Case Report
Received on 23.06.2016, **Accepted on** 04.07.2016

Indian Journal of Obstetrics and Gynecology
Volume 4 Number 3, September - December 2016
DOI: http://dx.doi.org/10.21088/ijog.2321.1636.4316.16

A Rare Case of Scar Endometriosis Presenting with Recurrent Wound Dehiscence after Seven Months of C-Section

Shikha Seth*, Neelam Swaroop, Vandana Verma***, Yasmeen******

Abstract

Endometriosis means presence of functioning endometrial tissue outside the uterine cavity. It can sometimes occur in previous surgical scar. Scar endometriosis is a rare entity and should be suspected if cyclical increasing swelling, nodularity, or pain is present following obstetrical and gynaecological surgeries in past.

We are reporting a rare case of scar endometriosis, which led to sudden scar dehiscence with bleeding after seven months of caesarean section and remained unhealed despite repeated attempts of wide excision followed by resuturing along with medical treatment. Finally pituitary downregulation was done with GnRH analogue and wound was allowed to heal by secondary intention.

Keywords: Endometriosis; Scar Endometrioma; Wound Dehiscence; Non Healing Wound.

*Professor, **Associate Professor, ***Assistant Professor, **** Resident, Dept of Obstetrics & Gynaecology, U.P. Rural Institute of Medical Sciences & Research (RIMS &R), Saifai, Etawah U.P., India 206130.

Shikha Seth,
Professor, Dept of Obstetrics & Gynaecology, U.P. Rural Institute of Medical Sciences & Research (RIMS &R), Saifai, Etawah U.P., India 206130.
E-mail: drseth_shikha@yahoo.com

Introduction

Commonly endometriosis remain confined to pelvis and has been reported to occur in as many as 44% of women undergoing laparoscopy. Extra-Pelvic endometriosis is defined as presence of endometrial tissue (glands & stroma) outside the pelvis which responds to hormonal milieu of the body, is fairly uncommon and often difficult to diagnose as we suspect it very late. The various sites for extra pelvic endometriosis are bladder, kidney, bowel, omentum, lymph nodes, lungs, pleura, umbilicus, abdominal wall & abdominal scars [1]. Although most of the time abdominal endometriosis develop in previous obstetric or gynaecological surgical scar (as caesarean, hysterectomy, myomectomy, episiotomy, amniocentesis needle tract, port scar in laparoscopy) but rarely it can have spontaneous occurrence also [2]. Diagnosis is initially confused with incisional granulomas, hernia or abdominal wall tumors. This is to familiarize with one rare presentation of the scar site endometriosis which was initially misdiagnosed as non healing wound. Risk factors for Scar endometriosis are caesarean section & other gynae surgeries, menorrhagia, alcohol consumption, primiparity etc [3].

Case Report

A 30 year old G4P4A0L1women presented to the gynaecology OPD with complaint of bleeding followed by infra umbilical vertical midline caesarean scar wound dehiscence after sevem months of surgery. On examination the upper half of scar skin and subcutaneous fat was found gaped with intact rectus sheath although no bleeding points, hemorrhagic or necrotic areas were found. Wound margins was found healthy and without any slough or infective discharge.

She had history of caesarean done seven months back for previous two caesarean section with scar tenderness. Post operative period was absolutely uneventful and she

was satisfactorily discharged on 8th post op day after total stitch removal. She reported for routine post natal visit after 6 weeks along with baby immunization and every thing was found well. She fully breast fed her baby and remained amenorrhoric for the first six months. She started weaning at sixth month and had her first period in the seventh month. Around the same time she had sudden pain in abdomen and landed up into wound gaping followed by bleeding from the wound site. She also had past medical history of epilepsy for which she was on sodium valproate 300mg twice daily and clobazam 5mg HS. There was no history of any convulsion episode in past 2 years. Her weight was 80kg and had BMI of 30.28.

Initially the relation of gaping with the start of menstruation was not taken seriously into consideration and thought of as coincidence. Wound was sutured under anaesthesia after removing the scared area. She remained well and went home after stitch removal on 10th day. After 15 days she again reported in outpatient department with bleeding and gaped wound. Few purplish foci seen near the base in the gaped midline infra umbilical wound which were bleeding (Figure1). This time also it corresponded with the menstruation and the scar endometriosis was suspected. This time wound margins were extensively excised to remove the area infiltrated with endometrial tissue and send for histological confirmation followed by resuturing and she was given depot medroxyprogesterone 150 mg IM for suppression of any remaining ectopic endometriotic lesion. But the wound refused to heal and she again reported after 15 days with gaping of middle third of the wound with multiple bleeding points, granulation tissue at the base and clear margins. Histology report suggested presence of endometrial cell foci in the excised scar. This time she was treated with CO 2 Laser vapourisation of the specific bleeding points along with GnRH agonist (Luprolide 3.75mg IM) and allowed to heal by secondary intention with regular wound care.

