University Journal of Surgery and Surgical Specialities

ISSN 2455-2860 2018, Vol. 4(1)

A CASE OF SCAR ENDOMETRIOSIS

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Abstract : Ectopic endometrial tissue associated with post operative scar is Scar endometriosis. 30 percent of scar endometriosis is associated with pelvic endometriosis. Scar endometriosis is commonly associated with pelvic surgical scars and occasionally in abdominal surgical scars. Its medical treatment is temporary and definitive treatment is surgery

Keyword : Endometrium, scar endometriosis, endometrioma

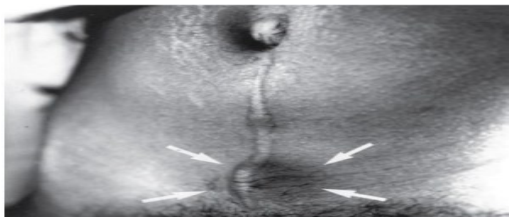
Endometriosis is defined as ectopic endometrial tissue outside the uterine cavity. Endometrial tissue associated with post operative scar is “Scar endometriosis”. Endometriosis(1) is associated with Ø 10 % in menstruating women Ø 15-30 % in infertile women Ø 15% in chronic pelvic pain , and Ø 15% is familial 30% of scar endometriosis is associated with pelvic endometriosis.

Case report

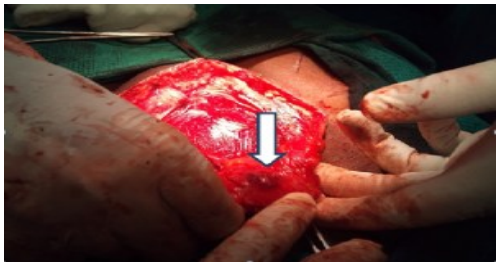
A 27 yrs old female presented with c/o pain in the lower abdomen for 8 months , cyclical pain associated with menstruation, h/o lower abdominal swelling 6 months ,progressed to attain the present size ,increased in size during menstrual periods. No h/o menorrhagia, dysmenorrhea, dyspareunia, hematuria, malena, haemoptysis. Patient married 6 yrs ago, and completed her family

P2 L1 A0
P-1 FTND male 5yrs old
P-2 IUD hysterotomy (26 wks) 3 yrs ago

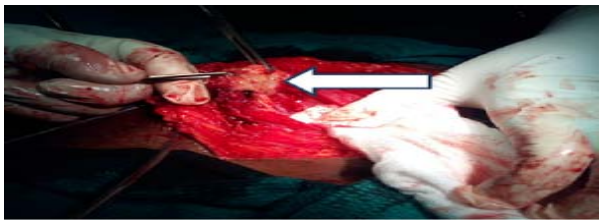
On examination, Pt moderately built and well nourished, general condition is fair, CVS & RS normal. Per abdomen: lower midline surgical scar present, about 3x3 cm size swelling present in the lower end of the scar ,skin over the swelling is normal, ,on head raising test - swelling becomes more prominent ,swelling is not warm, not tender, margins are well defined, skin is pinchable , firm in consistency , surface smooth ,moves along with rest of tissues, no other palpable mass, no free fluid, hernial orifices are free, PV, PR normal Complete blood count- with in normal limits ESR – Elevated, abdomen and chest x ray are normal USG abdomen with pelvis showed parietal wall swelling in the suprapubic region, both ovaries and uterus normal, other viscera appear normal. CT abdomen showed a parietal wall swelling, otherwise normal study. Aspiration cytology had features suggestive of endometriosis. Intra-operatively a 3x3 cm subcutaneous swelling, a yellowish white swelling about 4x4 cm size involving the lower part of the right rectus abdominis muscle. Wide excision of both the sub-cutaneous and rectus muscle swelling was done. Exploration of peritoneum and pelvis done and was found to be normal. Anatomical repair of the abdominal defect done, an onlay prolene mesh fixed .Post operative period was uneventful HPE: Scar endometriosis, all margins free of lesion

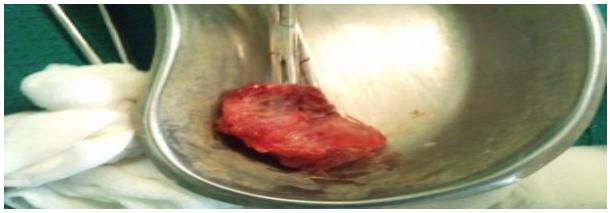


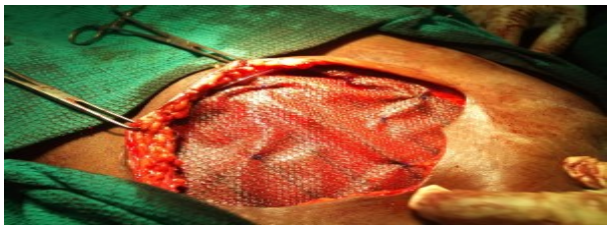
scar endometriosis



subcutaneous endometrioma rectus muscle endometrioma excised specimen







onlay prolene mesh fixation

Discussion

Scar endometriosis(2) is commonly seen in
Classical caesarean section,
Hysterotomy,
Episiotomy,
Myomectomy,
Post operative amputated cervical stump
Tubal stump
Post LSCS (0.04 to 0.8 %)
Umbilical hernia repair (rarely)
Usually occur 2 to 7 years after the surgery

Aetiology(3)

Implantation theory, Metaplasia theory, Metastatic theory, Hormonal theory, Immunological theory,
like various theories explained the pelvic endometriosis.
Pelvic endometriosis is commonly associated with retrograde menstruation.
20% of the patients are asymptomatic(4) .
Clinical features(5): Cyclical pain, waxing and waning of the swelling at the time of menstruation.
Lesion mostly occurs with in 5 cm of surgical scar, symptomatic lesions usually measure 2 to 7 cm in
size.
Diagnosis of scar endometriosis should involve detailed history taking and pelvic examination
Stitch granuloma, hematoma, incisional hernias, metastatic neoplasms, desmoid tumor like skin lesions, should be considered for differential diagnosis
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Investigations(3)

USG-cystic structures with low-level internal echoes, and occasional thick septations, thickened walls, and echogenic wall foci.
COLOUR DOPPLER STUDY- demonstrates pericystic flow, but not intracystic, flow.
MRI -noninvasive method, appears as a hyper intense mass on T1-weighted sequences, with a tendency towards hypo-intensity in T2-weighted sequences, a hypo-intense ring is often seen surrounding the endometrioma, which is enhanced after contrast administration ,and to detect pelvic endometriosis .
ASPIRATION CYTOLOGY – shows endometrial and stromal cells.
EXCISION BIOPSY is confirmatory.
DIAGNOSTIC LAPROSCOPY is the vital investigation for pelvic endometriosis
CA-125(6) titre used is for follow-up and to detect recurrences

Treatment

Treatment may be surgical or non surgical. Non surgical treatment include OCP, progesterone pills, danazole, aromatase inhibitors, GNRH analogues temporarily relieve symptoms. Recurrence is common after withdrawing the drugs with in 6 months Treatment of scar endometriosis associated with pelvic endometriosis is, excision of the scar endometriosis and the usual treatment for pelvic endometriosis. Definitive treatment of Scar endometriosis is excision(7), with lesion free margins and repair of the defect.
Recurrence is the rule if excised inadequately.

Conclusion

1)	Treatment of choice for Scar endometriosis is local excision with lesion free margins.
2)	Medical management is only temporary and symptomatic.
3)	Scar endometriosis is one of the important differential diagnoses to be considered while treating

scar lesions in women of child bearing age group.

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