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Case Series

Case series of scar endometriosis at three different scar locations

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ABSTRACT

Endometriosis is a common clinical condition which often present to the gynaecologist with a typical history of cyclical abdominal pain, discharge and swelling. It can be present in pelvic and extra pelvic sites. Here we present a series of different case of endometriosis at three different scars.

Keywords: Endometriosis, Pelvic, Extra pelvic sites

INTRODUCTION

Endometriosis is the growth of endometrial tissue in ectopic locations, primarily within the pelvic cavity affecting the women in reproductive age group. It can rarely occur in other extra pelvic sites like urinary bladder, gastrointestinal tract, lungs, beneath the skin in whom who have undergone obstetric surgical interventions. The aetiology of endometriosis is complex and multifactorial. Various theories are being proposed to describe its pathogenesis and are yet to be proved.[1] The prevalence of extra pelvic endometriosis is between 9% and 15% in the literature.[2] The gastrointestinal tract is the most common location of extra pelvic endometriosis (and extragenital pelvic endometriosis when referring to rectum, sigmoid, and bladder). Gastrointestinal involvement is reported in up to 3.8–37% of women diagnosed with endometriosis.[3,4] Here we present a series of different case of endometriosis at three different scars.

CASE SERIES

Case of abdominal scar endometriosis

A 28-year P2L2 with both lower segment caesarean section (LSCS) with abdominal tubectomy at 2nd LSCS two and half years ago at a local hospital, had to undergo secondary suturing for wound dehiscence. She presented two years later to the same hospital, with pain and swelling at the LSCS scar site during menstruation since the past six months. She was investigated and underwent excision of abdominal scar endometriosis one and half month ago in that hospital. She thereafter reported to our hospital with the complaints of aggravation of pain and swelling. Local examination revealed indurated irregular tender mass just above the left lateral end of Pfannenstiel scar, 4×3 cm size, 14-weeks gravid uterus size fixed to skin, immobile. On bimanual examination, uterus was anteverted and fixed to anterior parieties and fornices were free. Ultrasonography (USG) pelvis showed ill-defined hypoechoic lesion with subtle internal vascularity of 6×2.3 cm in left anterior abdominal wall near the left lateral end of scar predominantly involving the muscle layer also: features suggestive of scar endometriosis. Hypoechoic linear extension seen from the undersurface of the lesion up to anterior wall of uterus including cutaneous plane of LSCS scar likely due to adhesions. Magnetic resonance imaging (MRI) showed features suggestive of scar endometriosis in rectus abdominis muscle and subcutaneous plane of anterior abdominal wall at the LSCS scar site. CA 125 was 32. Intraoperatively endometriosis extended from subcutaneous tissue, rectus sheath, rectus muscle of both sides extending to anterior uterine wall as shown in Figures 1 and 2 complete excision was done and sent for

histopathology which reported consistent with scar endometriosis.

Figure 1: LSCS scar endometriosis.

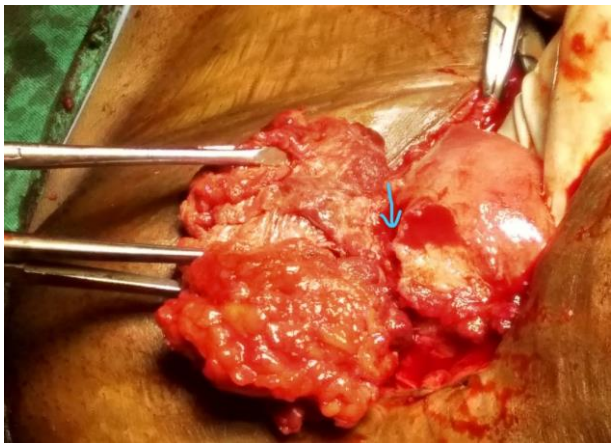

Figure 2: LSCS scar endometriosis extending into the left cornu of uterus.

Post operatively patient was given injection leuprolide 3.75 mg IM for 3 consecutive months. Patient was followed up for 1year and she was asymptomatic and free from dysmenorrhoea.

