

A BIZARRE SURGICAL AFTERMATH

CAESAREAN SCAR ENDOMETRIOSIS TREATED WITH EXCISION AND MESHPLASTY

DR.L.SUKANYA¹, DR.NIDHI SHARMA¹,DR. SUDARSHAN .P.B²

¹DEPARTMENT OF OBSTETRICS & GYNAECOLOGY, ²DEPARTMENT OF GENERAL SURGERY
SAVEETHA MEDICAL COLLEGE AND HOSPITAL,INDIA

INTRODUCTION

Endometriosis is defined as the presence of endometrial like stroma and glands outside the uterine endometrial area. Scar endometriosis is a rare disease with non-specific symptoms like pain and swelling at the scar site especially during menstruation. The incidence¹ may vary between 0.03 to 0.1 % and the onset² may vary from 3 months-12 years.

CASE REPORT

32 years old multiparous lady, known case of diabetes, had two caesarean section previously in 2012 & 2015. Second Caesarean was done electively along with PPIUCD insertion and had superficial surgical site infection managed with antibiotics and resuturing done.

She was asymptomatic for 4 years and started developing small lump over right side of the scar site with pain and bleeding during menses from day 3 of menses for 5 days. With working diagnosis of scar endometriosis she was prescribed previously with NSAIDS and oral progesterones for 6months but discharge persisted despite conservative management done.

On examination:a hyperpigmented,hard indurated tender mass of 6*4cm present in the right side of scar site with 2mm orifice and chocolate brown fluid seen oozing from it. No other mass seen. Per speculum & vaginal examinations were normal.



FIGURE A



FIGURE B

FIGURES:
A- CECT-SOLID SOFT TISSUE MASS 2*8.3*3.4CM(CC*AP*TR) IN DEEP SUBCUTANEOUS PLAN OF ANTERIOR ABDOMINAL WALL EXTENDING TO DEEP MUSCULATURE OF RECTUS ADHERING TO ANTERIOR UTERINE WALL. COPPER T INSITU.

B-SCAR ENDOMETRIOSIS WITH EXTERNAL ORIFICE(POINTED BY ARTERY FORCEPS)

FIGURES:
C-SCAR ENDOMETRIOTIC TISSUE ATTACHED TO ANTERIOR SURFACE OF UTERUS

D-SUBLAY POLYPROPYLENE MESH

E-EXCISED TISSUE CONTAINING SCAR,ENDOMETRIOTIC TISSUE,RECTUS SHEATH AND MUSCLE

TREATMENT

WIDE EXCISION WITH MESH PLASTY

Scar excision by wide margins done by dissecting anterior and posterior rectus sheath and rectus muscle. Scar adhered to anterior uterine wall but no communication present.

Posterior rectus defect closure with 2-0 vicryl and 15*15cm polypropylene **sublay mesh fixation** with trans abdominal repair done on both sides and drain placed followed by rectus muscle and sheath closed.15*15cm trulene mesh placed as **onlay mesh** and another drain placed.

HPE: Features consistent with scar endometriosis showing foci of endometrial tissue composed of tubular and cystic dialted glands surrounded by endometrial stroma.

Postoperative period managed with antibiotics , sugar control and clean dressing.

