Original Research Paper

Volume-9 | Issue-9 | September - 2019 | PRINT ISSN No. 2249 - 555X | DOI : 10.36106/ijar

Gynaecology

SCAR ENDOMERTRIOSIS (A SERIES OF 5 DIFFERENT CASES IN TERTIARY CARE LEVEL)

Dr Nirmala Sharma	Department of Obstetrics and Gynecaology. Government Medical College, Kota Rajasthan
Dr. Kumkum Gupta*	Department of Obstetrics and Gynecaology. Government Medical College, Kota, Rajasthan *Corresponding Author
Dr Amar Singh Sonkria	Department of Obstetrics and Gynecaology. Government Medical College, Kota Rajasthan

ABSTRACT Endometriosis is described as the presence of functioning endometrial tissue outside the uterine cavity. Scar endometriosis is a rare event which usually develops after pelvic operations as a result of spilling of endometrium from uterus and/or fallopian tubes according to Sampson's endometrium spilling theory.

The symptoms are nonspecific, typically involving abdominal wall swelling and pain at the operative site at the time of menstrual cycle. Its diagnosis can sometime be ddifficult and may be confused with various other surgical conditions like Suture granuloma, wound abscess, sebaceous cyst, lipoma, hematoma etc.….

We studied short series of 5 cases of scar endometriosis in which two post caesarean delivery another two post laparoscopic surgery and last one in episiotomy scar after normal vaginal delivery.

This article highlights scar endometriosis and reviews the literature to elucidate physical signs and symptoms that may lead to earlier diagnosis, treatment prevention of endometriosis.

KEYWORDS : Scar Endometriosis, Dysmeorrhea

INTRODUCTION

Endometriosis is a common and distressing health problem of women. Endometriosis is the presence of endometrial tissue outside the uterine cavity .Its generally occur in the pelvic sites as ovaries [amongst 50%] followed by the uterine cul-de-sac uterosacral ligament ,posterior surface of uterus and broad ligament ,pelvic peritoneum ,bowel, and rectovaginal septum. Extra pelvic endometriosis can be found in the unusual place such as the nervous system, thorax, urinary tract ,gastrointestinal tract and cutaneous tissues and its most frequent location is in the anterior abdominal wall 1,2

Abdominal wall scar endometriosis usually after cesarean section .3 There are reports of endometriosis of tubal occurs ligation, salpingectomy, ectopic pregnancy, laparoscopy, after hysterotomy, epsiotomy, and hysterectomy 1,4,5 so endometriosis of abdominal wall indicate the embedding of ectopic endometrial tissue in the layer of abdominal wall following various surgical procedure of pelvis .with current era of increase use of laparoscopy ,a few case reports have described development of abdominal wall endometriosis at port site. Endometrial cells are inoculated directly into the surgical scar area and can progress to endometriosis in optimal condition. This causes various clinical symptoms due to proliferation of these cells under the influence of female hormones. Although scar endometriosis has many different clinical presentations, most common clinical symptom and signs are swelling and tenderness on local site and cyclic pain.

Its exact prevalence is unknown because it can be diagnosed only after surgery either open or laparoscopy but it is estimated to be present in 3-10% of women in the reproductive age group and 25-35% of infertile women. The incidence of scar endometriosis has been reported to be 0.03-0.4 %.

The aim of this article is that scar endometriosis is a rare and may be some time difficult to diagnosed which can lead to both patient and physician frustration. One should maintain a high level of suspicion in any woman presenting with pain at surgical site, most commonly following pelvic surgery. A thorough history and physical examination should always be performed, and every surgeon should consider this entity in their differential diagnosis.

DIFFERENTIAL DIAGNOSIS:

- Dermoid tumor or fibromatosis
- hematoma
- suture granuloma
- keloid
- lipoma
- wound abscess
- seroma

CASE REPORT 1

A 30 year old female of para 2,live birth 2 (P2L2) present with a painfullesion in stitch line ,for last 2 year. The lesion used to increase in size and become more painful during menstruation . she has undergone lower segment cesarean section 2 year back. On per abdominal examination a painful tender lesion about 3x2 cm was found at upper end of the stitch line in left side ,which was smooth surface and firm consistency. The rest systemic and general physical examination was systemic normal. Ultrasonography revealed a hypoechoic lesion of 4x3x3 cm seen in the subcutaneous fat layer over left iliac fossa region. ultrasound guided aspiration cytology done and chocolate coloured mucoid material aspirated .FNAC done , cytosmear revealed loosely cohesive cluster of endometrial stroma cells with fine vacuolated cytoplasm suggestive of endometriosis . A wide excision of endometriotic tissue was done, specimen sent for histopathology.

