# Adenomyosis and its Homoeopathic Treatment: An Integrative Approach

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ABSTRACT

Adenomyosis is a benign gynecological disorder characterized by the presence of endometrial glands and stroma within the myometrium, resulting in uterine enlargement, dysmenorrhea, chronic pelvic pain, and abnormal uterine bleeding. It predominantly affects women of reproductive age and significantly impairs quality of life. Although conventional treatment modalities such as hormonal therapy and hysterectomy are commonly employed, they may not always be suitable for women desiring fertility preservation. Homoeopathy, with its individualized and holistic approach, offers a complementary therapeutic option aimed at symptom relief and improvement of overall well-being. This article reviews the pathophysiology, clinical features, diagnosis, and management of adenomyosis, with special emphasis on homoeopathic therapeutics.

**Keywords:** Adenomyosis, Homoeopathy, Dysmenorrhea, Menorrhagia, Uterine Disorders, Individualized Treatment

**Abbreviations: NSAIDs- Nonsteroidal anti-inflammatory drugs**
**MRI- Magnetic Resonance Imaging**

## INTRODUCTION

Adenomyosis, also labelled Uterine Endometriosis, is a relatively common condition in which islands of endometrium are found in the wall of the uterus. Its observed frequently in elderly women. More than 1/3rd of the hysterectomy specimens from women aged and above reveal the presence of Adenomyosis. The diseases often co-exist with uterine Fibromyomas, pelvic endometriosis (15%) & endometrial **carcinoma**(1).First described in **1860 by the German** pathologist **Carl von Rokitansky,** the histopathologic finding was termed **"cystosarcoma adenoids uterinum."**(2)

Accurate demographics and disease prevalence are unclear due to previous underreporting and under-diagnosis. Estimates range from **5% to 70%** with more recent data suggesting a prevalence of **20% to 35%**.(3)

Adenomyosis commonly presents with heavy menstrual bleeding, severe dysmenorrhea, chronic pelvic pain, and infertility. The disease has a substantial impact on women's physical, emotional, and social health**.** Chronic pelvic pain, severe dysmenorrhea, menorrhagia, fatigue resulting from anemia, and infertility can significantly impair daily activities, work productivity, interpersonal relationships, and overall quality of life. The persistent nature of symptoms may also contribute to psychological distress, including anxiety, irritability, emotional exhaustion, and reduced self-esteem. While conventional medicine primarily focuses on hormonal suppression and surgical intervention, homoeopathy seeks to address the individual patient's symptom totality and constitutional predisposition. Homeopathy is highly useful for symptomatic management of adenomyosis. The

symptoms including heavy/prolonged menstrual bleeding, pain during periods/intercourse, and spotting between periods can be managed effectively with homeopathy.

## DEFINATION:

Adenomyosis is a benign gynecological disorder characterized by the presence of ectopic endometrial glands and stroma within the uterine myometrium, accompanied by hypertrophy and hyperplasia of the surrounding smooth muscle tissue, resulting in diffuse or focal enlargement of the uterus. It commonly presents with heavy menstrual bleeding, dysmenorrhea, chronic pelvic pain, and may be associated with infertility and adverse reproductive **outcomes**.[1]