Case of episiotomy scar endometriosis

A 28-year P1L1 delivered vaginally 4yrs ago presented with severe pain at the episiotomy wound for the past 2 years during menstruation. There was intermittent passage of brownish discharge from the perineal site and pain in lower abdomen since past 2 months. She was a known case of hypothyroidism on treatment. Per abdominal examination--tenderness was noted in suprapubic and both iliac regions. On local examination there was a hard nodular tender mass in perineum on the right side, of about 5×4×5 cm with 2 blocked openings. On per speculum examination there were multiple endocervical polyps and anterior lip of cervix was hypertrophied with two large Nabothian cysts. Bimanual examination showed bilateral forniceal tenderness, no mass was palpable. She was diagnosed as acute PID with chronic cervicitis with hypertrophy, with episiotomy scar endometriosis. She was treated with antibiotics for the PID and investigated further. A sinofistulogram was done which showed features of scar endometriosis which was not communicating with the anus as shown in Figures 3 and 4.

Figure 3: Episiotomy scar endometriosis.

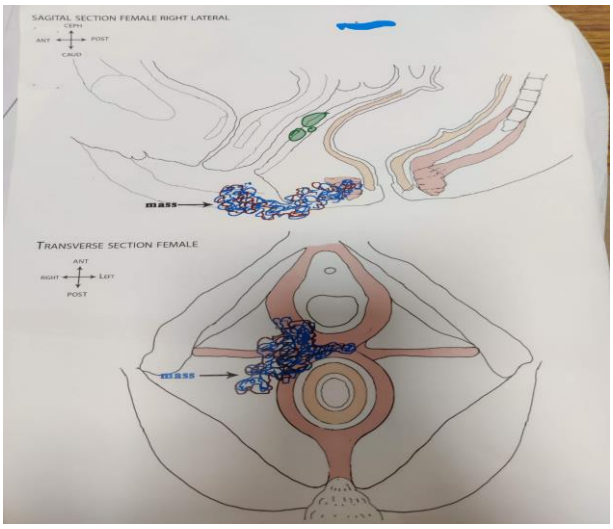

Figure 4: Sinofistulogram.

She underwent endocervical curettage, dilatation and curettage with excision of 2.5 cm of the anterior lip of cervix with Nabothian cysts. At the same sitting, she underwent excision of scar endometriosis from the episiotomy wound with dissection between vaginal and rectal wall planes. Histopathological examination (HPE) reports showed polypoidal endocervicitis with Nabothian cysts, endometrium in proliferative phase, and scar endometriosis. Post operatively, patient was given injection leuprolide 3.75 mg for 3 consecutive months. After 6-months patient conceived spontaneously and delivered by planned elective LSCS. Now patient is asymptomatic.

Case: LSCS scar endometriosis

A 39-year patient with history of two previous LSCS and concurrent sterilisation at the second LSCS, presented with excessive bleeding with passage of clots and associated with severe dysmenorrhoea since 2-3 years, which would start two to three days premenstrual and continue even two to three days post menstrual. On per abdominal examination deep seated tenderness in hypogastric region near the LSCS skin scar site. Per speculum and bimanual examination showed uterus of 12 weeks POG size with tenderness through anterior fornix. Both lateral fornices were free and non-tender. She was investigated and made a diagnosis of symptomatic fibroid uterus with adenomyosis with failed medical management.

Patient underwent Total abdominal hysterectomy and bilaterally salpingectomy. On cut section of uterus, there was an endometrial submucosal polyp and LSCS scar endometriosis was noted at the narrowest fibrosed part of the isthmic region of the cervix as shown in Figure 5. Histopathology reported as submucosal fibroid polyp with myohyperplasia with LSCS scar endometriosis.