Histopathological finding confirmed the diagnosis of scar endometriosis [1]

CASE REPORT 2

A 35 year old woman present with pain and tenderness swelling above midline of stitch line on abdomen since 5 month. Obs over history P1L1. History previous cesarean 3 year back. Pain is more intense during mensturation .,it is relieved after taking analgesic drugs but after few days pain become exaggerated and more sever. After clinical examination , USG GUIDED ASPIRATION CYTOLOGY done and sharp dissection was performed with scalpel with in the area of incision from the previous cesarean section . the cystic mass which surrounded by fibrosis was removed carefully with safe margin. Specimen sent for histopathologyical examination .

CASE REPORT 3

A 32 year old woman present with recurrent attack of mild abdomen pain and discomfort since 1 year . her pain relived temporary by intake of analgesics . on examination the palpable mass about 5 cm diameter felt at left upper quadrant just above umbilicus .it is a firm and mobile . She has undergone diagnostic laparoscopy 3 year ago for primary infertility. The routine biochemical marker test beta hcg and CA 125 were with in normal range. Usg revealed a well defined rounded mass located in left upper abdomen just below the rectus abdominus muscle

.it was nonhomogenous partly cystic with thin wall and internal ecogenic content inside so surgical intervention was recommended . operative intervention done through upper left para median incision just near the mass on exploration of the peritoneal cavity . There was a dense mass attached to posterior rectus abdominius muscle just under the scar of previous laparoscopic trocar port site .a sharp dissection and separation of adhesion done carefully then complete excision of the mass with safety margin done. Tissue sent for histopathology was conformed of scar endometriosis .

CASE 4

A 35 year old female present with a pain full nodule over the episiotomy scar site for 3 year. She had a history of normal vaginal delivery 10 year back. On examination a tender irregular raised nodule measuring 4x3 cm was present on left perineal region over the site of the previous episiotomy scar was advised FNAC of the nodule which revealed cluster of rounded epithelial cells with rounded nuclei and modrate cytoplasm which were suggestive of endometriosis . the scar with nodule was excised with safety margin and sent for histopathology. The histopathological feature were consist with scar endometriosis .on follow up patient was relieved of her complaint after surgery.

CASE 5

A 35 year old female g3p2l2 presented with a painful noduler swelling on laparoscopy scar above the umbilicus . painful nodule become more intense during her menstruation. She had a significant history of dysmenorrhea. She had undergone MTP with LS. On per abdominal examination a painful tender lesion of about 3x4cm was found at the trocar site above umbilicus. This was initially suspected to be a stitch granuloma and she was given a course of routine antibiotics and anti-inflammatory agents and asked to come to the gynecologic outpatient clinic regularly, in order to enable us to observe the course of lesion, but the lesion kept on gradually increasing in size. Fine-niddle aspiration cytology (FNAC) of the above lesion showed sheets and clusters of epithelial cells appearing of foam glands, degenerated cells, and hemosiderin laden macrophage suggestive of endometriosis.

The lesion was excised with safety margin and tissue sent for histopathological to confirm scar endometriosis.

CONCLUSION-

endometrioma is a well circumscribed mass of endometriosis .abdominal wall endometrioma present as a painfull swelling resembling surgical lesion such as hernias ,haematomas , granulomas ,abscess and tumors. Incidences of scar endometriosis. 0.03-0.4% The simultaneous occurrence of pelvic endometriosis with scar endometriosis infrequent ,our patient also did not have associated pelvic endometriosis Preoperative diagnosis is difficult to make and sometime the diagniosis is made after excision only. We could make provisional preoperative diagnosis due to the discolouration and clinical experience. FNAC has been reported to be accurate in diagnosis. Treatment of choice is wide excision of the lesion and may sometimes require mesh placement . Medical treatment with the use of progestogens ,oral contraceptive pillsand danazol is not effective and give only partial relief in symptoms .

REFERENCES

1. Schorg jo, schafferji, halvorson lm,et al.endometriosis introduction in. schorge jo,eds.williams gynecology is ted.new work ;mcgraw hill medical;2008 225-230
2. Dordevic m,jovanovic b,mitrovic s,dordevic g,randovnovic d,et al.[2010] abdominal rectus muscle endometriosis aftr caesarean section ;extrapelvic localization of endometriosis . bratisal lek listy 111;345-348.
3. Cristescu c,vvelicu a,marinescu b,patrasscu a,trascu et,et al.2013 endometriosis-clinical approach based on histological finding .rom j morphol embryo 54; 91-97.
4. Mederio fc ,cavalcante di,Medeiros ma,eleutero j jr.2011.fine needle aspiration cytology of scar endometriosis ; study of sevencase ond literature review.diagn cytopathol39;18-21.