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CASE REPORT

CASE REPORT OF SCAR ENDOMETRIOSIS

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ABSTRACT

Endometriosis is described as the presence of functional endometrial tissue outside uterine cavity. Scar endometriosis is a rare disease and is difficult to diagnose. It commonly follows obstetrical and gynecological surgeries. Diagnosis is usually made only after excision of the diseased tissue. A case report of a patient with troublesome scar after caesarean section is presented.

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INTRODUCTION

Extrapelvic endometriosis is a condition where in the endometrial glands and stroma are present outside the pelvis (Pattersond and Winburn, 1999; Blanco *et al.,* 2003). It can be present on the kidney, bowel, lungs, pleura and abdominal wall (Wolf and Singh, 1989). Previous surgical scar is the site where abdominal endometriosis develops and can be confused with abscess, lipoma, incisional hernia which can delay the diagnosis (Koger *et al.,* 1993; Horton *et al.,* 2008). Scar following gynaecological and obstetric surgeries contribute inmajority in the development of scar endometriosis but rarely, it is also seen following appendicectomy and trocar tract ofa laparoscope (Padmanaban *et al.,* 2003; Bhowmick *et al.,* 1986; Chatterjee, 1980). The incidence of scar endometriosis following gynaecological and obstetric operations is around 0.03-1.08% (Teng *et al.,* 2008). Usually presents as cyclical painful mass in the scar region and its size and intensity of pain differs during the menstrual cycle. Diagnosis is usually by US, CT and MRI. The present case evaluates a case of scar endometrioma and the literature is reviewed.

CASE REPORT

Mrs X aged 30yrs attended gynecology OPD of our hospital with chief complaints of swelling and pain in the incisional site since 9 months. Patient had undergone 2 previous LSCS and the last one was 8yrs back.

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Post operative period was uneventful. The swelling was on the left side of the incision and used to gradually increases in size during menstruation. Pain was dull aching at the swelling site and intensity was associated with menstrual cycle. On examination, general examination was within normal limits. Per abdomen, a bluish mass of about 4*5 cm was seen on the left side of the suprapubic transverse scar which was tender, firm in consistency and fixed. USG revealed an ill defined homogenous focal lesion with low level echoes measuring 3.8*3cm anterior to the scar site suggestive of scar endometriosis. CT scan showed asoft tissue dense lesion seen deep in the left side of lower abdominal wall measuring 2.4*3.2*3cm. With the diagnosis of scar endometriosis, patient was posted for surgical excision. A wide local excision of the mass was done with closure of fascial defect. A hard fibrous mass was excised which was adherent to the external oblique aponeurosis. Post operative period was uneventful and scar healed well. Histpathology confirmed the diagnosis of scar endometriosis.

Histopathology

Photomicrograph showed multiple endometriosis foci – endometrial glands, stroma, hemosiderin pigment and haemorrhage among fibrofatty and collagen tissue.

DISCUSSION

Scar endometriosis is a rare and often misdiagnosed condition (Wolf *et al.,* 1996). Patients presenting with this condition are usually referred to surgeons or dermatologist and hence delays diagnosis and treatment (Wolf *et al.,* 1996).