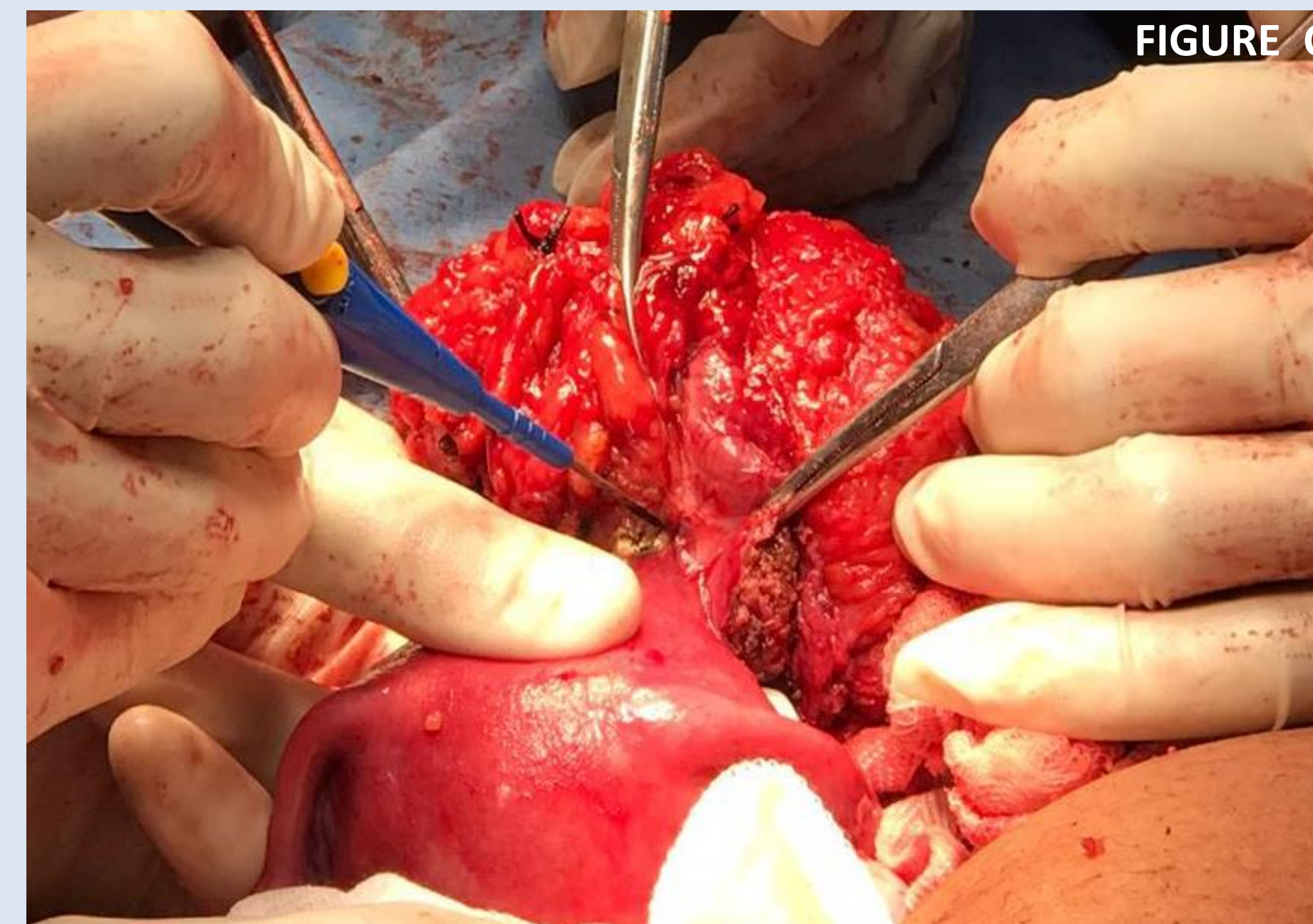


FIGURE C

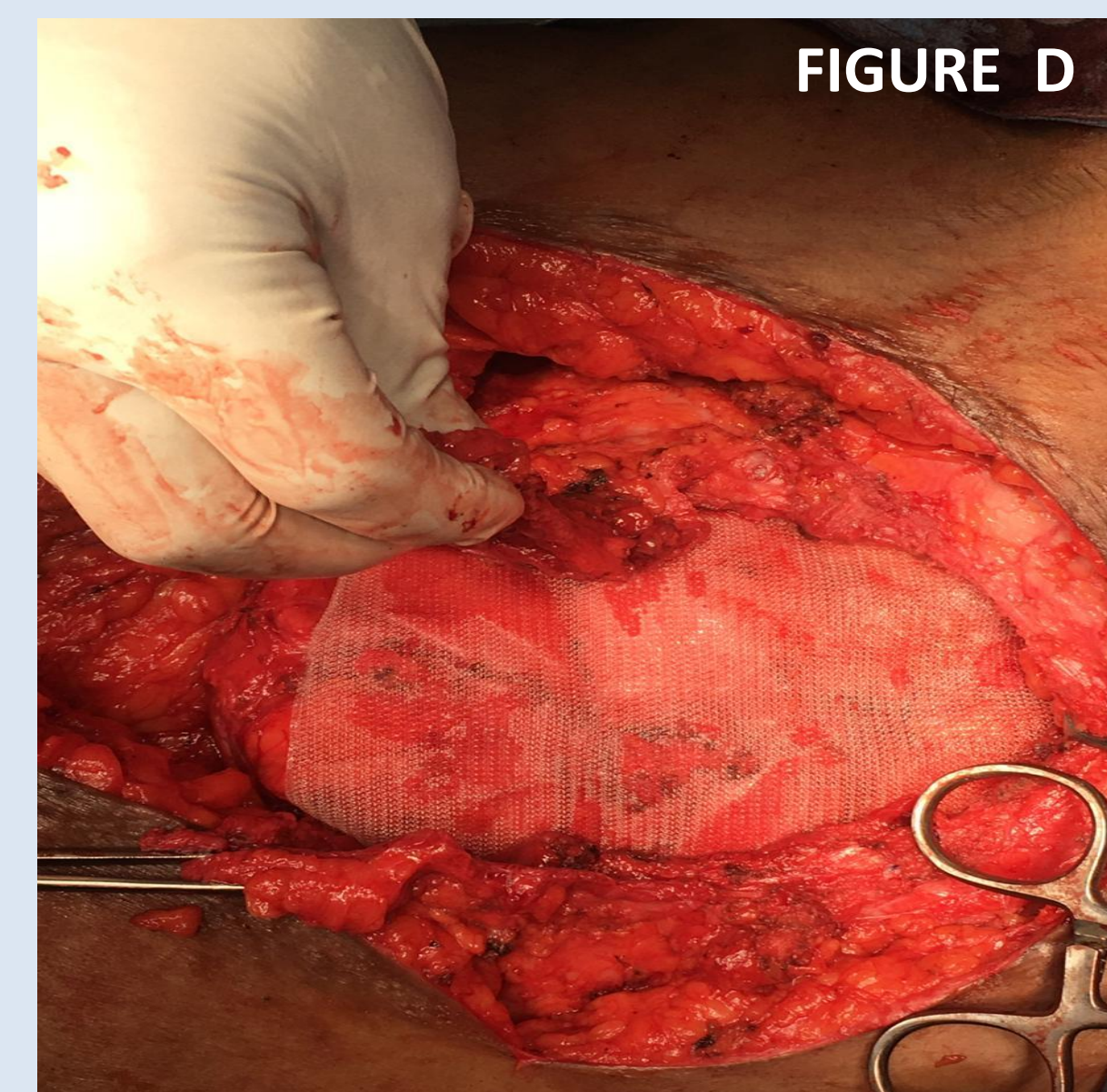


FIGURE D

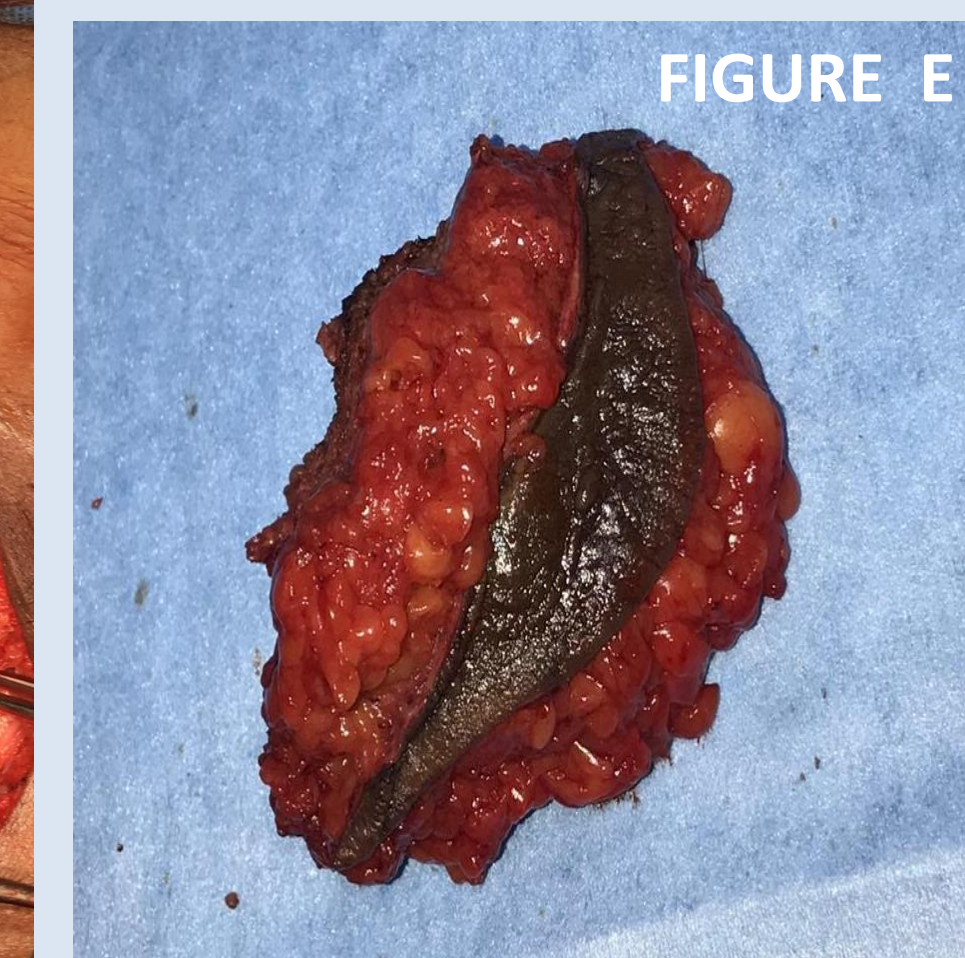


FIGURE E

DISCUSSION

Direct mechanical implantation seems to be the most plausible theory for scar endometriosis. During caesarean section endometrial tissue might be seeded into the wound and proliferates under hormonal influence. When a proper pre diagnosis cannot be achieved, it can be easily mixed with other conditions like hematoma, neuroma, hernia, granuloma, abscess, scar tissue, neoplastic tissue, or even metastatic carcinoma. Correct preoperative diagnosis is achieved in 20% to 50% of these patients³

Local wide excision, with at least a 1 cm margin, is accurate treatment of choice for scar endometriosis. As expected, the larger and deeper lesions to the muscle or the fascia are more difficult to excise completely and may entail a synthetic mesh placement ⁴ or tissue transfer for closure after resection as done in the index case.

CONCLUSION

Frequency of scar endometriosis increasing by induced number of cesarean sections and laparoscopy performed in recent years. A proper history and physical examination during menses can help in arriving at a diagnosis. A wide local excision is the mainstay treatment. Prevention of scar endometriosis can be done by excluding the decidua while closing the uterus and using different mops & needles for different layers during closure of abdomen.

REFERENCES

¹Wolf GC, Singh KB. Cesarean scar endometriosis: a review. Obstet Gynecol Surv. 1989

²Barisic GI et al.Perineal endometriosis in episiotomy scar with anal sphincter involvement. Int Urogynecol J Pelvic Floor dysfunction,2006

³ A. S. Sevdal et al.“Extrapelvic endometriosis: diagnosis and treatment,” The American Journal of Surgery, 1993

⁴ G. K. Patterson and G. B. Winburn, “Abdominal wall endometriomas: report of eight cases,” American Surgeon, 1999.