

UTERINE AND EXTRA-UTERINE ENDOMETRIOSIS

(An Analysis of 47 Cases)

by

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Introduction

Endometriosis is a well recognised clinico-pathological entity belonging to the domain mainly of gynaecologist and rarely of surgeons. Depending on diagnostic criteria its incidence has variously been recorded in world literature.

According to Jeffcoate (1975) endometriosis, being a disease of affluent society, is seldom encountered among African and Asian women. But its incidence is not very rare in this part of the globe.

However, actual prevalence of this lesion is difficult to ascertain because apart from sporadic reports from India of a few cases of endometriosis, that too mostly developing in scars, no elaborate study of appreciable number of cases has been attempted (Bhat *et al*, 1977; Sinha and Sinha, 1977; Ghosh and Dutta, 1978; Nagar *et al*, 1979; Datta *et al*, 1979; Sen Gupta *et al*, 1979). So we are prompted to present 47 cases of endometriosis of which 14 were scar endometriosis, a variant regarded to be rare.

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Material and Methods

During a period from June, 1974 to July, 1979, of a total of 454 gynaecological operations in a single unit at Eden Hospital, Medical College Hospitals, Calcutta, in 47 cases the biopsy material provided histological diagnosis of endometriosis. Once the histological diagnosis was available the clinical data of these 47 cases were analysed regarding age, parity, common presenting symptoms, site of lesion, past history of operation and pre-operative provisional diagnosis. Eight of the 14 scar endometriosis cases formed the basis of a previous publication (Sengupta *et al*, 1979).

Age

The age distribution of the patients was even in nature with 13, 17 and 16 cases in 3rd, 4th and above 4th decade respectively. Only 2 cases were at extremes of reproductive age, 18 and 48 years. While majority of the scar endometriosis occurred in patients below 30 years age, other types were seen to be commoner beyond 30 years of age.

Parity

Though it is commonly agreed that endometriosis is commoner in nulliparous women, in the present series only 11

patients were nulliparous (24%). Of the 36 multiparous women P₁, P₂, P₃, P₄, P₅, and P₆ and above were 2, 7, 5, 11, 0, and 11 respectively. The absence of P₆ women in this series might not bear any significance.

Symptomatology

While most of the patients had manifestations of uterine dysfunction (excessive vaginal bleeding—21 cases, irregular vaginal bleeding—7 cases, dysmenorrhoea—5 cases), 5 and 3 cases were hospitalised with lump in abdomen and infertility respectively. In 14 instances painful scar, aggravating during menstruation, was the presenting symptom. Only 1 case having painful scar also had a sinus. While 1 patient was asymptomatic, in 4 patients various symptoms co-existed.

History of Operation

Of the 14 patients presenting with painful scars, history of operation was available in all. While 3 and 6 patients respectively have had ligation of tubes and combined ligation of tube and hysterectomy, in 2 cases tubal ligation followed suction evacuation. In 2 patients, ovariectomy apart from tubal ligation was done. Appendectomy along with broad ligament cyst removal was the nature of the operation in a single case. However, in none of these cases history of caesarean section was present.

Site

Apart from 14 patients having scar endometriosis, in 21, 6 and 6 patients uterus, ovary, uterus and ovary combined were the site of endometriosis. In no case endometriosis involved genitalia or intestine.

Treatment

Scars were excised with liberal margins in 14 cases of scar endometriosis. In

22 instances, abdominal hysterectomy with bilateral salpingo-oophorectomy was the treatment. In 4 and 2 cases, abdominal total hysterectomy and Ward Mayo's operation had to be done. Removal of chocolate cyst along with plication of round ligament and appendectomy were done in 2 instances each. One case each had ovarian cystectomy and ovariectomy with extended hysterectomy.

In none of the cases recurrence followed. Most of the cases are asymptomatic till date.

Discussion

The prevalence of endometriosis in our country is undetermined. While rests of histologically benign endometriosis tissue is often placed within the myometrium (adenomyosis or endometriosis interna), distinctive clinical features are often lacking or correlation with the degree of symptoms with the extent of pathological process is frequently flimsy. On the contrary, endometriosis externa causes various troublesome clinical features and problems thus leading to its earlier detection. Of the endometriosis externa, scar endometriosis is detected rather promptly due to characteristic periodic pain and swelling. In spite of associated clinical confusion, histological study of tissue however provides instant conclusive diagnosis in almost every case.