Fig. 1. Usg image of scar endometriosis

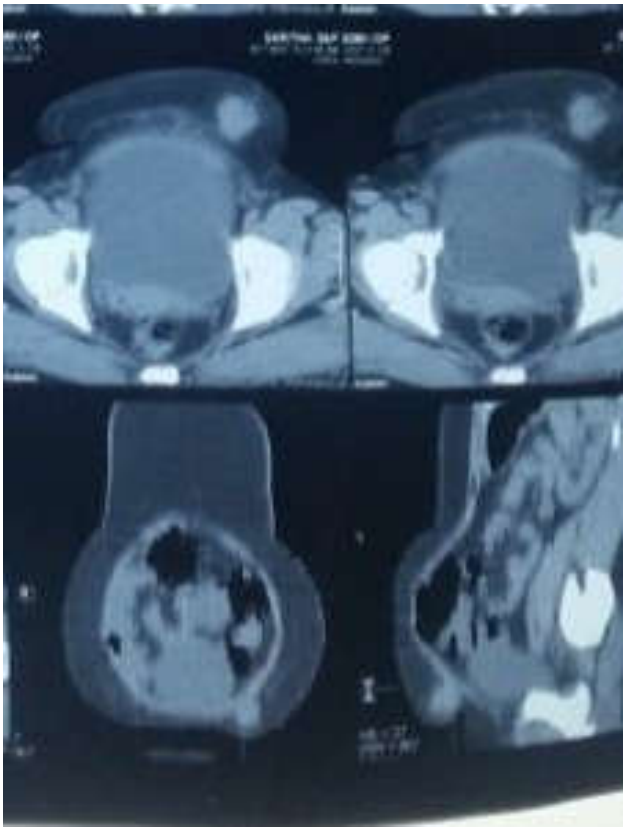

Fig. 2. MRI picture

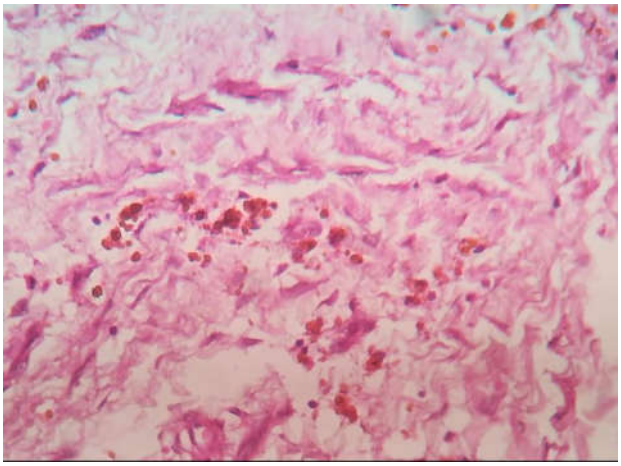

Fig. 3. H&E photomicrograph

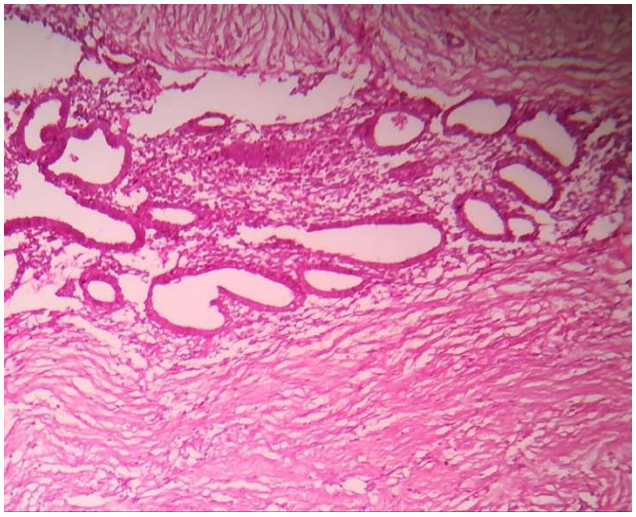

Fig. 4. H&E photomicrograph

Scar endometriosis is the most common site after caesarian section followed by episiotomy, hysterotomy, hysterectomy and laparotomy scar (Blanco *et al.,* 2003). Incidence following caesarian section is around 0.03-1.08% (Teng *et al.,* 2008; Gunes *et al.,* 2005; Hensen *et al.,* 2006). Mechanical transplantation of endometrial or placental cells into the wound area during surgical procedure and its subsequent growth under the influence of estrogen leading to the development of endometriosis is one of the postulated theory and the other being that multipotent mesenchymal cells differentiate into endometrial tissue in response to hormonal functions (Patterson and Winburn, 1999; Horton *et al.,* 2008; Hensen *et al.,* 2006). Classically cyclical pain is described but constant and noncyclical pattern have also been reported functions (Patterson and Winburn, 1999; Horton *et al.,* 2008; Chatterjee, 1980). The interval between the surgical procedure and presentation varies from 3months to 10years (Patterson and Winburn, 1999; Horton *et al.,* 2008; Hensen *et al.,* 2006). In our case it was seen after 8years. Definitive diagnosis of scar endometrioma is not possible though various non invasive diagnostic imaging modalities like USG, CT AND MRI give relatively correct diagnosis but lacks specificity (Francica *et al.,* 2003; Pados *et al.,* 2008). Definitive diagnosis is by histopathology. Lipoma, sebaceous cyst, hemangiomas, lymphangiomas, desmoid tumors are some of the differential diagnosis of scar endometriosis (Savelli *et al.,* 2012; Ozel *et al.,* 2012). Though FNAC has been documented as an important confirmatory investigation (Gupta, 2008) theoretically it has the potential to seed the needle tract with endometrial cells and cause recurrence (Gupta, 2008).

Francica *et al.* in their series stated diagnostic USG features of scar endometriosis as

1. Hypoechoic inhomogeneous echo texture with internal scattered hyperechoic areas.
2. Regular margins, often speculated, infiltrating the adjacent tissue.
3. Hyperechoic ring of variable width and continuity (Francica *et al.,* 2003)

Wide excision is the treatment of choice (Blanco *et al.,* 2003) with fascial defect closure. Medical line of treatment with combined oral contraceptives, progestogens, Danazol or GnRH analogues offers only partial relief of symptoms and recurs after the treatment is stopped.

Conclusion

Scar endometriosis though rare should be suspected when a woman in the reproductive age presents with pain and swelling in the scar region. USG and CTMRI are useful diagnostic tools. Complete surgical excision is the treatment of choice and care should be taken to prevent intra operative autoinoculation in order to prevent recurrence. Medical treatment may not give permanent relief but can be offered to patient who refuse surgery.

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