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A Case Report of Cesarean Scar Site Endometriosis: Diagnosis and Management

Medhat Monir K Fadel[1], Mariam Sherif S Zaki[2]

[1] Department of Reproductive Health and Family Planning, National Research Institute,[2] Department of Occupational and Environmental health, Benha University, Qalyubia, Egypt.

Corresponding author: Medhat Monir K Fadel, Email: medhat.fadel@nhs.net

ABSTRACT

Endometriosis is a frequent clinical problem in women of reproductive age, which means the presence and proliferation of endometrial glands and stroma outside the uterus, the most common site of endometriosis is in the pelvic cavity, extra pelvic endometriosis as on the surgical scar (as caesarean section, laparoscopic incision, episiotomy, and hysterectomy scars) which is relatively rare, it is clinically presented by chronic pelvic pain, dysmenorrhea, dyspareunia, subfertility, infertility, and poor both maternal & fetal outcomes and even stillbirth. Caesarean section endometriosis is presented with cyclic pain and bleeding from the scar site. Our 33- year case presented with a scar site endometriosis after the third Cesarean section. MRI was done to exclude uterine fistula and a definite diagnosis has been made by histopathology. Management involved different modalities of treatment including medical management, Mirena coil insertion. However, the definite treatment was surgical excision of the endometriotic lesion and reclosure of the skin incision.

Keywords: Endometriosis, Caesarean section, scar, management.

INTRODUCTION

Endometriosis, which means the presence and proliferation of endometrial glands and stroma outside the uterus, the most common site is the pelvic cavity, extra pelvic endometriosis which is relatively rare, endometriosis on the surgical scar tissue is the common example which can occur after hysterectomies, episiotomy, laparoscopic procedure and after Caesarean sections. [1,2]. Endometriosis is a frequent clinical problem in women of reproductive age which affects 5–15 % of them [3]. Abdominal wall endometriosis (which is commonly on the Cesarean scar) is the most common type of extra pelvic endometriosis, with a reported incidence of 0.03–3.5 % [4-6] .it is characterized by the presence of endometrial tissue in the subcutaneous muscles-fascia layer following cesarean sections [7]. endometriosis is usually clinically manifested with chronic pelvic pain, dysmenorrhea, dyspareunia, subfertility as about 30%- 50% of patients have difficulty in getting pregnant, poor maternal and maternal outcomes, and even stillbirth [8,9].

As the diagnosis of endometriosis is difficult, it is only confirmed by pathology, the gold standard diagnostic tests are laparoscopy and biopsy; however, most accurate noninvasive diagnoses are magnetic resonance imaging (MRI) and transvaginal ultrasound for the detection of deep endometriosis with 83%-91% sensitivity and 98% specificity, respectively [10,11].

CASE REPORT

33 years old, 6 months post-delivery by Cs. It was her third delivery and she had two previous Cs. The last Cs was technically difficult, and it was complicated by extensive adhesions. postoperatively on day 4 there was wound infection and gapping of the wound which has been treated successfully by broad-spectrum antibiotics: Co-Amoxiclav for 1 week.

6 months post-delivery she started to have menses, menses were very painful not as usual before, and in the first two months, she observed pain in the uterine scar and a change in color of the scar to blue. In the third month, she started to develop bleeding from the scar site. The bleeding was only during the time of menses and it was associated with pain in the scar site and painful menses. the pain was so severe that it required twice admission to the hospital to control pain. The bleeding from the wound was dealt with as wound infection, broad-spectrum antibiotics were administrated three times: two during the hospital admissions and one with the local GP. Many wound swabs have been done with no significant growth. The characteristic feature was the dramatic improvement of symptoms after stopping menses. This raised suspicion about the nature of the lesion. The primary impression was the presence of uterine fistula: connection of the endometrium with the skin, U/S scan and MRI have been requested, no abnormality could be detected apart from a chocolate cyst in the right ovary suspecting endometrioma.

Hysteroscopy and laparoscopy have been arranged: Hysteroscopy does not show any abnormality in the uterine cavity. The laparoscopic examination was very limited because of extensive adhesion around the lower uterine segment.

IUS: Mirena coil has been inserted, it controlled the painful menses, however it causes unexpected spotting which was not acceptable by the patient. Therefore, it has been removed. A trial of using GnRH analogs was made to control the symptoms. It has been tried for six months, during which it causes dramatic relief in her symptoms, complete stopping of menses and pain.

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Three months after stopping the GnRH injection, she started to regain painful menses, and bleeding from the wound site was recurrent again.

The decision was made for surgical exploration of the wound: a small mass of vascular tissue 3* 3 cm has been removed from the subcutaneous tissue in association with the overlying skin, and space was closed. Exploration of the whole scar was made which does not reveal any fistula, the rectus sheath was closed and healed. The tissue has been sent for histopathology which revealed endometriotic tissue in association with fibrous tissue.

In the next two months: No bleeding or pain from the scar site, however, symptoms of painful menses were still present.

Mirena Coil has been inserted again after 2 months postoperatively. It controlled the painful symptoms and the monthly spotting became more tolerated by the patient.

DISCUSSION

Endometriosis is a very common gynecological problem that affects more than 10% of the women in the childbearing period. It is characterized mainly by cyclic abdominal pains during menstruation. most of the lesions of endometriosis are in the pelvis, mainly in the pouch of Douglas, ovaries, or around the tubes. However, some lesions can be presented in remote areas and it is not uncommon to find lesions in the lung, liver, GIT [1].

The definite treatment of endometriosis is local excision; however, it may be not applicable in many cases due to surgical difficulties.

Medical treatment can represent a good alternative to surgery, COC, POP, Depot Provera, Mirena coil, and GnRH analogs represent the main modality of management in moderate to severe endometriosis, while analgesics can be used in mild cases.

The main problem of medical management is the high recurrence rate after stopping, the side effects and it is interference with fertility [12].

In the reported case above the medical management, options were not successful due to side effects, however, it has been used as complementary therapy after successful surgical management.

The definite diagnosis of endometriosis should be made by examining the tissue histologically to confirm the presence of active endometrial tissue outside the endometrial cavity [13].

CONCLUSION

Scar site endometrioma should be considered as one of the differential diagnosis in the presence of suggestive symptoms for it. The definite treatment of it is surgical excision of the endometriotic lesion.

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