

Adenocarcinoma in situ cervicis uteri

Adenocarcinoma in situ (AIS) of the uterine cervix is a premalignant glandular condition. It is the only known precursor to cervical adenocarcinoma and if it is well treated then occurrence of invasive disease can be prevented. According to recent studies the usual interval between clinically detectable adenocarcinoma in situ and early invasion appears to be at least five years.

It is well known that AIS and adenocarcinoma of the cervix are less common than squamous cell cervical cancer (SCC) and its precursor. SEER data (The Surveillance, Epidemiology and End Results United States national cancer database) showed that among cervical cancer cases, 25 percent were adenocarcinoma and 70 percent squamous cell carcinoma. The mean age of occurrence is 36,9 years. AIS is almost always asymptomatic and rarely women present with cervical bleeding. It is typically detected as abnormal cervical cytology in these order: glandular lesion (50-69%), squamous lesion (26-31%), mixed lesion (15%) and in 4% cytology was negative.

Diagnostic methods after abnormal cytology includes colposcopy-directed biopsy, endocervical curettage, or cone biopsy.

Lesion usually originate at the cervical transformation zone and extend proximally within the endocervical canal. 10 - 15 percent of patients with AIS have multifocal disease. There are no obvious colposcopic features that allow definite diagnosis of AIS and adenocarcinoma, as no clear criteria have been established for recognizing glandular lesions. The most important facts in diagnosis of glandular lesions are high degree of training and skill. In many cases of AIS (50% approximately) the lesion is entirely within the canal and may easily be missed if the endocervical canal is not properly visualized and investigated. Patterns like elevated ones with an irregular acetowhite surface, atypical blood vessels as branch-like or root-like vessels can suggest glandular disease. A variegated patchy red and white lesion with small papillary excrescences and epithelial buddings and large crypt openings in the columnar epithelium can also be associated with glandular lesion.

Colposcopic diagnosis of adenocarcinoma in situ depends on several factors: well educated colposcopist, strict adherence to the step-by-step approach to examination, the use of a grading index, close attention to surface blood vessels, the appropriate use of endocervical curettage to rule out lesions in the canal and the taking of a well directed biopsy of sufficient tissue on which to base a reliable histopathological exam.

Key words: colposcopy, glandular lesions, adenocarcinoma in situ cervicis uteri

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