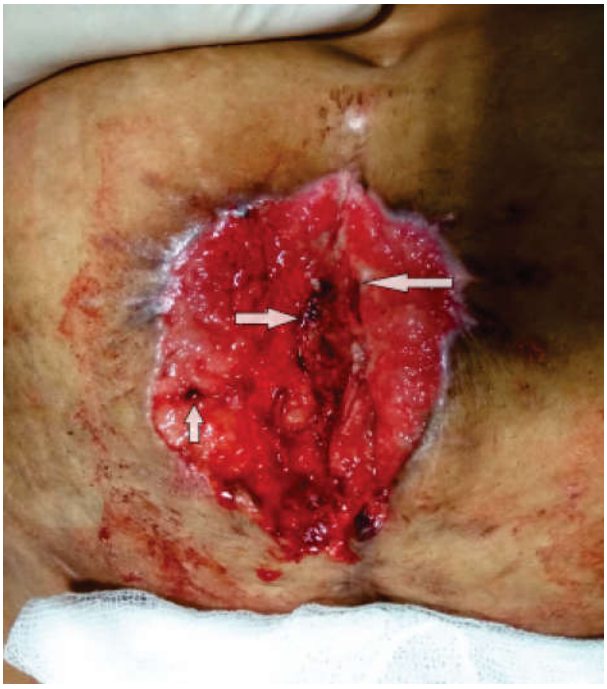

Fig. 1:

Discussion

Endometrioma is well circumscribed mass of endometrial tissue both gland and stroma along with the degenerating blood which collects during menstrual phase of cycle. Mostly abdominal wall scar endometrioma presents as painful swelling often mistaken as hematoma, granulomas, hernia, abscess or tumor.

Time interval between operation and presenting symptoms is not fixed and can vary from 3 months to 10 years. Etiology is transportation of endometrium during surgical procedures and subsequent stimulation by estrogen to produce emdometrioma. Incidence of scar endometriosis following hysterectomy is 1-2% whereas after caesarean section the incidence is low of 0.03 – 0.4% only [4].

The reason for higher incidence after hysterectomy is explained as the basal endometrium has more pleuripotential capabilities and can result in cellular replication compared to deciduas of the pregnancy for producing endometrioma Sonography can detect nonspecific solid hypo-echoic mass with scattered internal echoes in the abdominal wall near scar. Colour Doppler can contribute in diagnosis. CT & MRI (preferably) can be of much use in cases of small lesions due to their high spatial resolution and detection of abdominal wall planes [5]. Diagnosis can be confirmed only by histopathology. FNAC has been reported to be accurate but may not be 100 % sensitive. FNAC identified clusters of epithelial endometrial like cells, endometrial like stromal cells, and heaemosiderin laden macrophages in the lesion.

Treatment of choice as per literature is wide excision. Medical treatment by hormonal suppression or downregulation of Hypothalamic Pituitary Ovarian (HPO) axis, with the Progestogens, Oral contraceptive pills, Danazol, GnRH analogues is not much effective and gives only partial relief in symptoms. In our case, wound remained resistant to

heal even after wide excision twice and despite Depot Progesterone to suppress the ectopic endometrial tissue. Recurrence requires re-excision. In cases of continual recurrence possibility of malignancy should be kept in mind.

To prevent scar endometriosis it has been suggested that at the end of surgery specially caesarean section or of uterus or tubes the abdominal wall wound should be cleaned thoroughly [6]. Abdominoplasty and reconstruction with or without polypropylene mesh should be considered if defect is large due to wide excision [7].

One should suspect endometriosis in scar when women presents with pain & swelling along with past history of obstetric or gynae surgery. On literature search few case reports and case series has been found however, pathognomonic clinical symptoms of scar endometriosis were present in all of them, similar to our case but scar dehiscence after seven months of surgery which is not responding despite wide excision is never mentioned [4,8].

Conclusion

Scar endometriosis is rare and difficult to diagnose. It is often misdiagnosed. A high index of suspicion is recommended whenever a woman presents with cyclical symptoms of pain, swelling, bleeding from scar site after obstetric or gynaecological surgery.

References

1. Markham SM, Carpenter SE, Rock JA. Extra pelvic endometriosis. Obstet Gynecol Clin North Am 1989; 16:193-219.
2. Ideyi SC, Schein M, Niazi M, Gerst PH. Spontaneous endometriosis of the abdominal wall. Dig Surg 2003; 20:246-248.
3. N. S. Nominato, L. F. V. S. Prates, I. Lauar, J. Morais, L. Maia, and S. Geber, "Caesarean section greatly increases risk of scar endometriosis," European Journal of Obstetrics Gynecology and Reproductive Biology 2010; 152(1) 83–85.
4. Chatterjee SK. Scar endometriosis: A Clinicopathological study of 17 cases. Obstet Gynecol 1980; 56: 81-84.
5. Balleyguier C, Chapron C, Chopin N, Helenon O, Menu Y. Abdominal wall and surgical scar endometriosis. results of magnetic resonance imaging. Gynecol Obstet Invest 2003; 55:220-224.
6. Wasfie T, Gomez E, Seon S, Zado B. Abdominal wall endometrioma after cesarean section: a preventable complication. Int Surg 2002; 87:175-177.
7. A M Collins, K T Power, B Gaughan, A D Hill, and B Kneafsey. Abdominal wall reconstruction for large caesarean scar endometrioma. Surgeon 2009; 7(4) : 252–253.
8. Oh EM, Lee WS, Kang JM, Choi ST, Kim KK, Lee WK, A surgeon's perspective of abdominal wall endometriosis after a caesarean section incision: 9 cases in single institution. Surg Res Prac. 2014; (dx.doi.org /10.1155/2014/765372).