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RARE CASE OF SCAR ENDOMETRIOSIS FOLLOWING LAPAROTOMY FOR ECTOPIC PREGNANCY

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INTRODUCTION

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 is sometimes confused with other dermatological or surgical conditions which may delay the diagnosis.

Scar endometriosis commonly follows obstetrical and gynaecological surgeries. The diagnosis is frequently made only after excision of the diseased tissue.

Scar or incisional endometriosis is a rare entity reported in 0.03-1.08% of women following obstetric or gynaecological surgeries.[1] Abdominal wall or scar endometriosis usually occurs after surgical procedures, especially after caesarean section.[2] There are reports of endometriosis after tubal ligation, salpingectomy, inguinal hernia repair, ectopic pregnancy, laparoscopy, and hysterectomy.[3,4] There are few cases of primary cutaneous endometriosis without prior surgery, such as at the vulva, perineum, groin, umbilicus, and extremities.[5]

Presenting here a rare case of scar endometriosis which occurred seven years after laparotomy for an ectopic pregnancy.

KEYWORDS: Scar endometriosis, ectopic pregnancy, FNAC.

CASE REPORT

Mrs XYZ was admitted a rural medical college with complaints of pain in abdomen and lump in abdomen since three to four years. The pain got aggravated during menses and also the pain radiated to the back and thigh. It was associated with body ache and fever. There were no relieving factors.

The lady had been married for eleven years and had two children. First was a FTND, followed by ectopic pregnancy seven years back for which exploratory laparotomy was done. Last child birth was five years back which was a FTND. Her menstrual cycles were regular and last menstrual period was one month back. There was no history of any major illness in the past nor any such complaints in the family members.

On examination the general examination was normal. Systemic examination was also normal. On per abdominal examination a nodule was noted over the midline over the laparotomy scar.

It was tender to touch. On per-speculum examination, there was a cervical erosion present and hence a Pap smear was taken. On per-vaginal examination, the uterus was bulky, anteverted and anteflexed. Bilateral fornices were free.

All the routine investigations were done. CBC, KFT, LFT and electrolytes were within normal limits. Ultrasound of abdomen and pelvis was done which showed the uterus and ovaries to be normal in size, shape and echo-texture. CECT scan of the pelvis was suggestive of the diagnosis of endometrioma or desmod tumour. Hence FNAC was done from the lump under ultrasound guidance. FNAC report was suggestive of the diagnosis of scar endometriosis. Pap smear was normal.

The excision of the endometriotc nodule was done via an infra-umbilical incision. A 3×2 cm nodule was excised along with the adjacent tissue. The nodule was in the sub-cutaneous plane, extending up to the rectus sheath. However the rectus sheath was intact and not involved. Histopathological examination of the specimen confirmed the diagnosis of scar endometriosis.

DISCUSSION

The diagnosis of scar endometriosis may be challenging. It can be frustrating both for the patient and the treating physician. Scar endometriosis can be diagnosed by a high level of suspicion in any woman presenting with pain at an incisional site, most commonly following

pelvic surgery. The pain is colicky like pain which gets aggravated during menstruation. Clinical diagnosis can be made by careful history and physical examination, imaging studies, FNAC and histo-pathology of the excised tissue. In our patient the diagnosis was suspected because of the history of aggravation of pain at the time of menstruation. Diagnosis was made by FNAC after which excision of the endometriotic nodule was done.

Many theories have been postulated for scar endometriosis. However, the most generally accepted theory is the iatrogenic transplantation of endometrial implants to the wound edge during an abdominal or pelvic surgery.[6,7,8]

Miraglia et al[3] analysed 30 years of incisional endometriosis after caesarean section and found the incidence of scar endometriosis to be 0.08%. Blanco et al[9] reported 10 cases of scar endometriosis of which 9 cases followed caesarean section and one occurred in laparotomy for ectopic pregnancy. In a study by Pathan et al[10] seven cases occurred in caesarean and one occurred in a hysterectomy scar.

Medical treatment with the use of progestogens, oral contraceptive pills, and danazol is not very effective. Hence the management is mainly surgical. Local wide excision with at least 1 cm of margin, is the treatment of choice for scar endometriosis. Larger and deeper lesions up to the muscle or the fascia are more difficult to excise completely.

CONCLUSION

High index of suspicion is necessary for diagnosis of scar endometriosis. It is suspected when a woman presents with a painful swelling in the abdominal scar, which gets aggravated during the menstrual cycle. This condition can be confused with other surgical conditions. Diagnosis can be made with the help of imaging techniques and FNAC. Treatment is wide surgical excision of the affected area. The patients should be followed up for recurrence.

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