Case Report

# Hysterotomy scar endomertiosis- Case report and review of literature

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**Abstract**

**Background:** Endometriosis is a chronic gynecologic disorder where the functional and morphological endometrial glands and stroma are present outside the uterine cavity. Although it is benign in nature but can locally spread and disseminate. Its major site are urinary bladder, bowel, lungs, pleura, omentum, ovary, lymph nodes and abdominal wall.
**Key Word:** Hysterotomy scar endometriosis.

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## INTRODUCTION

Karl Von Rokitansky was the first to describe the term endometriosis. It is a chronic gynecologic disorder where the functional and morphological endometrial glands and stroma are present outside the uterine cavity.[1] It generally effects women of reproductive age group. Although it is benign in nature but can locally spread and disseminate. Its major site are urinary bladder, bowel, lungs, pleura, omentum, ovary, lymph nodes and abdominal wall. It may present over scar in abdominal wall as scar endometriosis. This happens due iatrogenic implantation of endometrial tissue into the wound which later proliferate under the effect of female hormones. Complete wide local excision of the tissue is required.

## CASE PRESENTATION

A 37-year Indian female P3 L2 A1, came with complain of painful abdominal scar. The pain increases during menstruation. There is no discharge from it. She had history of hysteroma due to failed MTP 5 years ago. she is otherwise healthy without any drug and allergy history. Family history was non-significant. Physical examination done during non menstruation phase revealed that the patient was conscious, oriented, vitally stable. On per andominal examination abdomen was scaphoid with thoraco abdominal respiration, a vertical scar present on hypogastium with pigmentation in it. abdomen was soft, non-tender, lump was present in hypogasrtuim 3 cm x 2.5 cm x 2 cm over scar, with no local rise of temperature, non-tender, irregular surface, ill-defined margin, firm, mobile with decreased mobility on leg raising, no Organomegaly. (FIG.-1)

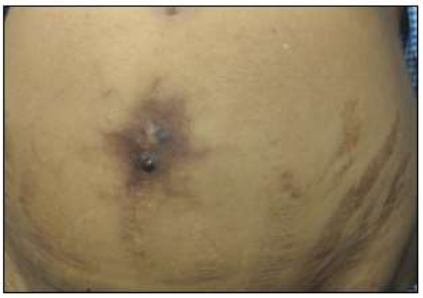

**Figure 1**

Ultrasonography revealed hypo echoic lesion with ill-defined margin of size 3.2 x 2.6x 2.0 cm in anterior abdominal wall infra umbilical region at the level of scar. On color doppler it shows hypo vascular lesion. Patient operated in non-menstruation phase. Intra operatively it shows a 4.5 x 3.5 x 3 cm lump adherent to scar anteriorly and anterior rectus sheath.

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FIG 1: Clinical photograph of. and few fibers of rectus abdominus inspectory findings muscle. It also showed sangria red discharge from specimen. Wide local excision was performed and rectus sheath is sutured and mesh is fixed with non-absorbable sutures. A negative suction closed wound drain kept and wound closed in layers. Procedure went uneventful. The sample was send to histoplathological examination. After 8 days of surgery, sutures were removed and wound healed adequately.

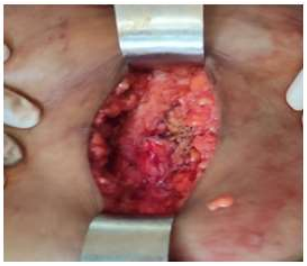

Figure 2

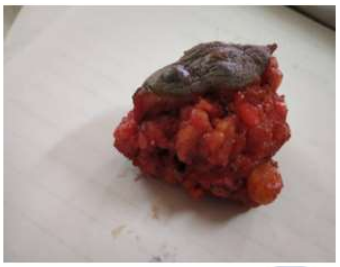

Figure 3

**Figure 2:** After wide local excision.

**Figure 3:** Specimen with skin and scar.

Histoplathological report reveals that on gross examination of specimen shows skin covered fibro fatty tissue and in cross section there were multiple tiny cystic cavities filled with blackish material. Microscopy sows lining of keratinized squamous epithelium. underneath shows adnexal stroma. Dermis shows round tubular dilated endomentrial glands surrounded by compact stroma along with hemorrhage and inflammation composed of lymphocyte and neutrophils. This gives an impression of scar endometriosis.

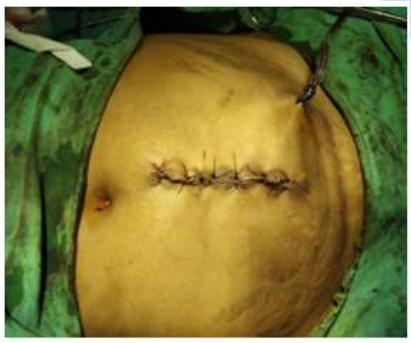

**Figure 4:** After excision

Figure 5

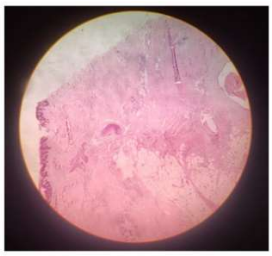

Figure 6

## DISCUSSION

Scar endometroma is rare disease for both surgeons as well as gynecologist. gyancal surgeries are usually the precipitating factor in which hysterectomy (2%) and cesarian section (0.4%) are the most common ones.[1]The accepted theory of mechanical implantation of endometrial tissue and this latter proliferate in response to female hormones. Endometrial tissue may have ability to implant and transplant during pregnancy. Hence hysterotomy for early abortion is a risk factor for developing scar endometriosis.[2] However Ideyi, S.C. *et al.*, reported case of endometroma in a scarless patient suggesting complex pathologenis in its development.[3] the period between surgery and presentation varies from months to years. P Goel.*et al.* found the median period of 2 years between surgery and presentsion[4] Patients presents mass over scar of previous surgery scar, which painful usually cyclic colicky pain. Generally, there is history of previous gynecological surgery sometimes nongynecological.[2] The preoperative diagnosis was confirmed by history, Examination, ultrasonography and FNAC from lump[5] in our study both FNAC and Ultrasonography was not diagnostic. the usg festures of scar endometroma(i). a hypoechoic inhomogenous echoexture with internal scatterd hyperechoic echoes. (ii) regular margis often infiltrated adgescent tissue . (iii) a hyperechoic ring of variable width an continuity.According to Sandeep *et al.* FNAC can be diagnostic in doubtful cases.[6] Drugs like oral contraceptive pill, progestogens and GNRH analogues may reduces symptoms , with recurrence after cessation of therapy.[1] Surgical treatment offers the best chance for both making a definitive diagnosis and treating this.[7] surgical excision done with 1 cm margin. In our case, there is infiltration to the rectus abdominus muncle hemcw after excision the defect is closed and polypropylene mesh is placed. In study of Vaz-de-Macedo C *et al.* the cases were operated and excision with polyproplelne mesh closure was performed.[8] Scar endometriosis is rare but is often painfull effecs the daily life of the patients. Hence thouough history, examination should be done and scar endometromma should be kept as a differential diagnosis.

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