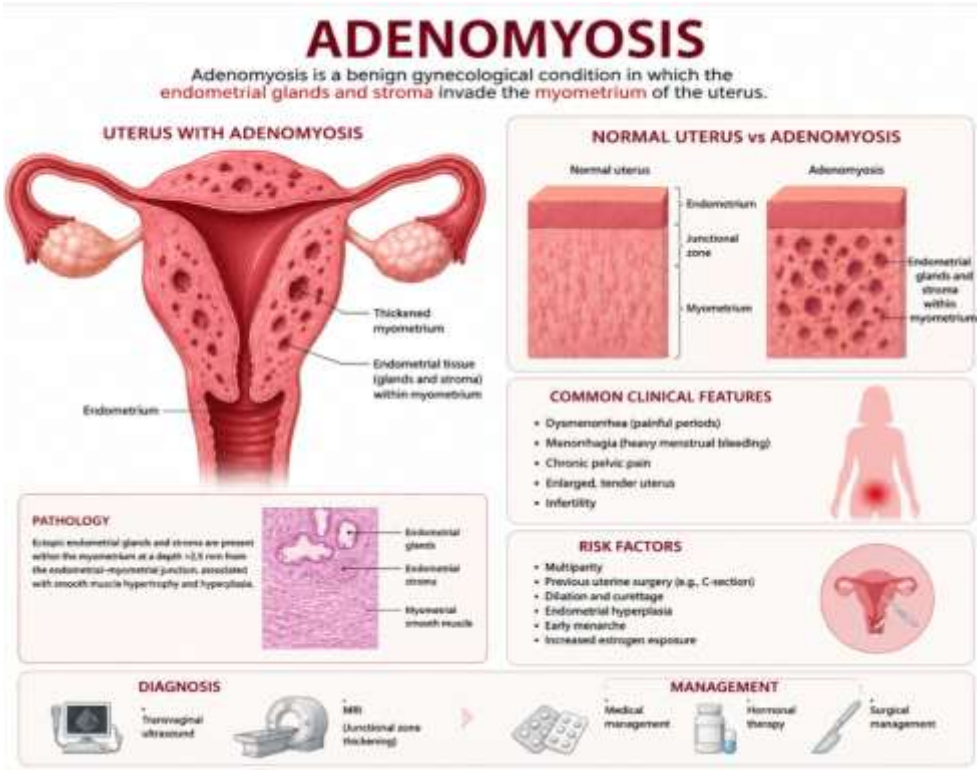



**Figure 1: Adenomyosis of Uterus**

## EPIDEMIOLOGY

Accurate demographics and disease prevalence are unclear due to previous underreporting and under-diagnosis. Estimates range from 5% to 70% with more recent data suggesting a prevalence of 20% to 35%..[3] Classically, adenomyosis is described as a disease of pre-menopausal, multiparous women in their thirties to forties; however, this reflects the inherent bias towards women undergoing a hysterectomy. Improvements in the diagnostic ability of ultrasound and MRI criteria have led to more insight about affected populations.

Risk factors for adenomyosis include conditions leading to increased estrogen exposure (increased parity, early menarche, short menstrual cycles, elevated body mass index, oral contraceptive pill use, tamoxifen use) and prior uterine surgery (dilation and curettage, caesarean section, myomectomy, etc.).[4]

## TYPES OF ADENOMYOSIS

### 1. By Growth Pattern

- **Diffuse Adenomyosis:** This is the most common type, characterized by widespread invasion of endometrial tissue throughout the uterine muscle (myometrium). It often causes the entire uterus to become enlarged and is strongly linked to heavy, prolonged menstrual bleeding (menorrhagia).[19]

- **Focal Adenomyosis:** This type presents as isolated, localized lesions of misplaced endometrial tissue within the uterine wall.[20]

- **Adenomyoma:** A specific subset of focal adenomyosis where the isolated lesions form distinct, benign tumor-like masses or nodules. These tend to be more common in younger patients and are frequently associated with coexisting endometriosis.[21]

## 2. By Location and Depth[22,23,24]

also classify adenomyosis by where it embeds itself in the uterine layers.

- **Intrinsic (Internal) Adenomyosis:** Tissue invades the inner, sub-basal layer of the myometrium, closer to the uterine cavity. It is strongly associated with heavy menstrual bleeding.

- **Extrinsic (External) Adenomyosis:** This form affects the outer layers of the uterine muscle near the serosa (the outer lining of the uterus). It is often found in patients who also have deep infiltrating endometriosis.

## 3. Structural Types (Rare)[25]

- **Cystic Adenomyosis:** A rarer form where fluid-filled cysts (lined with endometrial tissue) form within the uterine muscle.

