

Case Report

A Case Report of Scar Endometrioma, A Rare Entity

Javeria Mushtaq¹, Tayyiba Wasim², Jamshaid Feroze³

¹⁻³Department of Obstetrics & Gynaecology, SIMS/ Services Hospital, Lahore

Abstract

Scar endometriosis is an uncommon entity. Its diagnosis is often delayed because it often resembles to several surgical conditions and dermatological diseases. It is almost always iatrogenic in origin. Here we are discussing a 38 old year old women who presented with scar endometriosis after Lower Segment Caesarean Section (LSCS).

Corresponding Author | Dr. Javeria Mushtaq, Senior Registrar, Department of Obstetrics and Gynaecology, Services Hospital, Lahore **Email:** jiagee15@hotmail.com

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Introduction:

Endometriosis is an existence of endometrial glands and stroma outside uterine cavity. Its prevalence rate is 5 -10% among females of reproductive age¹. Common sites of pelvic endometriosis are uterine ligaments, ovaries, pouch of douglas, fallopian tubes, and pelvic peritoneum. Extra pelvic endometriosis is rare, most common sites are abdominal wall, bladder, omentum and umbilicus². Scar endometriosis is extra rare site 0.03-3.5% and is presented as painful mass at or near previous surgery scar site. Scar endometrioma usually develop after general surgery and obs and gynae surgeries, after hysterectomy 1.08-2% cases and LSCS 0.03-0.04%^{1,3}. Among various theories regarding scar endometriosis a more suggestive theory is that endometrial tissue directly implant in scars during operation under hormonal stimulus. The cells in endometrial issue proliferate; the cellular transport theory or neighbourhood tissue may undergo metaplasia leading to scar endometriosis called coelomic metaplastic theory.

Case Report:

A 38 years old women who presented in gynaecology outpatient on 31-12-2020, with a painful swelling at right angle of previous LSCS transverse scar 6 years ago. Her first delivery was a full term healthy female child through a LSCS at private clinic six years back. Mother

initially felt a mass at the site of operation 4 month after her caesearan. At first, it was not associated with cyclical pain but from last 2 year, she has history of pain in mass, which was initially cyclical, mild in intensity and relived by medication, but from last one year, she has continuous pain, mild to moderate in intensity, no aggravating

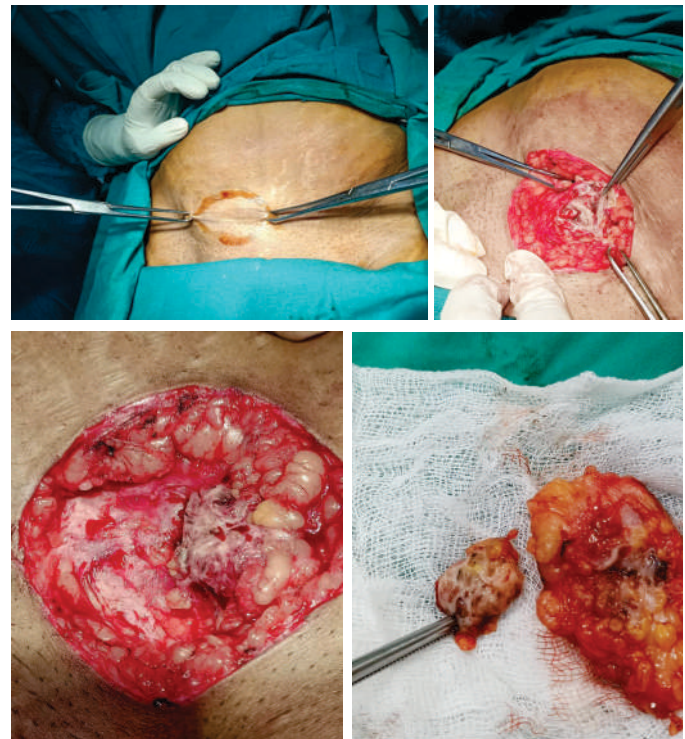


Figure 1: Endometriosis in scar after Lower Segment Caesarean Section (LSCS).

not radiating to any site, No history of bleeding or discharge from mass, No history of dysmenorrhea and dyspareunia. She has history of diagnostic laparoscopy 9 years back for work up of infertility, which was uneventful according to patient as no record available. On examination, 4*3cm tender swelling, firm in consistency, on right angle of low transverse scar. On ultrasound an oval to rounded pre-dominant hypo-echoic heterogeneous lesion is noted in the subcutaneous tissue below the skin at site of scar with internal hyper echoic echoes. This lesion is 5mm to skin and measuring 3.1*1.5cm findings suggestive of scar endometrioma. On gross examination of excised endometrioma, irregular greyish black mass with areas of congestion and haemorrhage was seen.

Histopathology:

Histological examination reveals skin covered tissue. The epidermis was unremarkable. Underlying tissue reveals foci of endometriotic glands and stroma embedded with in skeletal muscle.

Diagnosis was excision of endometrial tissue; consistent with endometriosis and no evidence of granulomatous inflammation or malignancy seen

Discussion:

Scar endometriosis is diagnosed clinically by detailed history and careful clinical examination. It presents usually with a mass near the previous surgical scar, associated with colicky pain during menstruation.⁴ Usually, patient gives history of some gynaecological or rarely a non-gynaecological abdominal surgery. In such scenario the right diagnosis depends on a cautious history and examination with due consideration to endometriosis in provisional diagnosis. Endometriosis in scar is very unusual and this case is very interesting as time interval between surgery and symptoms was 6 years.

Appropriate diagnosis is essential, as scar endometriosis resembles many surgical conditions like, granuloma, scar tissue, neuroma, hematoma, hernia, abscess, neoplastic tissue and metastatic carcinoma, which leads to wrong referral to general surgery often. Usually the diagnosis is confirmed on histology. Correct pre-operative diagnosis is achieved in 22- 51% among these patients⁵.

Diagnostic validity using different methods is not yet

clear using ultrasonography, Doppler sonography, CT scan, MRI, or fine needle aspiration cytology. Imaging procedure doesn't make proper diagnosis but they help to have differential diagnosis⁶. Sonographic features are nonspecific. On ultrasound, it appears as heterogeneous mass, but there may be a predominantly hypoechoic echotexture with internal scattered hyperechoic echoes surrounded by a hyperechoic ring with variable vascularity and width, may be present. The finding on a CT scan might show a well demarcated soft tissue nodule with heterogeneous enhancement after contrast with surrounding tissues with streaky appearance⁷. The most sensitive diagnostic modality is an MRI which most accurately locates the anomaly relative to a previous C-section scar and the signal features of background endometriosis. It also helps in pre surgical mapping of deep pelvic endometriosis^{6,7}. The diagnostic tool for final confirmation reported in some studies is fine needle aspiration however, one must be aware of the fact that it can lead to re-implantation of potential malignancies during the process⁸. Histological diagnosis is the definitive modality^{4,9}.

Surgical treatment like wide local excision with at least a 1cm margin is appropriate even in recurrent lesions. Though recurrence of scar endometriosis is very less likely. The larger and deep lesions extended deeply to fascia and muscle are difficult to excise completely and if the excision goes deeply, it may need a synthetic mesh placement after resection¹⁰. Medical treatment only relief symptoms, Danazol, progesterone and GnRH can be used but once treatment stopped, recurrence occurs along with side effects¹¹. The incidence of concomitant pelvic endometriosis with scar endometriosis is 15-28% therefore it is advisable that all such patients must undergo a simultaneous pelvic examination with a follow up by a gynaecologist^{2,5,8-11}.

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