

Tubectomy Scar Endometriosis - A Rare Case Report

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ABSTRACT

Introduction: Endometriosis is one of the most distressing problem of women in reproductive age group. It is defined as the presence of functioning endometrial tissue outside the uterine cavity, and may be found either inside or outside the pelvis. Ovary is the most common organ to be involved (almost 50%) followed by pouch of douglas and broad ligament. Rare sites are thorax, CNS, urogenital tract and also skin where prior surgery was undertaken.

Case report: In this article a rare case of tubectomy scar endometriosis presenting with cyclical abdominal pain at scar site will be discussed

Conclusion: Scar endometriosis is rare and is difficult to diagnose. This condition is often confused with a stitch granuloma or a non-healing scar and hence can pose a diagnostic dilemma and can be diagnosed by histological examination alone. It has been reported in 0.03-1.06% of women following obstetric and gynecological surgeries. With this case report we will try to bring awareness about this, often misdiagnosed, rare condition called scar endometriosis.

Keywords: Tubectomy, endometriosis

INTRODUCTION

The term endometriosis was coined by Rokitansky in 1860. It occurs in 8-15% of women of reproductive age group, and 25-35% of women with primary or secondary infertility. It is identified in 1-2% of women undergoing sterilization or sterilization reversal, in 10% of women undergoing hysterectomy, 16-31% of laparoscopies, and in 53% of adolescents with severe pelvic pain.

It is usually seen within the pelvis. Common sites are ovaries (50%) followed by cul de sac, uterosacral ligaments, posterior surface of uterus and broad ligament, pelvic peritoneum, bowel, rectovaginal septum and even distant sites. Extrapelvic sites include CNS, thorax, urinary tract, gastrointestinal tract and cutaneous tissue, and its most frequent site is abdominal wall.^{1,2} Scar endometriosis which occurs after surgical procedures is more common after cesarean section. The incidence of endometriosis after cesarean section has been reported to be 0.03%-0.4%.

Myer was the person who first reported a case of endometriosis in an abdominal scar.³ The exact incidence of scar endometriosis following tubal ligation could not be found in literature. Scar endometriosis presents clinically as a painful, palpable subcutaneous mass, associated with cramps and bloating during menses.

CASE REPORT

A 28 year old lady, presenting to the gynecology OPD at Mysore Medical College and Research Institute. She was a P2L2, previous 2 normal vaginal deliveries, who had undergone abdominal tubectomy 2 years back, presented with complaints of cyclical pain at the tubectomy scar site since 6 months. Her

general physical examination was normal. Local examination revealed a 4cm nodule at the left angle of the scar in the hypogastric region.

She was subjected to USG which revealed an irregular hypochoic lesion in the subcutaneous plane of the left lower abdomen, measuring about 16×7×13mm with peripheral vascularity as seen in figure 1.

FNAC of the lesion showed clusters of epithelial cells with few glandular structures mixed with spindle cells, suggestive of scar endometriosis as seen in figure 2.

Wide local excision was done and the specimen shown as in figure 3 and 4 was subjected to histopathology. Microscopy revealed fibrocollagenous adipose nodular tissue with dispersed dilated endometrial glands and stroma suggestive of endometriotic nodule as seen in figure-5. Post operative was uneventful. Follow up did not reveal any recurrence.

DISCUSSION

Endometriotic lesions over the anterior abdominal wall presents as a painful swelling in the scar which is associated with cyclical pain and increase in size of the mass due to hormonal influences that can cause changes in size, cutaneous bleeding and bruising. It commonly occurs after operation on uterus and tubes. The interval between the surgery and presentation may vary from 3 months to more than 10 years.

The etiology of scar endometriosis is thought to be due to transportation of endometrial tissue during surgical procedures and subsequently stimulation by estrogen to produce endometriosis.^{4,5}

The differential diagnosis of scar endometriosis can be a hernia, hematoma, neuroma, suture granuloma, lipoma, abscess, sebaceous cyst and neoplastic tissue or even metastatic carcinoma.

