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CESAREAN SCAR ENDOMETRIOSIS –A CAUSE OF PAINFUL SCAR AND SEVERE DYSMENORRHOEA

Gynaecology

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ABSTRACT

Endometriosis is described as the presence of functioning endometrial tissue outside 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 gynecological surgeries. The diagnosis is frequently made only after excision of the diseased tissue. A case report of a patient with a troublesome scar after a caesarian section is presented. Surgical excision led to the diagnosis of scar endometriosis. The pathogenesis, diagnosis and treatment of this somewhat rare condition are discussed.

KEYWORDS

Scar endometriosis , Cesarean section , dysmenorrhoea

Scar endometrosis

Endometriosis is defined as the presence or growth of ectopic endometrial tissue[1]. Endometriosis occurs in 5% to 10% of all women, often resulting in debilitating pain and infertility. Although most frequently found in the pelvis, reports citing extrapelvic endometrial locations range from the lungs to the extremities[2]. Incisional or scar endometriosis has also been described, however, with a much rarer incidence (fewer than 1% of affected patients) [1,3]

Caesarean scar endometriosis is the most frequently reported form of this disorder and is usually benign. [4] The most common locations of abdominal wall endometriomas are old surgical scars from obstetric or gynaecological procedures. Scar endometriosis presents clinically as a painful, palpable subcutaneous mass, associated with cramps and bloating during menses. It is easily confused with other conditions, such as keloids, haematoma, stitch granuloma, abscess, inguinal and incisional hernia [5]

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A case report of a patient with a troublesome scar after a caesarian section is presented. Surgical excision led to the diagnosis of scar endometriosis. The pathogenesis, diagnosis and treatment of this somewhat rare condition are discussed.

CASE REPORT :

33yrs female presented with mass abdomen from 5-6 years,associated with severe dysmenorrhoea.She noticed mass abdomen 5-6 years back .There was no increase in the size of mass from the time she noticed and had severe dysmenorrhoea which started 5-6 days before starting of menses and continued through out cycle and 10 days after menses.

Menstrual history : L M P 30/4/14 . She resumed cycles after 2 years after her last child birth and initial cycles were irregular for 1- 11/2year with mild to moderate dysmenorrhoea.Followed that her cycles were regular with progressively increasing dysmenorrhoea.

Her present cycles were regular 28-30 days with moderate flow 2-3 pads per day with severe dysmenorrhoea. No hisory of passage of clots. No history of intermenstrual bleeding or post coital bleeding per vagina.

Obstetric history

$P_5 L_1 D_4$ last child birth 9 years back.

- 1. FT –Fch vaginal delivary –hydrocephalus still born baby.
- 2.FT- Fch vaginal delivary –early neonatal death .
- 3.FT-Mch LSCS-late neonatal death because of anaemia
- 4.FT –Fch LSCS –still birth because of cardiac anamoly .
- 5. FT-Fch LSCS- Alive and healthy 9 years old

Under went inter val sterilisation after 2 years informed only one sided tubectomy could be done because of dense adhesions.

- PAST HISTORY : no significant past medical illness.

ON EXAMINATION

Her general condition being fair no pallor icterus, cyanosis, clubbing, edema, lymphadenopathy.Pulse rate 80 beats per minute.Blood pressure. 120/80 mm of Hg.Cardiovascular system and respiatory system examination were normal.

Abdominal examination

Obese abdominal.Puckered indurated scar present in the supra pubic region .No evidense of organomegaly. Per speculum examination Cervix and vagina healthy.Per vaginal examination Uterus adherent to anterior abdominal wall . Exact size of uterus could not be made out.Traction test positive.

DIAGNOSIS

FNAC showed possibities as skin adenexal tumour, basal cell carcinoma.

Biopsy showed scar endometriosis.

