Case Report

A Case Report On Abdominal Wall Scar Endometriosis

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ABSTRACT

Endometriosis is the presence of functional endometrial tissue outside the uterus. While it commonly involves the pelvic viscera and peritoneum, it can also occur at extra-pelvic sites. Scar endometriosis or incisional endometriosis is an infrequent occurrence of endometriosis at the site of a previous surgical scar, mostly following an obstetrical or gynecological procedure. It typically presents as swelling and abdominal pain at the scar site at the time of menstruation. USG is an accessible and reliable diagnostic tool, although in doubtful cases CT-scan or MRI may be required. Surgical excision offers diagnostic confirmation, therapeutic benefit as well as prevents recurrence. This is a case report on cesarean section scar endometriosis, managed at a tertiary level center with emphasis on its diagnosis and treatment.

INTRODUCTION

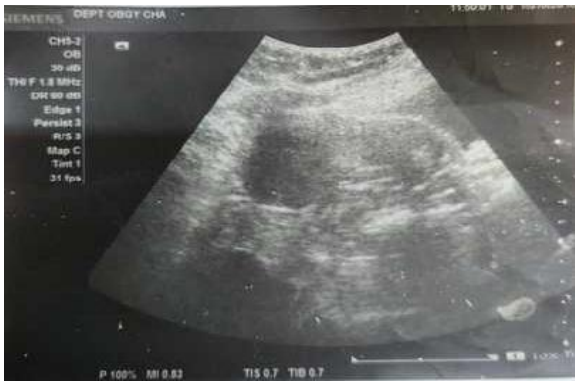
It is a chronic gynecologic disorder where the functional and morphological endometrial glands and stroma are present outside the uterine cavity. [1] The most frequent sites of implantation are in the pelvic cavity such as the ovaries, posterior cul-de-sac, uterine ligaments, pelvic peritoneum, bowel, and recto-vaginal septum but it can also be found in extra-pelvic sites such as nervous system, thorax, urinary tract, gastro-intestinal tract, and in cutaneous tissue. Scar endometriosis is an infrequent type of extra-pelvic endometriosis, occurring in old surgical scars, mainly from obstetrical and gynecological procedures. The symptoms are non-specific, typically involving swelling and abdominal pain at the scar site at the time of menstruation. Diagnostic imaging includes USG and CT-scan or MRI in doubtful cases. Most cases need to be managed with surgical excision which provides confirmation of diagnosis, therapeutic relief and prevents recurrence.

CASE REPORT

A 35 year old female patient, Para-2, Abortion-1, Live issue-2, presented with complaint of cyclical abdominal pain with swelling at the site of previous cesarean section scar since 2 years. Initially, she had complaint of dysmenorrhea which started about 4 years back. Her obstetrical history was suggestive of two full-term emergency Cesarean sections performed 10 years and 5 years back.

On per-abdominal examination, about a lemon-sized swelling was felt between skin and uterus below the subcutaneous fat plane. Per-vaginally, uterus was found to be anteverted, adherent to the anterior abdominal wall, which gave the impression that the mass in the scar may be connected to the uterus.

On imaging, USG showed a 53 X 13 mm sized ill-defined heterogeneously hypo-echoic lesion without internal vascularity at the suture site in the inter-muscular plane anterior to uterus which appeared to communicate with uterine wall, suggesting the possibility of scar site endometriosis.



A complementary MRI report revealed 14 X 60 X 50 mm sized ill-defined altered signal intensity lesion at the site of previous CS scar in lower abdominal wall in the rectus abdominis muscle.

The clinical history, physical examination and radio-imaging led to the diagnosis of scar endometriosis.

Plan of management was decided and patient was posted for surgery under spinal anesthesia. Abdomen was opened through the transverse scar of previous 2 cesarean sections. In the middle 1/3rd of scar, about 4 X 5

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cm sized thick, indurated, black colored tissue with chocolate colored fluid was noted.[fig.1] Uterus and bladder were found to be adherent to the anterior abdominal wall scar. The patch of endometriosis extended upto the anterior uterine wall.[fig.2] Peritoneum was opened from the lateral side. Sharp dissection was done to separate uterus and bladder from the anterior abdominal wall. Total Abdominal hysterectomy was done.Ovaries were normal and were preserved. On exploration, no other lesions of endometriosis were found. Patch of endometriosis involving the rectus muscle from upper and lower sides was resected.[fig.3] All the suspicious tissue was thoroughly removed from the scar site and the tissue obtained was sent for histological examination.

Post-operative period was uneventful. Biopsy report confirmed the presence of scar endometriosis. Patient

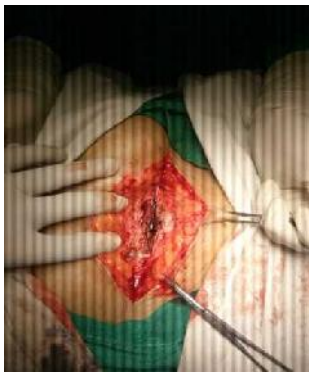

Fig. 1 :
Patch of endometriosis in the middle 1/3rd of scar

Fig. 2 :
Endometriosis involving anterior wall of uterus

Fig. 3 :
Patch of endometriosis involving rectus Muscle being resected.

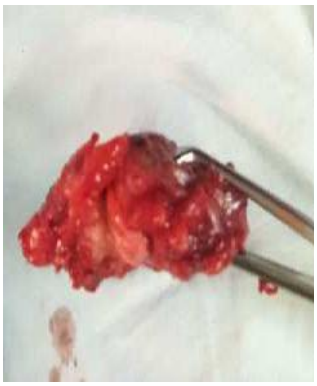

Fig. 4 :
Resected patch of endometriosis

was discharged after stitch removal and was called for follow-up at 6 monthly intervals. Follow-up at 12 months after surgery revealed no recurrence of complaints.

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.[2] The incidence has been estimated to be only 0.03% to 0.15% of all cases of endometriosis. [3]

Although many theories have been postulated regarding its pathogenesis, the most accepted is direct mechanical implantation of endometrial tissue to the wound edge during abdominal or pelvic surgery, most commonly a cesarean section.

Classically, patients present with cyclical increase in the intensity of pain and size of the endometrial implants. However, majority of the patients have non-specific complaints like tenderness on palpation or a raised scar, which makes the diagnosis challenging.

Although this is ultimately a histopathologically-confirmed diagnosis, preoperative imaging including ultrasound, computed tomography, and magnetic resonance imaging may be helpful in the diagnosis and assessment.[4]

Management includes both surgical excision and hormonal suppression.[5, 6] Hormonal suppression using oral contraceptive pills, progestational and androgenic agents like danazol can be tried but these agents have been found to be only partially effective with high risk of recurrence. The treatment of choice is always total wide excision of the lesion, which is diagnostic and therapeutic at the same time.[7]

CONCLUSION

This patient was successfully managed with surgical approach alone without any adjuvant medical treatment with no recurrence.

With rising incidence of cesarean sections and various other gynecological surgeries, the occurrence of scar endometriosis can be expected to rise. Hence, for such patients, history taking and physical examination should be done thoroughly keeping in mind the possibility of scar endometriosis as a delayed post-operative complication.

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