detected by hyperintense myometrial spots, which are the findings most specific to adenomyosis. Second, the usefulness of fat-saturated turbo-spin echo sequences for the detection of adenomyosis has never been demonstrated. Third, breath-hold T2-weighted sequences (true fast imaging with steady-state precession and turbo-inversion-recovery sequences) offer better differentiation between focal adenomyosis and uterine contrac-
tion, optimize the accuracy of MR imaging for the diagnosis of adenomyosis and reduce interobserver variability, while fast spin-echo T2-weighted images and breath-hold T2-weighted sequences appear to have similar accuracy (Bazot et al., 2003).

Concerning the MR imaging criteria, Kunz et al. considered that a junctional zone maximum of $>11$ mm ($JZ_{\text{max}}$) was alone sufficient for the diagnosis of adenomyosis (Reinhold et al., 1996). In our experience, isolated $JZ_{\text{max}} >11$ mm has a sensitivity and specificity of, respectively, 62% and 96% for the diagnosis of adenomyosis (Bazot et al., 2001). The combination of $JZ$ thickness with high-signal-intensity myometrial spots, $JZ_{\text{max}}/\text{entire myometrium} >40\%$ and regular homogeneous uterine enlargement increases the accuracy of MR imaging in women with adenomyosis who do not have associated leiomyomas, raising the sensitivity and specificity to 87% and 100%, respectively (Bazot et al., 2001). Regarding clinical implications, using a $JZ_{\text{max}}$ threshold of $10$ mm as a criterion of adenomyosis, Kunz et al. found a very high prevalence of adenomyosis in the ‘total endometriotic’ group (79%) compared to both ‘healthy controls’ (9%) and ‘total controls’ (28%) (Kunz et al., 2005). These results contrast with those of a recent study in which only 44 (27%) of 163 women with pelvic endometriosis proven by laparoscopy and histology had adenomyosis on pre-operative MR imaging (Bazot et al., 2004).

Finally, like Kunz et al. we also found that uterine adenomyosis was the main determinant of infertility in a series of 34 women undergoing laparoscopic segmental colorectal resec-
tion for endometriosis, 22 of whom wished to conceive (Darai et al., 2005).

References


but rather with a variable time interval with endometriosis usually coming first and followed by adenomyosis as the main determinant with respect to infertility. Thus, in this dynamic process of disease development no static value for the prevalence of adenomyosis in endometriosis can be expected. This value varies dependent on the study population chosen. In our study, all patients or couples including the ‘healthy’ and ‘total controls’ were suffering from infertility and were seeking treatment by assisted reproduction, increasing the probability that both the peritoneal and the uterine variant of the disease had developed in these women.

References


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doi:10.1093/humrep/dei449