



CESARIAN SCAR ENDOMETRIOSIS: A RARE CASE REPORT

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ABSTRACT Endometriosis, most commonly seen in the pelvic region, but can also occurs in non-pelvic sites, giving a diagnostic challenge. Abdominal wall endometriosis is a rare type of extra-pelvic endometriosis that develops in less than 2% of women following pelvic surgeries. A twenty six year-old female presented with painful abdominal mass in surgical outpatient department. She was diagnosed clinically as Desmoid tumor but on further radiological evaluation and histopathological examination, it was found to be a case of previous LSCS scar endometriosis. We, the department of pathology, report a case of abdominal wall endometriosis.

KEYWORDS : Cesarean section, extra-pelvic endometriosis, lump lower abdomen, pain during menses, rare.

INTRODUCTION

The presence or development of endometrial tissue outside of the uterine cavity is described as endometriosis.^[1] It affects about 5% to 10% of all women. Extra-pelvic endometriosis is unusual, accounts for only 12% of reported cases.^[1] The bladder, kidney, colon, omentum, lymph nodes, lungs, pleura, extremities, umbilicus, hernial sac and abdominal wall are all potential sites for extra-pelvic endometriosis. Among these, one of the rarest forms of endometriosis is endometriosis of the abdominal wall.

Endometriosis of the abdominal wall is described as the implantation of endometrial tissue outside the peritoneum, which includes lesions caused by surgical incisions as well as can develop spontaneously.^[2] Prevalence of abdominal wall endometriosis ranges from 1% to 2%.^[3] The diagnosis is challenging, bringing the patient severe pain and discomfort.

CASE HISTORY

A twenty six year-old female, presented with gradually enlarging painful swelling on the anterior abdominal wall for 18 months. The discomfort, pain and size of swelling increased during menses. She had history of previous two caesarean sections. Rest all other patient's history was unremarkable. On ultrasonography, an irregular hypochoic space occupying lesion was seen [Figure-1]. She underwent wide excision of abdominal mass and it was sent for histopathological analysis.

We received a grey tan fibrofatty mass measuring 4.5x3.2x2.3cm having variegated cut surface along with few tiny cysts in the center and adipose tissue at periphery [Figure -2]. Histopathology showed well defined endometrial glands and stroma with fibro-collagenous and adipose tissue [Figure-3]. Fair number of hemosiderin-laden macrophages were also seen [Figure-4]

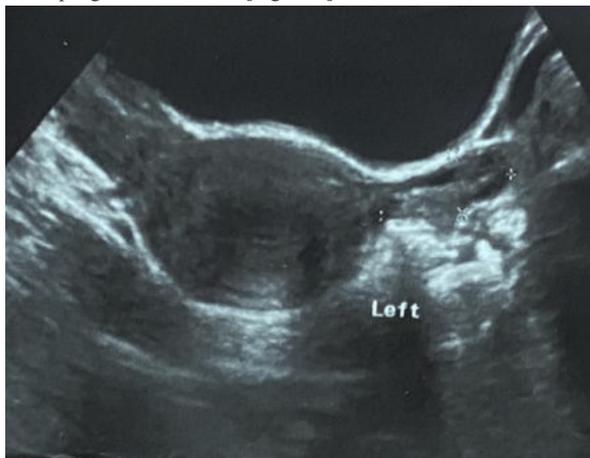


Figure 1: USG image showing hypochoic space occupying lesion.



Figure 2: Gross specimen showing gray-tan variegated cut surface of the lesion, surrounded by fibrofatty tissue.

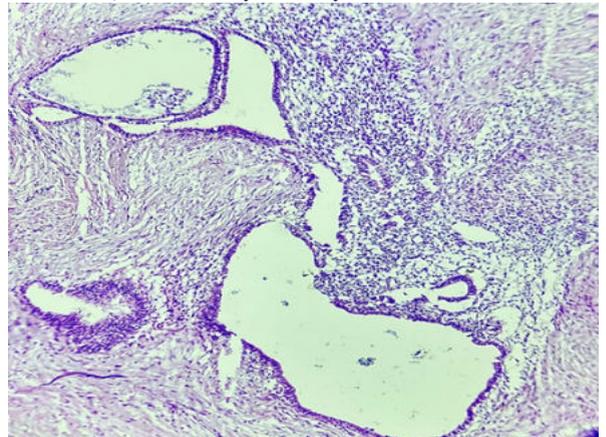


Figure 3: H&E stained microphotograph showing dilated endometrial glands and stroma (x100).

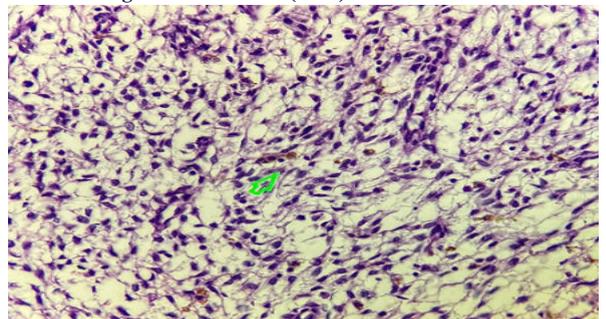


Figure 4: H&E stained microphotograph showing hemosiderin laden macrophages (arrow)(x400).

DISCUSSION

Abdominal wall endometriosis was first documented by Meyer in 1903. Endometriosis implants developing in the subcutaneous tissue of surgical scars occur most frequently after gynaecological and obstetrical procedures, including caesarean sections, hysterectomies, cystectomies, tubal ligations, and amniocenteses.^[4] Hernias (incisional), other abdominal wall tumors, lipomas, haematomas, granulomas, metastases from distant tumours, and desmoid tumours are among the differential diagnoses for endometriosis of the abdominal wall.^[5,6] According to Nominato et al., caesarean section remains the most common surgical procedure related to the development of abdominal wall scar endometriosis.^[7]

The time between surgery and the development of the disease is extremely difficult to predict. According to case reports, the time span can range from six months to ten years.^[8] This diagnosis has also been reported in the absence of previous surgery on rare instances. Several theories about the pathogenesis of abdominal wall endometriosis have been proposed, such as the implantation theory, the coelomic metaplasia theory, and the lymphatic or hematogenous dissemination theory.^[9] The pathogenesis of endometriosis in a parietal scar is explained by an iatrogenic direct implantation theory, which suggests that endometrial cells escape through an incision made in the uterus during the surgical procedure and are implanted within the abdominal wound.^[4]

In our case, the patient believed the discomfort was caused by the surgery, which resulted in a delayed diagnosis. The duration of time between surgery and onset of symptoms, the rarity of the disease and similarity to other diseases all play a role in determining a prognosis.

In these circumstances, surgical removal of the tumour within safe margins is the gold standard treatment. This enables for histopathological analysis of the specimen to confirm the diagnosis of endometriosis of the abdominal wall.

CONCLUSION

Delay in diagnosis is the major fallback of the disease. Early diagnosis and treatment will be helpful for the patients.

Conflicts of Interest

The authors declare no conflict of interests.

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