

Case Report:

Scar endometriosis: a case report with diagnostic dilemma

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ABSTRACT:

Endometriosis is a common gynaecological condition which sometimes presents to general surgeon as a small granuloma or lump in abdomen. Endometriosis can sometimes occur in a previous surgical scar. Scar endometriosis is rare and difficult to diagnose. It mostly follows obstetrical or gynaecological surgeries. This condition is commonly confused with a stitch granuloma or non-healing scar. It can pose a diagnostic Dilemma and is established by histological examination only. We report two cases of scar endometriosis following tubal ligation.

KEYWORDS: abdominal wall, endometriosis

Introduction

Occurrence of scar endometriosis following obstetrical and gynaecological operation is well known. Myer described the first case of endometriosis in an abdominal scar^{1,5}. The exact incidence of Scar endometriosis following tubal ligation could not be found in literature². Steck and Tsenov have reported scar endometriosis following caesarean section^{8,9}. Chatterji also described this entity following abdominal hysterectomy. Endometriosis in patients with scar is more common in abdominal skin and subcutaneous tissue compared to muscle and fascia. Endometriosis involving the recti muscle and sheath is rare. The simultaneous occurrence of pelvic endometriosis with scar endometriosis has been found to be infrequent. But scar endometriosis following tubal ligation is a rare entity and hence two cases of this entity are described.

Case report

CASE I

40 year old female was admitted, with painful hypogastric scar for last 11 years. She had undergone abdominal tubal ligation 11 years back. Typically pain occurred during menstruation. Her general physical examination and systemic examination were within the normal limits. Local examination revealed 5 cm scar in the hypogastric area 0.5cm rose above abdominal wall [Figure 1]. No signs of inflammation or ulcer present. It was firm non tender with no induration and had restricted mobility.

With an elliptical incision, scar was excised which extended up to the posterior rectus sheath. Defect was repaired in layers. Excised tissue revealed endometrial glands in endometrial stoma and cut edges of the excised tissue were free of endometrial glands [Fig 2]. Post operative period was uneventful.

Two years after the excision the patient is healthy and recurrence free.



Figure 1 showed scar area with bluish discoloration

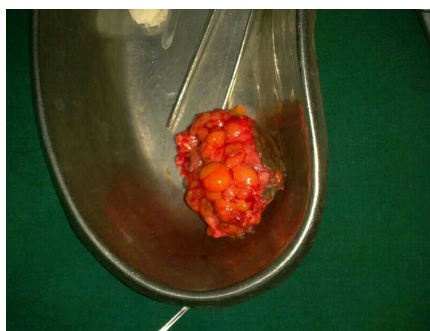


Figure 2 showed excised tissue which showed endometrial tissue

CASE II

A 26 year old female presented with complain of pain in tubal ligation scar for last 1 year. Her general physical examination was normal, local examination revealed 4 cm scar in the hypogastric area which was raised above the abdominal wall, firm in consistency, non-tender with restricted mobility. The scar was excised which extended up to the peritoneum. Incision was closed in layers, excised specimen histopathologically showed evidence of endometrial glands. Post operative period was uneventful and patient is symptom free since last 3 years.

Discussion

Endometriosis is a well circumscribed mass of endometrium. Abdominal wall endometriosis presents as a

painful swelling in scar that is why these cases first report to a general surgeon, where a diagnosis of a stitch granuloma or keloid is made. Scar endometriosis commonly occurs after operation on uterus and tubes. The interval between operation and presentation may vary from 3 months to more than 10 years. The aetiology of abdominal wall endometrioma is thought to be result of transportation of endometrial tissue during surgical procedures and subsequently stimulation by oestrogen to produce endometriosis. Simultaneous occurrence of pelvic endometriosis with scar endometriosis is infrequent; our patients also did not have pelvic endometriosis. Various diagnostic methods have been described in literature, till recently the use of USG has hardly been reported in literature and described as non specific. FNAC has been reported to be accurate in diagnosis⁷, but as reported all FNACs were not diagnostic⁵. Four patients in his series were not diagnosed by FNAC. CT scan and MRI are other investigating tools which show solid well circumscribed mass and delineating planes between muscle and subcutaneous tissue, but keeping the cost into consideration, very seldom the patient can afford it. Endometriosis should be kept in mind after the tubal ligation. Such patients can present with painful scar which may be wrongly diagnosed as keloid, granuloma, dermoid or functional.

It is suggested that following tubectomy the excised portion of tubes should be routinely be subjected to histopathology which may reveal endometrial tissue and such patients can be followed up. Surgery is the answer to the problem and leads to complete cure and hormones are not the answer as attempted by some. Stress has been given on proper excision of the scar i.e. cut edges should be free histopathologically from the endometrial tissue.

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