Active endometriosis is common in ages between 30 and 40 years. However incidence spectrum ranges from menarche and menopause (Jeffcoate, 1975). Our youngest patient was 18 years old, while the oldest was 49 years who had delayed menopause. However scar endometriosis occurred more in younger age group (3rd decade), compared to other type (3rd decade onwards). This may be due to more frequent adaptation of tubectomy as a Family Planning measure by younger

age group in recent times (Dutta *et al*, 1978). Of 14 scar endometriosis cases in this series, 13 followed tubectomy and 1 appendicectomy.

Jeffcoate (1975) considers classical caesarean section to be an etiological factor in scar endometriosis. Twentysix cases out of 56 cases of scar endometriosis observed by Steck and Helwing (1966) followed caesarean section. Such close correlation was not admitted by Novak (1974). Nora *et al* (1956) noted a rather low correlation and observed that endometriosis following caesarean section was only 1/15th in frequency compared to scar endometriosis following other surgical procedures. We did not encounter any cases following caesarean section. Whether the failure of endometrium to develop in scar following caesarean section is due to physiological incompetence of endometrium at full term pregnancy to implant or is due to refractory nature of the scar tissue itself is still a matter of confusion.

Endometriosis is often regarded as a disease of nulliparous women. But cause and effect relationship of infertility and endometriosis remain ill-explained. All the cases in Dutta *et al* (1978) series were parous women. But in their series only scar endometriosis cases were analysed. In our broadbase series, 77% of the patients have borne child suggesting that endometriosis is in no way incompatible with childbirth. Similarly, it is claimed that external and internal endometriosis seldom co-exist (Jeffcoate, 1975); even detection of one type is said to exclude the possibility of having the other type. We however found endometriosis of the ovary and uterus co-existent in 6 instances. Dutta *et al* (1978) also encountered both types in one patient.

As for presenting symptoms, menstrual disorder was the prime one followed by

lump in abdomen and infertility. As observed by different authors (Bhat *et al*, 1977; Ghosh and Dutta, 1978; Sengupta *et al*, 1979; Nagar *et al*, 1979; Dutta *et al*, 1978) pain and swelling drew the attention towards scar endometriosis. In a single case a discharging sinus was detected. Similarly, Ghosh and Dutta (1978) came across a uterocutaneous fistula in 1 of their cases. In rest of the cases of scar endometriosis, the pain and swelling mostly during menstruation, were highly suggestive.

In almost all the cases, operative removal of the ectopic endometrium led to cure. In none of the cases the lesion recurred. Similar is the experience of other authors.

Summary

Forty-seven cases of endometriosis were encountered in a span of 5 years among 454 gynaecological cases who were operated upon due to different confusing symptomatology. In 14 cases of scar endometriosis, the presenting symptoms, pain and increase in size during menstruation were highly suggestive. Majority of the cases belonging to other types had menstrual disorder and/or abdominal lump. While about three fourths of the cases were parous, the age distribution was characteristic, 3rd decade for the scar endometriosis group and 3rd decade onward for the other group. Of the 14 patients having scar endometriosis, 13 had tubectomy and 1 appendicectomy but scar endometriosis following caesarean section was not encountered in this series. The possible implications are discussed.

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References

1. Bhat, C., Narayanan, R., Barva, S. K and Nayak, P. N.: J. Obstet. Gynec. India. 27: 775, 1977.
2. Dutta, S., Dasgupta, P. K. and Ghosh, A.: J. Obstet. Gynec. India. 29: 487, 1978.
3. Ghosh Bani and Dutta, S. K.: J. Assoc. Medical Women of India. 69: 82, 1978.
4. Jeffcoate, T. N. A.: Principals of Gynaecology; 4th Edition; Butterworth Co., London, 1975.
5. Nagar, Misra, S. D. and Nagrath, A.: J. Obstet. Gynec. 29: 1093, 1979.
6. Nora, E. Sr., Mayer, K. A. and Carbonera, P.: Am. J. Obstet. Gynec. 71: 876, 1956.
7. Novak, E.: Gynaecologic and Obstetric Pathology, 4th Ed., W. B. Saunder Co., London, 1974.
8. Sinha, A. and Sinha, S.: J. Obstet. Gynec. of India. 24: 457, 1977.
9. Sengupta, A., Dutta, N., Chakraborty, T., Sinha, B. and Dutttagupta, H.: J. Obstet. Gynec. India. 29: 909, 1979.
10. Steck, W. D. and Helwing, E. B.: Clin. Obstet. Gynec. 91: 373, 1966.