# What Are the Different Adenomyosis Stages?

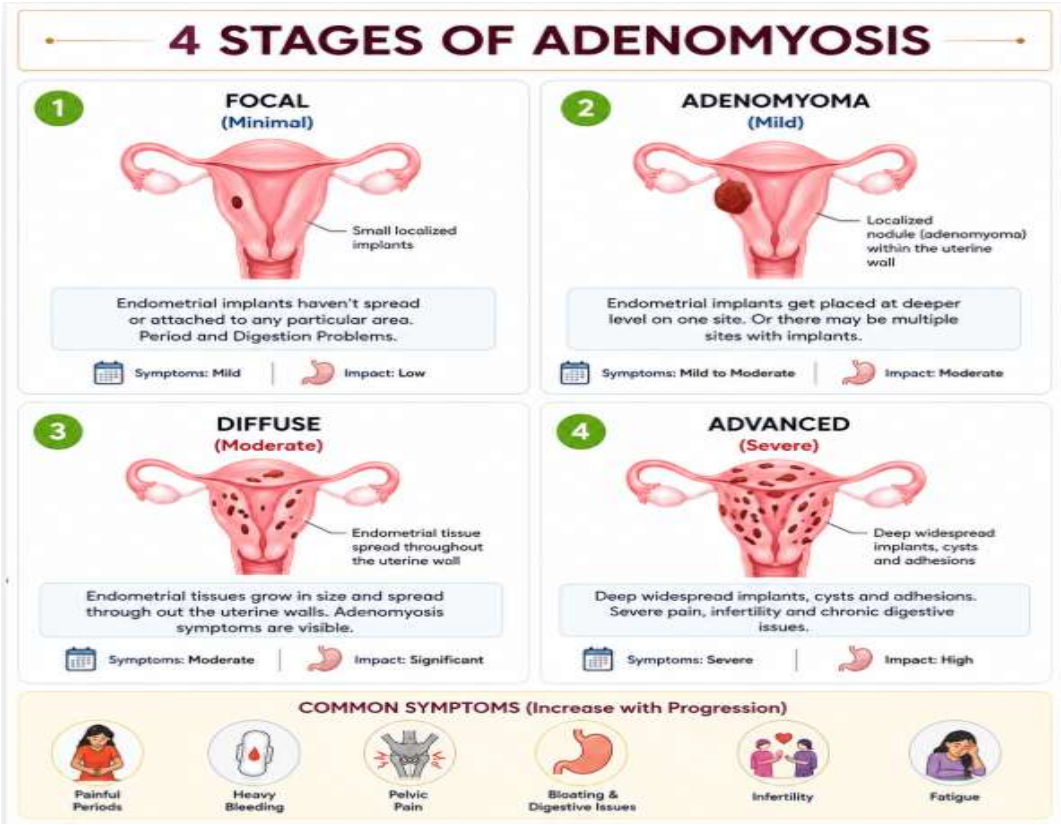



**FIGURE 2: STAGES OF ADENOMYOSIS**

## Stages of Adenomyosis:[19,20,22,23]

Adenomyosis can cause the uterus to become enlarged and can lead to pain and heavy bleeding during menstruation. The four stages of adenomyosis are:

### 1. Mild adenomyosis

This is when small areas of endometrium have broken through the uterine wall. There may be no symptoms at this stage.

### 2. Moderate adenomyosis

This is when larger areas of endometrium have broken through the uterine wall (focal adenomyosis). In this case, the growth of adenomyomas is not so wide across the uterine cavity. Symptoms may include pain during menstruation and sex, heavy bleeding, and fatigue.

### 3. Severe adenomyosis

This is when endometrium has broken through the uterine muscle in many areas (diffuse adenomyosis). Symptoms may include very severe pain during menstruation and sex, a sense of tightness and chronic pelvic pain, excessive bleeding, and fatigue.

### 4. Advanced adenomyosis

This is when endometrium has completely replaced the uterine muscle. Symptoms may include severe pain in the pelvic region, lower back and renal area, heavy bleeding, and infertility.

| Stage | Extent of Invasion | Clinical Severity |
|---|---|---|
| Stage I (Minimal/Mild) | Endometrial tissue invades less than one-third of the myometrium | Mild symptoms or asymptomatic |
| Stage II (Moderate) | Invasion extends to one-third to one-half of the myometrium | Moderate dysmenorrhea and menorrhagia |
| Stage III (Severe) | More than half of the myometrium involved | Severe pain, heavy bleeding, enlarged uterus |
| Stage IV (Extensive/Advanced) | Full-thickness involvement reaching near the serosa | Severe symptoms, infertility, significant uterine enlargement |

# PATHOGENESIS OF ADENOMYOSIS:

## How adenomyosis develops: -

Different theories have been proposed for the origin of Adenomyosis.

