ENDOMETRIOSIS OF THE ABDOMINAL SCAR

(Report of Two Cases)

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The endometriosis of the abdominal scar though rare, is well known clinical entity. The first case of endometriosis in laparotomy scar was reported by Meyer in 1903. In the past, medical treatment of endometriosis was disappointing with obvious drawback of testerone. But with the advent of oral progestogens the medical treatment of endometriosis has been tried by many workers all the world over. Most of the authors (Kistmer 1962; Linton 1962; Riva 1961; Meigs 1960; Scott and Te Linde 1955; Stanley 1962) have analysed and discussed the benefical effect of this prolonged oral progestogens (Pseudo-pregnancy method) in cases of internal and pelvic endometriosis only. There is only one report by Andrew *et al* (1959) who described regression of vaginal implants of endometriosis following hysterectomy under the effect of oral progestogens used for 22 weeks.

We report our experience of the management of 2 cases of endometriosis of the abdominal scar which did not regress with the pseudo-pregnancy method of treatment with Primolut-N for a period of 6 months.

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Case 1

Mrs. A., aged 30 years was seen by one of us with history of a lump in the abdominal scar following medical termination of pregnancy by hysterotomy along with sterilization done in August 1971 in some other hospital.

The lump was very tiny in the beginning and was considered to be inflammatory in origin. It did not respond to usual treatment for the control of infection with antibiotics and local fomentation and grew in size and assumed the present size within 6 months of operation. Patient described that this lump became more tense and tender during her menstrual period but it remained tender on palpation throughout the month.

Her menstrual history was normal. She had three normal deliveries at home. Children were born healthy and now growing well.

On examination, her general condition was good. Systemic examination did not reveal any abnormality. On abdominal examination, there was a subumbilical median scar about 4 inches in length. There was a lump approximately 2 x 1½ inches in dimension situated in the middle of the scar. There was no discolouration of the overlying skin. It was firm in consistency and little tenderness was present on palpation.

On deep palpation the whole mass was found to be extraperitoneal and could be lifted between fingers and the overlying skin was firmly adherent to the mass. Pelvic examination showed no other abnormality except deficient perineum.

All routine investigations, urine, blood etc.

were normal. A diagnosis of scar endometriosis was made on the basis of typical history. In the beginning the patient was reluctant to undergo surgical treatment, hence a course of medical treatment with analgesic and oral progestogens were given for 6 months. As mentioned before, it could not give her complete relief from the nagging pain and there was no evidence of dimunition in the size of the nodule. The treatment was costly and without improvement hence she agreed to undergo surgical treatment.

She was operated on 18-6-74 and the nodule was excised by an eliptical incision with a wide margin on both sides of the nodule. Great care was taken to avoid implants from this nodule while excising it. The mass was excised which was superficial to anterior rectus sheath (a portion of which was removed while excising the nodule).

The abdominal cavity was explored and there was no evidence of visible endometriosis in the abdomen and pelvis. The abdomen was closed in layers. The patient made an uneventful recovery and was discharged from the hospital on 10th postoperative day.

Since her operation the patient is having regular menstruation without discomfort and she is happy to get relief from her nagging pain for the last one year.

Description of specimen: Mass 2 x 1½ inches, cut-section showing fibrous consistency with areas of bluish islets like spots intermingled with yellowish area of subcutaneous tissue.

Microscopic: The section showed several islets of endometrial tissue in the subcutaneous region. (Fig. 1).

Case 2

Mrs. C. Devi, aged 35 years came with history of cyclic bleeding from the abdominal scar following caesarean section done about one and a half years ago in this hospital by one of the registrars on emergency duty.

She was discharged from the hospital on the 10th postoperative day in good general condition with apparently healed abdominal scar. She kept on visiting the Out-patient's Department off and on for persistence of discharge from the abdominal wound. In the beginning she was treated with oral antibiotic and local dressing and it was after quite some time before the diagnosis of scar endometriosis became evident after local infection had cleared off. She had a fistulous tract lined by endometrial tissue which bled during each menstruation. A preoperative hysterosalpingography was done to exclude the presence of uteroabdominal fistula which was confirmed when laparotomy was done for the surgical excision.

As mentioned in the previous case, this patient was frightened and reluctant to undergo second laparotomy and we had to resort to medical treatment which ultimately proved to be of no avail.

The failure of the medical treatment and annoyance of the cyclic discharge from the abdominal wound made her agreeable to undergo the surgical treatment. The whole of the tract along with some area of the heally skin around it was excised. As in the previous case, there were no visible areas of endometriotic implants in the pelvic or abdominal cavity. Uterus, tube and ovaries were healthy and normal.

The abdominal wound healed nicely and she was discharged from the hospital on 14th postoperative day. She was seen once after the operation with perfect abdominal wound.

Discussion

The presence of ectopic implants of endometrial tissue (endometrial stroma and endometrial glands) in regions remote from the uterine cavity, is one of the most mysterious and fascinating disease in the field of gynaecology. Though internal endometriosis is becoming more common among the educated group of women who belong to high socio-economic group and postpone their marriage and childbearing till late, the incidence of scar endometriosis as such is rather rare. After the first case report by Meyer in 1903 review of literature does not give exact incidence of the scar endometriosis except that by Greenhill (1942) who collected 390 cases of endometriosis in operational scar and found that out of these 390 cases 49 (i.e. 12.5%) were following hysterotomy, and maximum, 113 cases were following ventrifixation an incidence of 28.9%.

The review of our hospital records for the last 10 years, has shown a single case of scar endometriosis following caesarean-section.

Though there are various methods of spread of the endometriosis the direct method of extension and exfoliation and implantation of endometrial cells, appears to explain most of the cases of internal and external endometriosis. Scar endometriosis can be explained as a result of direct implantation following opening of the uterine cavity.

The object of presenting these cases is to impress our experience that oral progestogens has very little role in the treatment of scar endometriosis, which should always be removed by effective surgery in the beginning instead of wasting time and money in the medical treatment.

The possible beneficial effect of removal of a functioning corpus luteum (if any) at the time of hysterotomy for the termination of pregnancy, should be kept in mind, to reduce the possibility of favourable hormonal environment of the growth of scar endometriosis following implantation of endometrium (early decidua) after such a procedure which is likely to occur inspite of all possible care.

Summary

Failure of medical treatment with oral progestogens (Primolut-N) in 2 cases of endometriosis of the abdominal scar has been presented. The possible beneficial effect of the removal of corpus luteum (if found functioning) during termination of pregnancy by hysterotomy besides the usual care of avoiding implantation of endometrium, has been suggested.

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See Fig. on Art Paper II