SCAR ENDOMETRIOSIS-A CLINICO PATHOLOGICAL REVIEW OVER TEN YEARS.

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SUMMARY

This review of scar endometriosis spans a period of 10 years from 1980-89 in Eden Hospital. The incidence of scar endometriosis is 0.40% of all gynaecological cases. The commonest predisposing operation was hysterotomy with tubal ligation. Rectus muscle involvement was found in 26.4% cases. Post operative hormonal treatment was given in selective cases. Histological report in all cases confirmed scar endometriosis with no maligant changes.

INTRODUCTION :

Presence of ectopic functional endometrial tissue outside the uterine cavity is denoted as endometriosis. Palvic endometriosis is much more common than extra pelvic lesions and more particulary, extra peritoneal lesions are least encountered. Incisional endometriosis includes both ventral (abdominal) and vulval lesions. These endometriomata appear as subcutaneous nodules along the incision line. Cyclic pain and swelling of the nodules is the single most importamt symptom suggesting a clinical diagnosis of scar endometriosis. Wespi (1940) suggested the frequency might approach 5% among patients having cassarian or hysterectomy. Violation of the endometrial cavity has been reported to greatly facilitate the transplantation of ectopic endometrium. Indeed endometriosis has been reported along with needle tracts after amniocentesis and saline injections for abortions (Williams 1985, Kaunitz and Di sant Aqnese, 1979).

Perineal implantation of ectopic endometrium along episiotomy scar is uncommon, considering the magnitude of the scope of such implantation during vaginal delivery. Puerperal curettage has been said to sharply increase the incidence of vulval endometriosis. Endometriosis along vaginal and cervical lacerations has been reported, but is difficult to diagnose. Not all cervical endometriosis result in minimal metrorrhagia or contact bleading, necessitating a histological examination, many go unreported and undiagnosad (Fels, 1928).

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Accepted for Publication on 11/12/90

In this study, is presented a detailed clinco-pathological review of 124 cases of scar endometriosis operated at Eden Hospital from January 1980 to December 1989 - a period of 10 years.

MATERIALS AND METHODS :

All the 124 cases in this study had endometriotic lesions on ventral scars. Diagnosis was initially based on clinical features especially the characteristic complanits of cyclical pain, swelling and tenderness of the nodules along the scar. All of them had a history of previous laparatomy or minilaparotomy.

The initial diagnostic workup included a thorough pelvic examination under anaesthesia to detect any induration or a shotty feel of the parametria and pouch of Douglas, to note the size and mobility of the uterus. Thus a clinical examination was done in each case to detect (or exclude) any pelvic endometriotic lesions. Celiotomy was not done in any case, at the time of operation, due to the risk of intra peritoneal transfer of viable endometriotic implants.

Confirmation of diagnosis was based on the histological report of the lesions.

RESULTS AND OBSERVATIONS

TABLE-I

NATURE OF PRECEDING OPERATION

	Hysterotomy tubal ligation	SE & tubal ligation	LSCS	Myomectomy	Hysterectomy
Number of cases	80	20	18	5	1
Percentage	64	16	14	4	0.8

TABLE-II :

TIME INTERVAL BETWEEN PRECEDING OPERATION AND APPEARANCE OF SYMPTOMS.

	2yrs.	2-5yrs.	5-10yrs.	10yrs. more
Number of cases	21	18	67	18
Percentage	16.8	14.4	53.6	14.4

TABLE-III

EXTENT OF LESION

	Superficial fascia	Rectus sheath	Rectus muscle
Number of cases.	19	72	33
Percentage	15.2	57.6	26.4

In this series of 124 cases, almost all incisions were low transverse, either Pfennenstial or modified Pfennenstiel incision. Only 16 had a longitudinal scar, the lesions being located at its lower end. The logitudinal scars were mostly the result of previous caesarian section, but also resulted from hysterotomy. Out of 124 cases, 11 gave a history of delayed wound healing.

Table I shows the distribution of the preceding operation in 18 cases (14.4%), hysterotomy with bilateral tubal ligation in 80 cases (64%), myomectomy in .5(0.4%), suction evacuation with tubal ligation in 20 cases (16%).

Table II gives the time interval between the operation and the development of symptoms. In 67 cases (53.6%), symptoms appeared 5-10 years after the initial operative procedure.

Table - III gives an idea about the extent of

the lesions. In 19 cases (15.2%), the lesion was limited to the superficial fascia. In such cases, the endometriotic nodules were marble sized, discrete, two to three in number and easily dissectable. Excision of the superficial fascia and skin suture. Rectus sheath involvement was found in 72 cases (57.6%). Dissection of the nodules was done enblock including involved areas of the sheath. The defect in the sheath was corrected by mobilising it from the underlying recut muscle and suturing it with prolene. In 33 cases (26.40%), there was extensive involvement of rectus sheath and muscle. Dissection could not remove the entire area of involvement and a few foci had to be left behind.

The peritoneum was noted to be free of any involvement. There was clinical evidence of associated pelvic endometriosis in 16 cases (12.8%).

Hormonal suppression of ovarian function was not advocated in most cases, in view of the reported minimal responsiveness of scar endometriosis to hormones and also from our own observations as to the chances of recurrece. However 35 cases with extensive endometriosis were advised post-operative progestogens for 9 months. Till date 12 patients returned with a recurrence.

Histological report in all cases were confirmative of endometriosis with no malignant changes.

CONCLUSION

The incidence of scar endomatriosis in Eden Hospital is 0.35% of all gynaecological cases over the 10 year period and that of the operation of excision of scar endometriosis is 0.35% of all gynaecological operations.

Chatterjee (1980) reported an incidence of 1% of scar endometriosis among patients having hysterectomy and described associated pelvic endometriosis in 24% of 17 patients.

The etiology of endometriosis is an engima. With better understanding of the etiopathogenesis and the histological reponse to various treatment procedure, more statisfactory results will obtained.

ACKNOWLEDGEMENTS

We express our thanks and gratitude to the Head of Dept., Eden Hospital and the Superintendent of Medical College Hospital for allowing us to publish this paper.

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