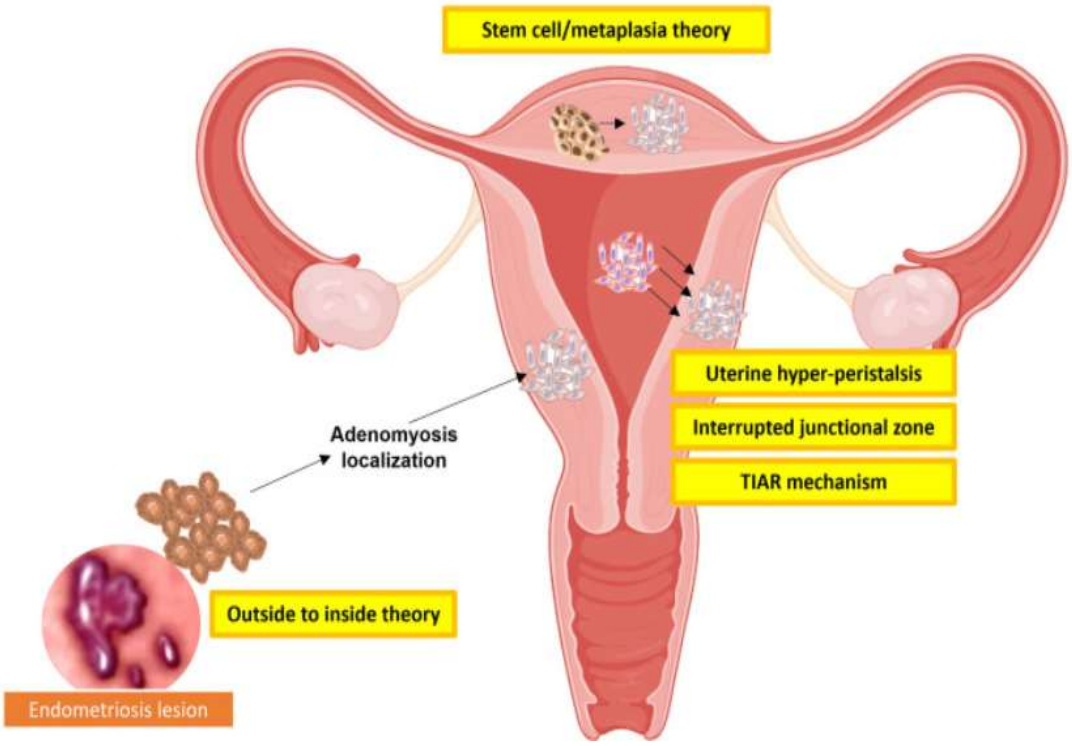



**Figure 3: Pathogenesis of adenomyosis.**

## Easy Memory Line

**"INVAGINATION – STEM CELLS – MIGRATION"**

- **Inside → Inside: endometrium pushes in**
- **Stem cells: new tissue forms inside**
- **Outside → Inside: external implantation**

**1. Invagination Theory**

Direct invasion of the basal endometrium into the myometrium through a disrupted endometrial-myometrial interface.

**2. Metaplastic Theory**

Differentiation of embryonic Müllerian remnants into endometrial tissue within the myometrium.

**3. Tissue Injury and Repair Theory**

Repeated uterine injury induces inflammatory responses that facilitate endometrial invasion.

**4. Stem Cell Theory**

Migration and differentiation of stem cells contribute to ectopic endometrial tissue formation.

**Hormonal factors, particularly oestrogen, play a significant role in disease progression.**

| Theory | Mechanism | Key Idea |
|---|---|---|
| 1. Inside–to–Inside Theory (Invagination / TIAR mechanism) | Endometrium invaginates into myometrium due to uterine hypercontractility and disrupted junctional zone with Tissue Injury & Repair (TIAR) response | Endometrial tissue grows inward into myometrium from the uterine lining |
| 2. Stem Cell / Metaplasia Theory | Stem cells or Müllerian remnants within myometrium differentiate into endometrial tissue | New endometrial tissue forms *inside the myometrium itself* |
| 3. Outside–to–Inside Theory | Endometrial cells migrate from endometriotic lesions and implant into myometrium | Endometrial tissue enters myometrium from outside sources |

# ETIOLOGY OF ADENOMYOSIS:

While the histology is well-described, the etiology of adenomyosis is not known definitively. Researchers have postulated several theories. The most commonly accepted theory is that

adenomyosis results from a disrupted boundary between the deepest layer of the endometrium (endometrium basalis) and the underlying myometrium. This process leads to a cycle of inappropriate endometrial proliferation into the myometrium with subsequent small vessel angiogenesis as well as adjacent myometrial smooth muscle hypertrophy and hyperplasia. Data demonstrating a higher prevalence of adenomyosis following dilation and curettage and caesarean section support this theory.[5,6]