CT Scan ABDOMEN and PELVIS showed –

Mildly enhancing irregular soft tissue dense lesion measuring 8×4 cms noted in sub cutaneous planes at the suture site suggestive of scar endometriosis ,granulation tissue.

Intraop findings

Uterus completely plastered to anterior abdominal wall.omental adhesions to uterus and abdominal wall released.TAH and BSO done.Endometroitic tissue and fibrous tissue in the sub cutaneous planes excised.Defect in rectus sheath after exision repaired with mesh replacement done. Post operative period was uneventful and suture removal done on fourteenth post operative day and patient was discharged on sixteenth post operative day. Patient came for follow up after fifteen days and was free of pain .

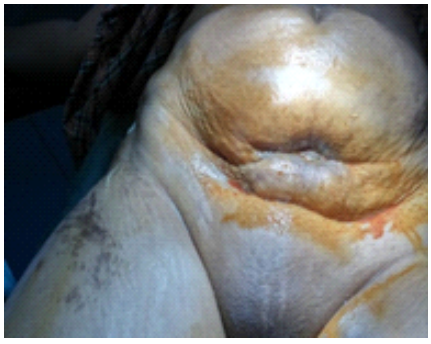

Fig1: Indurated and puckered scar at the centre of cesarean scar

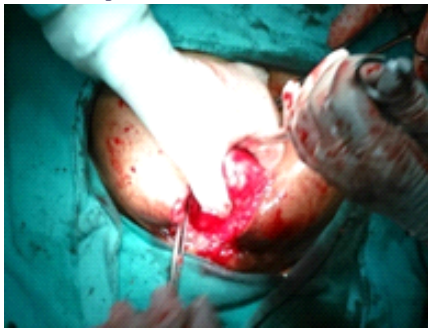

Fig 2 : uterus completely plastered to anterior abdominal wall

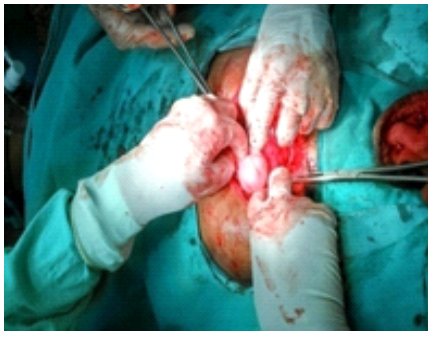

Fig 3 :right ovary seen with difficulty and left ovary could not be seen before release of adhesions

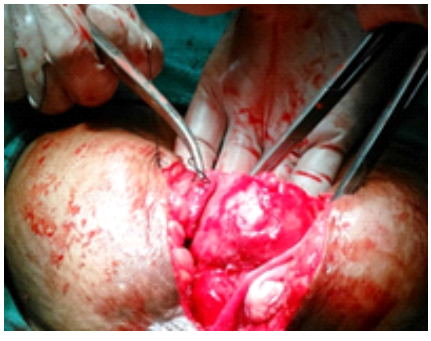

Fig 4 : adhesions between uterus and anterior abdominal wall released – raw area seen on anterior wall of uterus

Fig 5 : posterir surface of uterus with adnexal structures

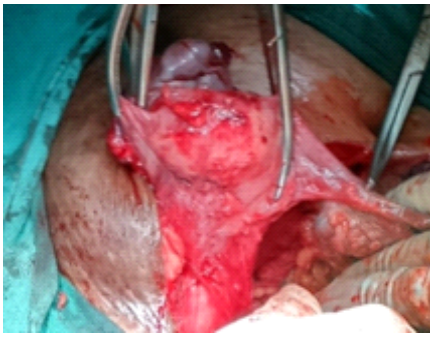

Fig 6: freed uterus after cutting of ip ligaments and indentation on anterior wall of uterus at the site of endometriosis

