CESAREAN SCAR ENDOMETRIOSIS--A CASE REPORT

*Alpana Singh, M. Jayasheela Reddy
Malla Reddy Medical college, Andhra Pradesh
*Author for Correspondence

ABSTRACT
Endometriosis is described as the presence of functioning endometrial tissue outside the confines of the uterine cavity. Scar endometriosis is a rare disease, and is difficult to diagnose. The symptoms are nonspecific, typically involving abdominal wall pain at the incision site at the time of menstruation. It commonly follows obstetrical and gynaecological surgeries. The diagnosis is frequently made only after excision of the diseased tissue. We present here a case of abdominal wall scar endometriosis in a woman who had undergone a caesarean section three years ago. Surgical excision led to the diagnosis of scar endometriosis. The pathogenesis, diagnosis and treatment of this rare condition are discussed.

Keywords: Abdominal Wall, Painful Scar, Menstruation, Scars Endometriosis

INTRODUCTION
Endometriosis, first described by Rokitansky in 1860, was defined as the presence and proliferation of endometrial tissue outside the uterine cavity, commonest site being the pelvis (Francica et al., 2003). However, extra pelvic endometriosis is a fairly uncommon disorder and difficult to diagnose. The various sites for extra pelvic endometriosis are bladder, kidney, bowel, omentum, lymph nodes, lungs, pleura, extremities, umbilicus, hernial sacs, and abdominal wall (Markham et al., 1989). Majority of the scar endometriosis have been reported after obstetrical or gynaecological procedures such as cesarean section, hysterotomy, hysterectomy, episiotomy, and tubal ligations (Padmanabhan et al., 2003; Bhowmick et al., 1986; Chatterjee, 1980). The incidence of scar endometriosis has been estimated to be only 0.03% to 0.15% of all cases of endometriosis (Francica et al., 2003; Kaloo et al., 2002).

Endometriosis, in patients with scars, is more common in the abdominal skin and subcutaneous tissue compared to muscle and fascia. The present study describes a case of scar endometriosis, and reviews the literature to elucidate signs and symptoms that may lead to an earlier diagnosis and prompt treatment.

CASES
A 32-year-old woman presented to the gynae OPD with complaints of pain and swelling on the right side of the transverse cesarean scar for the last 2.5 years. She had two cesarean deliveries - 6 and 3 years ago. She regained her menstruation after 6 months of her second caesarean, when she had this complaint of pain abdomen, and this phenomenon has been continuing since then. She described pain above the cesarean scar that increased during the menstruation period and then noticed a swelling above cesarean scar. She was an otherwise healthy woman with no significant medical history. Physical examination revealed a well-healed caesarean scar, with a solitary, nonmobile, nodular, tender mass of 3 x 3 cm at the right part of the scar (Figure 1). Transvaginal and transabdominal ultrasound showed a 4 cm × 3 cm oval-shaped heterogeneous mass in the subcutaneous and muscular planes, with no abnormalities of the uterus and ovaries. Based on characteristic history and examination findings, diagnosis of scar endometriosis was made. However other possibilities like hematoma, granuloma and desmoid tumour were considered.
The patient was posted for a wide local excision of the abdominal wall lump. Intraoperatively, extensive fibrosis of the scar to the fascia was noted. The lump was about 3 x 3 cm, firm, in the subcuticular plane extending to the abdominal wall muscles. Wide excision with clear margins was performed (Figure 2, 3). Postoperative period was uneventful and her pain subsided. Histopathology of excised mass showed fibroadipose tissues with interspersed endometrial glands and stroma in deep areas of dermis, confirming the diagnosis of scar endometriosis (figure 4).
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Figure 1: swelling at end of caesarean scar

Figure 2: Endometrial mass being removed from over the abdominal muscles

Figure 3: Firm, compact appearing endometrial mass
DISCUSSION

Endometriosis involving the abdominal wall is an unusual phenomenon which should be considered in
the differential diagnosis of abdominal wall masses in women. The usual clinical presentation is a painful
nodule in a parous woman with a history of gynecological or obstetrical surgery. The incidence has been
estimated to be only 0.03% to 0.15% of all cases of endometriosis (Francica et al., 2003; Kaloo et al.,
2002). However a study done by Chatterjee SK in 1980 showed 1.08-2% of scar endometriosis following
hysterotomy where as after cesarean section the incidence was 0.03-0.4% (Chatterjee, 1980). The reason
for higher incidence after hysterotomy has been given as the early decidua has more pleuripotential
capabilities and can result in cellular replication producing endometriomas. Many theories as to the cause
of scar endometriosis have been postulated; however, the most generally accepted theory is the iatrogenic
transplantation of endometrial implants to the wound edge during an abdominal or pelvic surgery
Francica et al., 2003; Kaloo et al., 2002; Tanos and Anteby, 1994; Douglas and Rotimi 2004). Time
interval between operation and presentation has varied from 3 months to 10 years in different series(Sax
et al., 1996).

The diagnosis of scar endometriosis may be challenging. Cyclical changes in the intensity of pain and size
of the endometrial implants during menstruation are usually characteristic of classical endometriosis.
Patients usually complain of tenderness to palpation and a raised, unsightly hypertrophic scar. A high
index of suspicion is recommended when a woman is presented with a post operative abdominal lump.
Good history taking and thorough examination with appropriate imaging techniques (ultrasound, CT or
MRI) usually lead to the correct diagnosis. MRI can be more helpful when the lesion is small because of
its high spatial resolution, furthermore it performs better than CT scan in detecting the planes between
muscles and abdominal subcutaneous tissue (Balleyguier et al., 2003).

Management includes both surgical excision and hormonal suppression (Wolf and Singh, 1989;
Schoelefield et al., 2002). Medical treatment with the use of progestogens, oral contraceptive pills, and
danazol is not effective and gives only partial relief in symptoms and does not ablate the lesion. The
treatment of choice is always total wide excision of the lesion, which is diagnostic and therapeutic at the
same time. Follow up of endometriosis patients is important because of the chances of recurrence, which
may require re-excision. In cases of continual recurrence, possibility of malignancy should be ruled out.
Hence, good technique and proper care during cesarean section may help in preventing endometriosis.
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REFERENCES