A second theory proposes an embryologic mechanism whereby pluripotent Mullerian stem cells undergo inappropriate differentiation leading to ectopic endometrial tissue. This theory has support from evidence demonstrating altered expression of specific genetic markers, in addition to case reports of endometrial tissue found in women with Rokitansky-Kuster-Hauser syndrome (Mullerian agenesis).[7,8,9,10]

# HISTOPATHOLOGY OF ADENOMYOSIS:

Histologic diagnosis of adenomyosis is the presence of endometrial stroma and glandular tissue within the smooth muscle of the myometrium. Different definitions of the required depth of invasion exist, some using an absolute measurement between 2.5 to 8 mm while others use a percentage. Additionally, several histologic grading classifications attempt to characterize the burden of disease.[11]

# CLINICAL FEATURES OF ADENOMYOSIS

**1. Menstrual abnormalities**

- **Heavy menstrual bleeding (menorrhagia)** – most common
- **Prolonged menses**
- **Dysmenorrhea** (progressively worsening, secondary type)

**2. Pain symptoms**

- **Chronic pelvic pain**
- **Severe secondary dysmenorrhea**
- Pain starts **1–2 days before menses and continues during period**
- **Deep, dragging uterine pain**

**3. Uterine changes (clinical exam)**

- **Enlarged, symmetrically bulky uterus**
- **Soft, "boggy" uterus**
- **Tender on palpation**
- May be **globular (diffuse enlargement rather than irregular)**

**4. Reproductive issues**

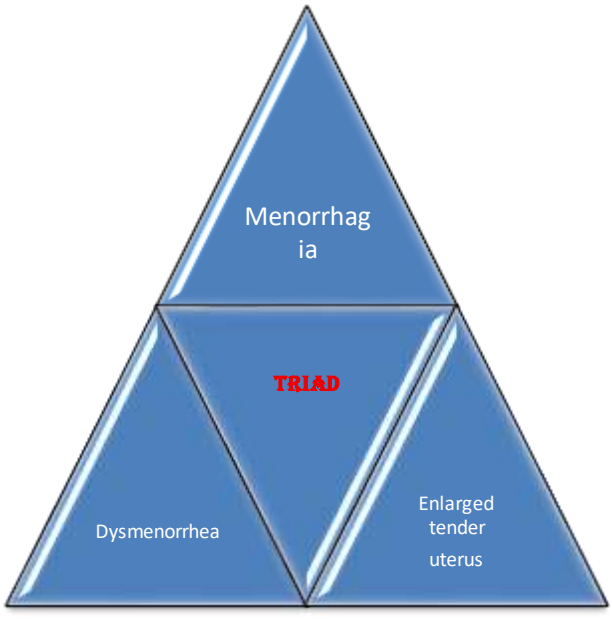
- **Infertility / subfertility**
- **Recurrent implantation failure**
- Early pregnancy loss (in some cases)

**5. Pressure symptoms (less common)**

- Urinary frequency (if enlarged uterus presses bladder)
- Pelvic heaviness / fullness

**6. Age pattern**

- Common in **30–50 years**
- Often in **multiparous women**




**Classic triad**

# DIAGNOSIS:

**1. Laboratory Evaluation**

Laboratory testing is useful to rule out other disease entities included in the differential diagnosis, in addition to identifying certain complicating features such as anemia due to heavy menstruation. While some biomarkers do exist, none are specific for adenomyosis.[12]

**2.Radiologic Evaluation**

Imaging is the primary means of making the diagnosis. Previously the preferred modality was MRI; however, recent data has shown the transvaginal ultrasound to match the sensitivity and specificity of MRI (89% sensitivity, 86% specificity). [13] The availability of ultrasound and the increased costs of MRI have led to ultrasound becoming the preferred modality for the initial evaluation, reserving MRI for equivocal cases.[14]

**3.Ultrasound**

Transvaginal ultrasound is the preferred diagnostic imaging modality for adenomyosis. The characteristic findings reflect the histopathologic changes of the disease process and can be broken down into three categories**:**

- Endometrial infiltration: Echogenic striations and nodules, myometrial cysts, and "lollipop" diverticula (cystic striations)
- Smooth muscle proliferation: Focal or diffuse myometrial thickening with indistinct borders more commonly involving the posterior fundus and heterogenous echotexture manifesting as "venetian blind" appearance of thin linear shadows
- Vascularity: Color Doppler demonstrating an increased number of tortuous vessels throughout the involved myometrium as opposed to leiomyomas which displace vessels.

