Original Research Paper

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WHAT THE MIND DOES NOT KNOW, THE EYES DO NOT SEE- EPISIOTOMY SCAR ENDOMETRIOSIS : A CASE REPORT

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ABSTRACT Endometriosis is defined as the presence of endometrial glands outside the uterine cavity. The prevalence of extrapelvic endometriosis is very rare 0.01%. Here we report a case of episiotomy scar endometriosis. A 36 year old female attended our OPD with complaints of pain in the perineum for 2 years. She had history of vaginal delivery 8 years ago. The diagnosis was a bit challenging here as the patient was misdiagnosed and mistreated for a long time. A proper and reassuring history led to achieving the right diagnosis. Also use of Magnetic Resonance Imaging (MRI) ruled out the possible involvement of anal sphincter and rectal involvement and helped in better planning of the surgery preoperatively. Hence, we stress upon giving important to history and also to use better imaging tools to offer the right diagnosis. The clinical triad of vaginal delivery with visible episiotomy scar, palpable mass at the scar site and cyclical pain, the clinical diagnosis of scar endometriosis was considered.

KEYWORDS : Endometriosis, episiotomy scar, anal sphincter , perineum.

INTRODUCTION

Endometriosis is the presence of functional endometrial glands which responds to hormones, outside the uterine cavity[1]. The prevalence of endometriosis is around 5-10% which higher prevalence (25 -50%) in infertile women.[1-2] It most commonly affects pelvis especially ovaries. Extra pelvic endometriosis is very rare accounting to 1% of all the cases. The incidence of perineal scar endometriosis is reported to be 0.3% to 1%.[3] This entity often leads to mis-diagnosis and delayed treatment. The possible explanation for scar endometriosis in our patient could be due to the implantation of viable decidual endometrial cells in the episiotomy wound during normal delivery. These implanted cells would have developed blood supply and might have become hormone responsive[3]. Surgical exploration and wide excision of the episiotomy site was done. Postoperative period was uneventful. The clinical, operative and pathological findings are reported.

CASE STUDY

A 36 yrs old female, para 2 live 2 came with the complaints of pain and swelling in the perineal region for 2 years which aggravated during menstruation. She had 2 vaginal deliveries and the last child birth was 8 years ago which was footling breech presentation for which she was given liberal episiotomy.

She started having pain during menstruation in her vagina 5 years after the second delivery, which was initially cyclical. But over the last 2 years it progressed to a continuous pain. She refrained from sexual activity for 2 years due to dyspareunia. Her menstrual cycles were regular with average flow. On inspection, perineum appeared normal.

Patient had a long treatment history for the same in many hospitals where she was prescribed pain killers, antibiotics, ayurveda treatment and she even underwent haemorrhoidectomy. Patient was given treatment with dienogest for 6 months.

Her condition having worsened rather than improvement, she attended our hospital. A proper history led to suspicion of endometriosis at the previous episiotomy scar site. Based on the clinical triad of vaginal delivery with visible episiotomy scar, palpable mass at the scar site and cyclical pain, the clinical diagnosis of scar endometriosis was considered.

Examination

A 4 x 3 cm ill defined tender nodular mass, hard in consistency was palpable during per vaginal examination at the site of previous left mediolateral episiotomy.
On rectal examination, a nodular mass was felt in the anterior wall but rectal mucosa was free.

Investigations

MRI was done to rule out anal sphincter involvement - T2-weighted image shows a multi-loculated hyperintense lesion of size 4 x 3 cm with thin dark internal septations in the left paramedian aspect of the perineum abutting the anal sphincter with Bicornuate uterus as an incidental finding. (Fig1).

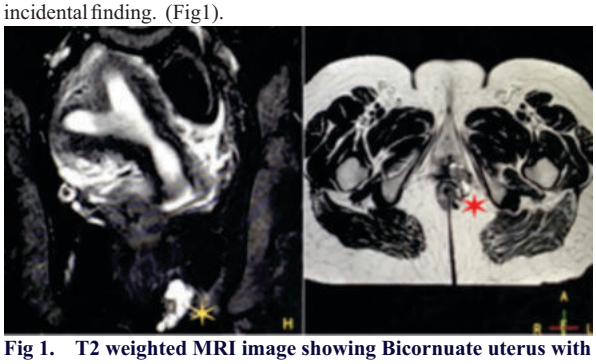

Fig 1. T2 weighted MRI image showing Bicornuate uterus with hyper intense lesion in perineum (*) abutting the external anal sphincter

Under spinal anaesthesia, Excision of the lesion en mass was done with 1cm wide margin. Cut section of the lesion showed haemorrhagic spots (Fig 2).

Fig 2. Gross pathology after excision showing hemorrhagic spots on cut section

HPE report shows presence of endometrial glands and stroma consistent with endometriosis surrounded by scar tissue. (Fig 3)

Fig 3. H&E strained slides showing presence of endometrial glands and stroma (arrow) with Hemosederin ladein cells (*)

DISCUSSION

Episiotomies are the most commonly performed procedure in obstetric practice. Though the incidence of episiotomy scar endometriosis is very rare, a misdiagnosis of this condition often affects the woman's quality of life. Zhu et al[4] proposed a triad of three typical characteristics of perineal scar endometriosis: Past perineal tear or episiotomy during vaginal delivery, A tender nodule or mass at the perineal lesion and Progressive and cyclic perineal pain. In our patient all the criteria were met. High index of clinical suspicion and a thorough history is sufficient to make a diagnosis of perineal scar endometriosis. Also, time interval between the symptom onset and Vaginal delivery should not be a hindrance to make the diagnosis. MRI is an essential imaging tool in cases of episiotomy site endometriosis to assess the extent of anal sphincter involvement and to plan the surgery accordingly.[5]

Surgical intervention is the best approach for treatment and permanent cure is usually achieved after complete excision of the perineal endometriosis.[6]

An attempt was also made to explore the possible risk factors for this condition in this patient. Difficult vaginal delivery, iatrogenic implantation, poor perineal hygiene post delivery seem to be the possible aetiology.

CONCLUSION

Diagnosis of any rare condition requires good knowledge and strong suspicion. In case of episiotomy or abdominal scar endometriosis, a delay in surgical management can result in progression of the disease and involvement of deeper planes and even possible malignant transformation. Hence it's prudent to opt surgical management when first line medical management fails.

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