The interval between the surgery and presentation may vary from 3 months to upto 10 years.⁶

Various investigations such as USG, Doppler sonography, computed tomography, MRI or FNAC often do not give a definitive diagnosis of scar endometriosis. Often the diagnosis is not confirmed until after histology has been performed. Correct pre-operative diagnosis is achieved in only 20-50% of the cases. USG is the most commonly used test. The lesion may appear as a hypochoic and heterogenous mass with messy internal echoes. On CT scanning the endometrioma may appear as a circumscribed solid or mixed mass, enhanced by contrast and shows internal hemorrhage. MRI is useful for pre-surgical

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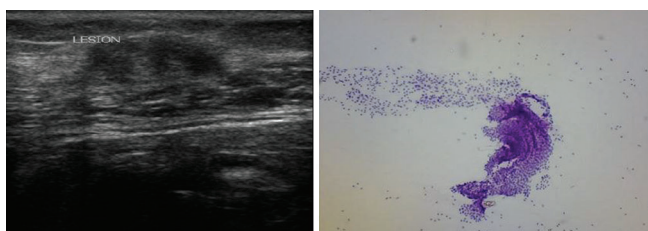


Figure-1: USG image of the lesion, **Figure-2:** FNAC of scar endometriosis showing endometrial glands with compact stroma in subcutaneous tissue.

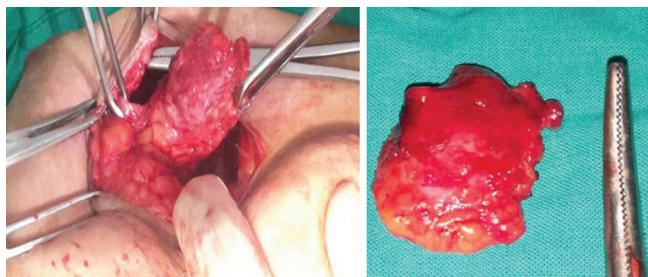


Figure-3: Endometrioma being excised, **Figure-4:** Gross appearance of the lesion.

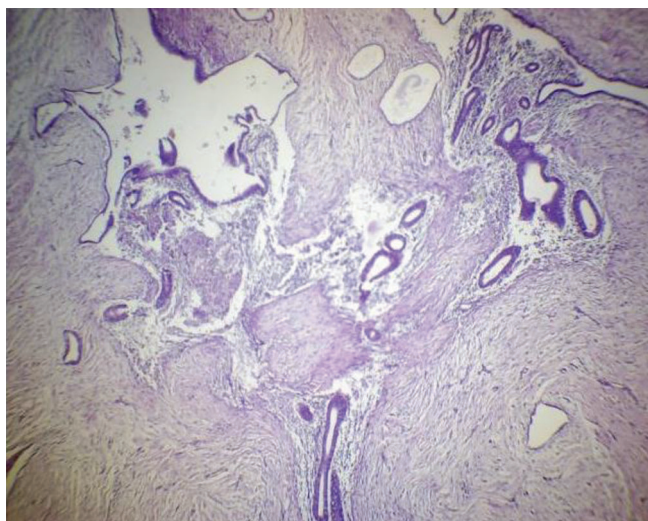


Figure-5: Histopathology showing endometrial glands, hemosiderin laden macrophages and few chronic inflammatory cells.

mapping of deep pelvic endometriosis. Infiltration of the abdominal wall and subcutaneous tissue is much better assessed by MRI. Its sensitivity is 90-92%. However very few patients can afford for CT and MRI. FNAC may help in accurate diagnosis, but it is accurate only for large masses, doubtful diagnosis and in atypical presentations.

Histology is the hallmark of diagnosis. It is satisfied if endometrial glands, stroma and hemosiderin pigment are seen. Local wide excision, with at least 1cm of margin, is the accurate treatment of choice for scar endometriosis and also for recurrent lesions. Recurrence rates are usually very low.

It is better to ligate the fallopian tubes beyond 4cm from the uterine cornua, which may prevent development of endometriosis and subsequent fistula formation at the tip of the ligated tube. It is recommended that following tubectomy the excised portion of the tubes should routinely be submitted for histopathological examination; in case endometrial tissue has been identified on HPR, then such patients can be followed

up. Hence surgery is the answer to the problem which leads to complete cure. There is only partial recovery followed by recurrence with hormone therapy.⁷

The incidence of concomitant pelvic endometriosis with scar endometriosis has been reported to be ranging from 14.2- 26%.

CONCLUSION

Whenever a women presents with a painful swelling in the abdominal scar, especially following previous gynecological or obstetric surgery, then the gynecologist should strongly suspect the possibility of scar endometriosis

A probable pre-operative diagnosis should be made. Medical treatment will not give complete cure. Wide excision of the scar with the endometrioma is the treatment of choice. The patients should be followed up for the occurrence of recurrent lesions.

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