4. **MRI**

Characteristic findings on MRI parallel the same features seen on ultrasound: [15,16]

- On T2-weighted imaging, uterine enlargement characterized by ill-defined, low-signal-intensity regions within the junctional zone is reflective of smooth muscle hyperplasia (junctional zone thicker than 12 mm is generally accepted as diagnostic)
- T2 hyperintense myometrial cysts reflecting regions of ectopic endometrial tissue (can also have increased intrinsic T1 signal or increased susceptibility in haemorrhagic foci)
- Contrast enhancement is generally not reliable for assessment of vascularity as compared to color Doppler ultrasound.

# DIFFERENTIAL DIAGNOSIS:

- Polyps
- Adenomyosis
- Leiomyoma
- Malignancy/hyperplasia
- Coagulopathy
- Ovulatory dysfunction
- Endometrial
- Iatrogenic

# PROGNOSIS:

Adenomyosis is a difficult diagnosis to manage as multiple clinical factors must be considered, including fertility, confidence in diagnosis, side effects of medical management, and risk of invasive procedures. Recent data showing an increased prevalence of adenomyosis in younger populations and asymptomatic patients reflects a spectrum of disease which is incompletely understood. Symptoms seem to correlate with the number of adenomyosis foci and the depth of invasion. [17] The consensus to treatment is a stepwise approach with medical therapy to include anti-inflammatory and hormonal agents with progression to minimally invasive procedures such as endometrial ablation/myomectomy or uterine artery embolization. The definitive cure remains hysterectomy.

# Treatment / Management:

## 1.Medical Therapies

Nonsteroidal anti-inflammatory drugs (NSAIDs) are one of the primary medical therapies. These medications target the cyclooxygenase enzyme which produces the prostaglandins responsible for painful cramping during menstruation.

## 2. Minimally Invasive/Surgical Therapies

Several interventional radiologic procedures exist which may be options for the patient who fails medical therapy but desires future fertility. MRI-guided and ultrasound-guided high-intensity ultrasound thermal ablation can be done to target focal disease. Uterine artery embolization reduces blood flow to the uterus as a whole, thereby inducing necrosis leading to an overall reduction in uterine size. These therapies show promise but require additional data on direct treatment comparisons and long-term outcomes.

Endometrial ablation may be considered in patients who do not desire future fertility but prefer a less invasive alternative to hysterectomy. Limitations include the inability to target deeper adenomyotic foci due to its superficial approach.

Myomectomy and partial hysterectomy are more invasive options that aim to preserve fertility. These options allow for targeting of deeper foci; however, subsequent scarring may lead to disease recurrence as the endometrial-myometrial interface is disrupted, a risk factor for adenomyosis. Additional considerations include the potential for future pregnancy complications due to altered uterine anatomy with an increased risk of uterine rupture, premature rupture of membranes, premature labor, and spontaneous abortion.

**Hysterectomy (gold standard)** remains the definitive cure for adenomyosis.

# HOMOEOPATHIC MANAGEMENT

Homeopathy is highly useful for symptomatic management of adenomyosis. The symptoms including heavy/prolonged menstrual bleeding, pain during periods/intercourse, and spotting between periods can be managed effectively with homeopathy.

**1. Sabina – To Manage Heavy, Bright, Red Menstrual Flow**

Sabina is prepared from young, fresh tops of the branches of a plant Sabina Officinalis. Sabina is highly beneficial to manage complaint of heavy periods in adenomyosis cases. Females needing Sabina complains of very copious menstrual flow that tends to have heavy clots. The blood is bright red in color and flows in gushes. The menses may also last for a longer duration and are frequently attended with pain and colic. The characteristic pain goes from sacrum to pubes. In some cases, intermenstrual bleeding also appears.

