What a painful caesarean section scar can reveal?

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Introduction

The parietal endometriosis is rare. Due to its rarity as well as the possibility of an inaccurate diagnosis, Its impact is usually underestimated. This pathology's major risk is transformation into a clear cell carcinoma.

Objective :

This research aims to study the epidemiology, the diagnosis procedure and the treatment of parietal endometriosis through the collected cases in our unit.

Methodology and research tools:

The patients operated for parietal endometriosis were 5. The diagnosis was confirmed by a histopathologic examination.

Results

The average age of patients was 36 [32 to 40]. The average gestity of patients was 3.75, and their average parity was 3.25. All of the women had at least one caesarean section, two of them had 2 C-sections, and only one woman had 3 C-sections. The last c-section was as an emergency for two cases, and scheduled for the rest. Only one woman had an infection of the c-section scar. Symptoms started to appear in an average period of three years and three months after the last caesarean section [two months – six years]. The main symptom that women reported was a chronic pelvic pain at the c-section scar. Signs of deep endometriosis were absent in all cases except for a patient that had a primary infertility of two years followed by a secondary infertility of five years that wasn't explored.

The medical examination of 4 women revealed only one node on the surgical scar trajectory. However, it revealed 3 nodes for the fifth woman with the medical history of postoperative infection.

The average size of nodes was 17.5mm for the major axis. The ultrasound during menstruation indicated the existence of superficial subcutaneous node on the operative wound. It was heterogeneous hyperechoic avascular in 1 case and vascular in the other case, with peripheral microcyst aspect.

For 3 patients that had MRI, nodes had hyperintense signal on T1-weighted imaging even after fat suppression and hypointense signal on T2-weighted imaging without any deep endometriosis signs.

All patients had undergone surgery with wide excision. The outcomes were simple for four women, and complicated for the fifth due to an infection of the wound. The histological confirmation was systematic, and neither of the women had any malignancy signs.

Pain escalated progressively after surgery. All patients were relieved with long term surveillance from two years up to eight.

Discussion

Abdominal endometriosis are two types, parietal endometriosis and visceral endometriosis. The parietal localisation is one of the rarest, 0,03 to 3,5% of all localisations[1]. Women of reproductive age are the most concerned [2]. Risk factors is mainly a history of uterin surgery regardless of its indication [2,3]. The risk increases dependly on the surgical history : 2,7 after a cesarean , 1,5 after a laparotomy for gynecological surgery and 0,5 for laparoscopic surgery[2,3]. Manifestations are various but the most common are chronic pelvic pain, dyspareunia and a mass in the abdominal incision[1-4]. One pathognominal fact is the catamenial recurrence of these signs[1-4]. In general, the diagnosis is clinical, but ultrasonography may be helpful. The CT scan of MRI are used when the diagnosis is doubtful but MRI has a best definition of the anatomy of the soft tissue mass and its surrounding strutures therefore helpful to guide the excision of the lesion, which is necessary to avoid degeneration into malignant tumor[3,4].

Conclusion

In most of the cases, the parietal endometriosis diagnosis is difficult which systematically leads to a delayed medical care. The MRI helps diagnosing the pathology and plan more conservative surgery. An excision is necessary in order to eliminate the risk of clear cell carcinoma.

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