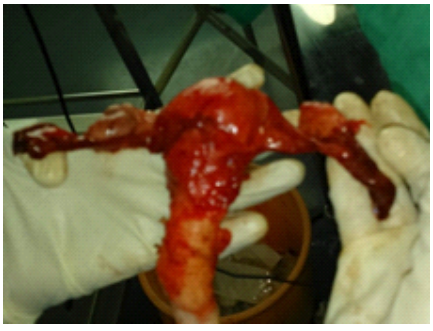

Fig 7: exterirised TAH and BSO specimen

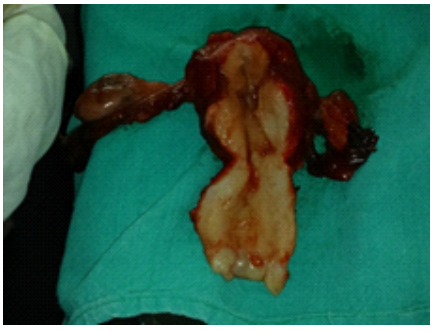

Fig 8: cut section of uterus with full thickness defect in anterior wall of uterus at the site of scar

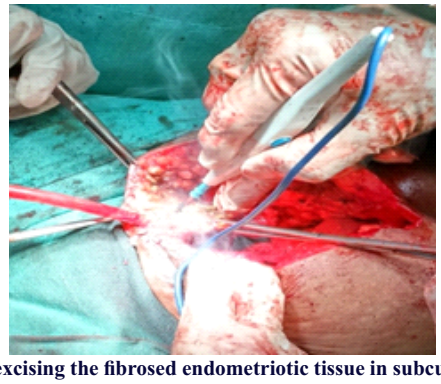

Fig 9: excising the fibrosed endometriotic tissue in subcutaneous planes

PATHOLOGY

Endometriosis is defined by occurrence of endometrial-like epithelium and stroma outside the uterine cavity. This condition is commonly seen in females of reproductive age. Grossly, endometriosis may present as small, dark red, black or bluish cysts or nodules on the surface of peritoneal and pelvic organs. Histologically, endometriosis is characterized by the ectopic presence of endometrial-like glands, spindled endometrial stroma and hemosiderin deposition either within the macrophages or in the stroma . In many cases, this diagnostic triad is not present, or the glands and stroma may be obscured by hemorrhage, foamy cells and hemosiderin-laden macrophages. When this occurs, the diagnosis may be suggested but histological confirmation may not be possible.

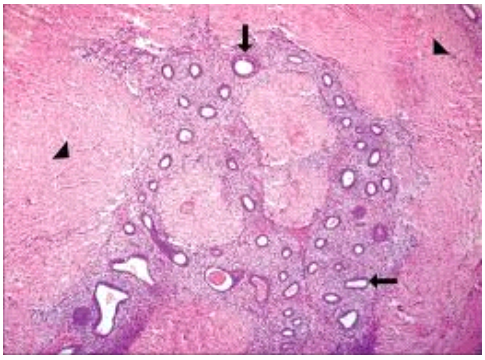

Fig 10: Hisopathological picture of scar endometriosis

DISCUSSION

Scar endometriosis is a rare entity reported in the gynecological literature, and presents in women who have undergone a previous abdominal or pelvic operation [6]. The incidence has been estimated to be only 0.03% to 0.15% of all cases of endometriosis[1,3]. 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[1,3,7,8]

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. However, in the largest reported series [9] to date, only 20% of the patients exhibited these symptoms. Patients usually complain of tenderness to palpation and a raised, unsightly hypertrophic scar.

Management includes both surgical excision and hormonal suppression. Oral contraceptives, progestational and androgenic agents have been tried. It is believed that hormonal suppression is only partially effective and surgical excision of the scar is the definitive treatment [10,11]. In our case the presenting symptom was severe dysmenorrhoea so we proceeded with hysterectomy.

CONCLUSION

Scar endometriosis is a rare and often elusive diagnosis that can lead to both patient and physician frustration. One should maintain a high level of suspicion in any woman presenting with pain at an incisional 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

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