**2. Thlaspi – For Prolonged Menstrual Bleeding**

Thlaspi is prepared from a plant Thlaspi Bursa Pastoris of the natural order Cruciferae. Thlaspi is very beneficial to manage prolonged menstrual bleeding in cases of adenomyosis. The menstrual bleeding may prolong for ten to even fifteen days where Thlaspi is indicated. The bleeding is also profuse with clots. Uterine colic appears during menses. Marked exhaustion attends excessive bleeding. The next periods start without recovery from the previous one. Sometimes the menstrual bleeding is profuse in every alternate month.

**3. Ustilago – For Heavy, Dark Menstrual Flow**

Ustilago is an excellent medicine to manage heavy menstrual flow dark in color in adenomyosis. Sometimes long black stringy clots pass with the dark blood. The blood may also have an offensive Odor. Motion tends to worsen the flow and the menses are also prolonged. Extreme pain may attend menstrual flow.

**4. Trillium Pendulum – For Bleeding between Periods**

Trillium Pendulum is prepared from the fresh root of a plant named Three-leaved Nightshade of the natural order Smilaceae. Trillium Pendulum works effectively to manage the complaint of bleeding between periods in cases of adenomyosis. For using Trillium, the menstrual flow appears at every two weeks duration. The blood is profuse and gushes out of the uterus and is bright red in color. This may cause the woman to faint. A bearing down pain in the pelvis is also felt. Pain in the hips and small of the back is also marked with a sensation as if they will fall into pieces.

**5. Calcarea Carb – For Early, Profuse and Prolonged Periods**

Calcarea Carb is a well-indicated medicine for treating early, profuse and prolonged periods in adenomyosis. Pains of cutting nature appear in the uterus during periods. Pain in the back also arise. Nausea may attend with the pain during periods. In some cases, headache and vertigo may be felt during periods. Anemia may be present due to frequent and profuse periods of long duration.

**6. Colocynthis – For Severe Cramps during Periods in Adenomyosis**

Colocynthis is prepared from the pulp of the fruit of plant Citrullus Colocynthis of the natural order Cucurbitaceae. It is very useful for managing severe cramps or pain during periods in adenomyosis. The pain tends to get worse after eating or drinking. Relief in the pain is obtained by bending double or by hard pressure where Colocynthis is indicated. The abdomen may be distended with a sensation of distress along with uterine colic. In cases requiring Colocynthis, the uterine pain may also begin to be felt before the periods. Great restlessness attends the menstrual colic.

**7. Magnesia Phos – For Painful Periods**

Magnesia Phos is another effective medicine for treating painful periods in adenomyosis. To use Magnesia Phos, the uterine pain may be cramping, drawing, darting, shooting, lightening like or cutting in nature. Warm applications tend to relieve the pain in cases needing Magnesia Phos. Along with uterine colic, a bruised sensation in the abdomen may also be felt.

**8. Viburnum – To Manage Uterine Pain Radiating down Thighs**

Viburnum is prepared from fresh bark of plant Viburnum opulus commonly named as High Cranberry of the natural order Caprifoliaceae. Viburnum is beneficial to manage uterine pain radiating down thighs in cases of adenomyosis. The entire pelvic region feels full and congested. Pain in the back also arises along with nausea. The menstrual flow is profuse and contains large clots. The blood may also be offensive.

**9. Sepia – For Painful Intercourse**

Sepia is considered in cases of adenomyosis to manage the complaint of painful intercourse. There may also be a tendency of early and copious periods. During periods, there may be a bearing-down pain in the pelvis and small of the back. Burning or shooting pain in the uterus may also be felt.

# CONCLUSION

Adenomyosis is a chronic, estrogen-dependent uterine disorder characterized by ectopic endometrial tissue within the myometrium, leading to progressive dysmenorrhea, menorrhagia, pelvic pain, and significant impairment in quality of life. The condition reflects a deeper disturbance in hormonal regulation, uterine function, and individual susceptibility, making it a suitable field for individualized therapeutic approaches.
Homoeopathy offers a holistic and constitutional method of management, aiming not merely at symptomatic relief but at addressing the underlying dynamic imbalance of the patient. By carefully evaluating the totality of symptoms—mental, general, and physical—homoeopathic treatment seeks to reduce pain, regulate

menstrual flow, improve uterine health, and enhance overall well-being. Remedies are selected based on individualized symptom patterns, disease expression, and patient constitution, rather than a disease-cantered approach.

homoeopathy provides a patient-centered and individualized therapeutic approach for adenomyosis, focusing on long-term regulation of symptoms and restoration of health at both physical and constitutional levels.

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