019;15(11):666–82. DOI: 10.1038/s41574-019-0245-z
8. Kitajima M., Khan K.N., Harada A., Taniguchi K. et al. Association between ovarian endometrioma and ovarian reserve. *Front. Biosci. (Elite Ed).* 2018;10(1):92–102. DOI: 10.2741/e810
9. Muzii L., Galati G., Di Tucci C., Di Felicianantonio M. et al. Medical treatment of ovarian endometriomas: a prospective evaluation of the effect of dienogest on ovarian reserve, cyst diameter, and associated pain. *Gynecol. Endocrinol.* 2020;36(1):81–3. DOI: 10.1080/09513590.2019.1640199
10. Pejovic T., Thisted S., White M., Nezhat F.R. Endometriosis and endometriosis-associated ovarian cancer (EAO). *Adv. Exp. Med. Biol.* 2020;1242:73–87. DOI: 10.1007/978-3-030-38474-6\_5







11. Chapron C., Vannuccini S., Santulli P., Abrão M.S. et al. Diagnosing adenomyosis: an integrated clinical and imaging approach. Hum. Reprod. Update. 2020;26(3):392–411. DOI: 10.1093/humupd/dmz049
12. Tellum T., Nygaard S., Lieng M. Noninvasive diagnosis of adenomyosis: a structured review and meta-analysis of diagnostic accuracy in imaging. J. Minim. Invasive Gynecol. 2020;27(2):408–18.e3. DOI: 10.1016/j.jmig.2019.11.001
13. Saraswat L., Ayansina D., Cooper K.G., Bhattacharya S. et al. Impact of endometriosis on risk of further gynaecological surgery and cancer: a national cohort study. BJOG. 2018;125(1):64–72. DOI: 10.1111/1471-0528.14793
14. Edi R., Cheng T. Endometriosis: evaluation and treatment. Am. Fam. Physician. 2022;106(4):397–404.

