

# Incisional Endometriosis: Report of 3 cases

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## ABSTRACT

*Incisional endometriosis is an underappreciated phenomenon in general surgery. It may occur more commonly than believed. The preoperative diagnosis often mistaken with other pathologic conditions. Cases of three women are presented who had complaints of pain and abdominal mass alongwith prior history of caesarean section. In all patients surgical excision was done.*

*Key words* Endometriosis, Caesarean section, Scar.

## INTRODUCTION:

Incisional endometriosis is a well described clinical entity in gynecologic literature. Endometriosis was first described by Rokitansky in 1860. It was defined as presence of functional endometrium outside the uterine cavity; commonest site being the pelvis. Endometriosis is a common disease that involves up to 8 – 15% of women in the reproductive age group. Extrapelvic endometriosis is a fairly uncommon event but can affect many sites, including the lungs, appendix, umbilicus, peritoneum and even the intestinal wall.<sup>1</sup> It occurs after operation on the uterus and tubes.<sup>2</sup> Incidence following hysterectomy is 1.08-2% whereas after caesarean section incidence is 0.03-0.4%.<sup>3</sup> There is a case report of involvement of the rectus abdominis muscle in a virgin abdomen.<sup>4</sup> We report 3 cases where presentation was with a painful abdominal wall mass.

## CASE REPORT:

Three patients presented between January 2010 and March 2011. All had a caesarean section; otherwise, their medical histories were not significant. The 3 women aged 30 year, 32 year and 37 year had undergone caesarean delivery 2 to 3 years back. All patients described a sharp pain at the site of the mass, occurring most often a few days before their menses and persists as low grade pain for 10-15 days of their menses.

On physical examination, each patient had a firm, mildly tender but not warm, non reducible mass in the scar line which was not fixed with the

overlying skin but attached with underlying structures. The masses measured about 3 x 3 cm in 30-year-old woman, 2 x 2 cm in the 32-year-old and 3 x 3 cm in the 37-year-old woman. Other physical and per vaginal examination were normal in all the patients. Preoperatively diagnosis was confirmed by fine needle aspiration cytology (FNAC) in all cases. Each patient underwent surgical excision. All masses extended from subcutaneous tissue but not through the fascial layers and were completely excised. Postoperative recovery was uneventful in all the cases.

## DISCUSSION:

The presence of endometrium has been documented in many organs of the body. Its occurrence has also been documented in incisions of any type where there has been possible contact with endometrial tissue, including episiotomy, hysterotomy, ectopic pregnancy, laparoscopy, tubal ligation, and caesarean section.<sup>5</sup> Time interval between operation and presentation has varied from 3 months to 10 years in different series.<sup>6</sup> In our cases presentation occurred between 2 to 3 year after surgery.

The etiology of scar endometriosis is straight forward and involves direct inoculation of endometrial cells or placental cells into the wound during the surgical procedure. To prevent surgical scar endometrioma, thorough saline irrigation of the surgical site before wound closure is recommended.<sup>7</sup> It is hypothesized that failure to close the parietal and visceral peritoneum with sutures at the time of caesarean section may markedly increase the postoperative occurrence of an endometrioma in the incision scar. Furthermore, endometrial tissue can be transplanted and survive at ectopic locations.<sup>8</sup>

A high index of suspicion is recommended when a woman present with a postoperative abdominal lump.

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Good surgical and gynaecological histories, as well as thorough examination with appropriate imaging techniques, usually lead to the correct diagnosis. However, imaging technique was not used in our cases. Fine needle aspiration cytology has been used to confirm the diagnosis and may be helpful in eliminating malignancy. There is concern that needle aspiration has the potential to seed the needle tract with cells and cause recurrence. False negative results are also reported in literature.<sup>9</sup> In our patient, preoperative diagnosis was confirmed by FNAC.

Treatment of endometriosis is medical or surgical. Medical therapy with oral contraceptives, progesterone and danazol, has been reported.<sup>10</sup> This gives only temporary relief of symptoms and does not ablate the lesion. Recurrence of symptoms is typical when there is cessation of the drugs. Moreover due to side effects, compliance is unlikely. For scar endometriosis, total wide surgical excision is gold standard both for diagnosis and treatment. It is often necessary to remove a portion of the abdominal fascia to achieve complete excision. In patients where large defect remains, mesh has been used for repair. Recurrence has been reported and managed successfully with re-excision.

General surgeons are infrequently involved in the management of scar endometriosis. When the diagnosis is made on clinical grounds, no further studies are necessary before wide excision. In the presence of frequent recurrences, malignancy should be suspected, which carries a poor prognosis.

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