SCAR ENDOMETRIOSIS FOLLOWING CAESAREAN SECTION

(A Case Report)

by

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Introduction

Endometriosis in scar tissue was first described by Russel in 1899. Sampson in 1924 demonstrated a case of adenomyoma in the scar of an abdominal incision to prove his point that endometrial tissue can be implanted. A brief review of literature reveals numerous cases where endometrial tissue has been demonstrated in laparotomy scars. Patients in whom the uterine cavity was opened form a sizeable fraction of these cases and the following report is one such case which was treated successfully.

Case Report

BJ, a 25 year old patient attended this hospital on 1-2-1975 with history of bleeding from an abdominal scar during menstrual periods for the past 7 years. She had no other complaint relating to menstruation or otherwise. She had undergone caesarean section (? classical) for cervical dystocia in 1968 elsewhere. The baby was deadborn and the postoperative period had been uneventful. But the lower portion of the abdominal wound did not heal completely and remained raw and reddish. Some months later, when she resumed menstruation she noticed blood stained discharge oozing out of this raw area. There was never any pain. This persisted cyclically for 7 years during which period she did not concieve. Her menstrual history was normal and regular

On examination, her general condition was good. Cardiovascular and respiratory systems were normal. Over the abdomen there was a right paramedian subumbilical scar, the lower portion of which appeared puckered and reddish. No sinus was detected on exploration.

Pelvic examination suggested a normal sized uterus being fixed to the lower portion of abdominal scar thus restricting its mobility. Fornices were free.

Routine Investigations: Normal.

Hb—11.2 g%

Hysterosalpingogram: Cervix elongated. Uterus showed spill through right fallopian tube but dye did not leave the left tube. Slight irregularity of uterine cavity was seen. No uterocutaneous sinus could be demonstrated.

Exploratory laparotomy was done on 19-2-1975. The uterus was found to be adherent to the lower portion of the abdominal scar and was also covered by omental adhesions. These adhesions were released and the uterus mobilised. The adnexae appeared healthy. The fibrous scar tissue all along the scar was excised and sent for hisopathology. Healing was by primary intention.

On serial section the scar tissue showed endometriosis near the dermis.

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Postopeatively the patient had normal periods and the lesion did not recur. The scar appeared healthy.

Discussion

Masson (1935) lists the order of frequency of ectopic endometrium in which scar endometriosis occupies the ninth place. As elsewhere, endometriosis in postoperative scars is invasive, noncapsulated, and consists of glandular epithelium similar to uterine lining. In pregnancy, decidual reaction is noticed.

Even though one third of the cases reported by Nora *et al* (1956) developed symptoms within the first year of operation, the average interval in the series from Mayo Clinic was 4.2 years. The most common clinical feature is a palpable nodule which becomes tender during periods (80%). In 15% there is noticeable swelling of this nodule and in 12% there is blood stained discharge from this area.

In the differential diagnosis the lesions to be considered are keloids, desmoid tumours, fibromas, unabsorbed sutures and foreign bodies. Adhesions, neuromas, true uterine and tubal fistulae and uteroabdominal sinus should be carefully excluded. Wide and deep excision of nodule and scar tissue offers permanent cure.

References

1. Masson, J. C.: Ann. Surg. 182: 819, 1935.
2. Nora, E. Sr. Mayer, K. A. and Carbonera, P.: Amer. J. Obst. & Gynec. 71: 876, 1956.

See Fig. on Art Paper XI