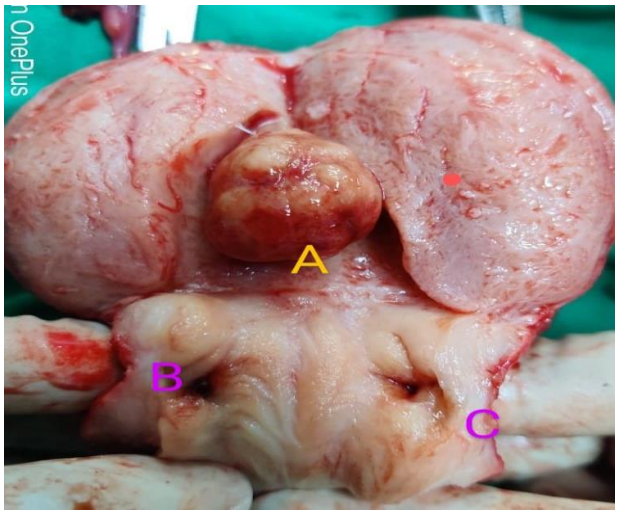

Figure 5: Specimen of uterus with fibroid polyp and endometriosis spots (A) submucosal fibroid polyp, (B) endometriosis spot, and (C) fibrosed LSCS uterine scar.

DISCUSSION

Endometriosis is a chronic gynaecological disorder which is mainly estrogen-dependent. It is characterized by the presence of uterine endometrial tissue outside the uterine cavity. Endometriosis may present as superficial and/or deep pelvic peritoneal implants and at extra pelvic sites. The main symptoms are severe, life-impacting pain mainly during menstrual cycle and also during sexual intercourse, bowel movements and/or urination. Usually in long standing deep infiltrating endometriosis it is associated with chronic pelvic pain, abdominal bloating, nausea, fatigue, and sometimes depression, anxiety, and infertility.

Scar endometriosis is the extra-pelvic endometriosis which seen at the surgical scar site. It is commonly seen in the caesarean section or hysterotomy scar. The possible cause for the development of this is the dissemination of endometrial tissue during a caesarean section or uterine surgery through mechanical transposition leading to iatrogenic implantation of endometrial tissue in the abdominal wall.[5]

Perineal scar endometriosis also called episiotomy scar endometriosis, is extremely rare (0.03–0.15%). It can be attributed to autologous transplantation of viable endometrial cells on episiotomy wounds after vaginal delivery, the risk is increased when manual uterine exploration or postpartum curettage are done. It can result in severe morbidity and prolonged agony in patients, due to damage of the adjacent structures like anal sphincter or rectum at later stages. Hence, early diagnosis is very important and MRI plays an important role in diagnosis and preoperative evaluation of the disease.[6,7]

Scar endometriosis is one of the challenging diagnosis due to non-specificity of symptoms. A detailed history taking and physical examination are the key for diagnosis. Diagnosis is mainly reached rather by exclusion than as a positive diagnosis process. These non-specific symptoms are cyclic abdominal pain, swelling, discharge from the scar site. Preoperatively there is need for radiological diagnosis with USG, MRI and sinogram which tells us the depth of invasion into the anatomical planes and thus plan the management.[8]

In our first case MRI was very helpful to look into the depth of invasion of endometriosis and which will help us to plan the surgery. If the endometriosis is not completely removed with 1 cm of clear margin, then the recurrence is high as in our 1st case where she represented with aggravated complaints of cyclical pain abdomen and swelling.

In our second case sinofistulogram was useful to assess depth of invasion especially formation of rectovaginal fistula.

Our third case was an incidental finding after hysterectomy when we cut open the specimen, we found the endometriosis at the LSCS scar. This patient presented with deep seated tenderness at the hypogastric region at the LSCS scar site. Hence always the detailed history taking and through examination of the patient is very much important for the diagnosis.

The available treatment options for surgical scar endometriosis are medical and surgical treatment. Drugs like oral contraceptive pills (OCPs), dinogest, gonadotropin-releasing hormone (GnRH) and danazol is usually prescribed but they provide only temporary symptomatic relief. The chances of recurrence are high with medical therapy. Definitive treatment of choice is wide surgical excision with at least 1cm clear margin and

avoiding contamination while handling the tissue is very important to prevent recurrence after surgery. The diagnosis is confirmed by the histopathological examination of the excised tissue which shows endometrial glands, stroma, and hemosiderin pigment are seen.

CONCLUSION

Scar endometriosis should always be suspected in any women of child-bearing age with cyclical pain, discharge and/or mass at the scar of previous delivery or following obstetric-gynecologic surgery. Imaging helps to confirm the diagnosis and histopathology proves the diagnosis. Margin free complete excision of endometriosis is mainstay of treatment and if done properly will prevent future recurrence.

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