

## CASE REPORT

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### A RARE CASE OF SCAR ENDOMETRIOSIS FOLLOWING EPISIOTOMY

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**ABSTRACT:** Endometriosis is defined as ectopic presence of endometrial glands and stroma. It mainly affects pelvic peritoneal surfaces, ovaries and uterine ligaments. Even it can rarely affect vulva, vagina or perineum secondary to obstetric and surgical trauma. We are presenting a case of scar endometriosis following episiotomy in a woman with a positive history and classical physical findings who underwent wide surgical excision. The recovery was good with excellent functional results. The optimal management is wide surgical excision with additional tissue pathology to reduce recurrence and rule out malignancy.

**KEYWORDS:** Cesarean section, Episiotomy, Endometriosis, Scar.

**INTRODUCTION:** Endometriosis is defined as extrauterine presence of functioning endometrial glands and stroma. It causes sterility and bothersome pain when localized intraperitoneally and extraperitoneally respectively.

In 1903 Robert Mayer through Bytom study first described endometriosis in postoperative scar.<sup>1</sup> Various theories have been involved in the etiopathogenesis like retrograde menstruation, immunologic, inflammatory, hormonal, coelomic, lymphatic and genetic. The extra peritoneal sites are mainly abdominal scar but also are seen in rarely in episiotomy scar, bowel, bladder, lungs, kidneys, brain, umbilicus and groin.<sup>2</sup> Cutaneous endometriosis in operative scars is rare.<sup>2,3</sup>

Clinical diagnosis is often confusing so it should be differentiated from hematoma, abscess, suture granuloma, desmoid tumour, soft tissue sarcoma and metastatic cancer.<sup>2</sup> It is usually diagnosed by clinical symptom of a slow growing lump in the scar or nearby area which is painful during menstruation. Sometimes it is associated with cyclic bleeding.<sup>2</sup> We present a rare case of endometriosis at the episiotomy scar who had complaints of cyclical pain.

**CASE HISTORY:** A 25 year old primipara presented to us with pain and swelling in the perineal region. She had progressive and cyclical pain coinciding with her menstruation. She had taken several antibiotic courses but had no relief. Pain was severe that it was preventing her from sitting, coitus and performing day-to-day activities. She had a history of vaginal delivery 2 years back with a left mediolateral episiotomy scar. She had complaints of pain in episiotomy site after six month and noticed swelling over perineum after 1½ of her delivery.

On examination there was a firm palpable nodule measuring 4x2 cm size at her episiotomy site. Internal examination was normal. She was planned for excisional biopsy for confirmation of diagnosis.

Wide excision was performed under spinal anesthesia. Grossly the swelling had small cysts and few areas with dark chocolate brown colored material. The boundary was not clear. The histopathological examination had ectopic endometrial glands with surrounding cellular stroma and

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squamous epithelium of vaginal wall. Post-operative period was uneventful. The patient was discharged on 7<sup>th</sup> day and followed up after 3 months with symptom free period.

**DISCUSSION:** The incidence of episiotomy scar endometrioma is less as compared to cesarean section scar.<sup>2, 3</sup> The etiopathogenesis of localization in surgical scar is related to the iatrogenic implantation during delivery or surgery. It is a steroid dependent condition with a peculiar genetic background.<sup>4</sup> Hormonal and immunologic factors play role in its pathogenesis. Transport theory suggests endometrial cells transport to distant location during surgery or any other procedure. 0.74% cases of perineal endometriosis were seen in episiotomy scar.<sup>4</sup>

The extraperitoneal sites are rarely involved.<sup>5</sup> It confirms that extra pelvic form is due to complication of surgery.<sup>6</sup> The incidence of scar endometriosis is 0.2% with CS as compared to 0.06% with vaginal delivery is reported in a large study series.<sup>7</sup> Cyclical symptoms of pain and bleeding at scar site is practically pathognomic in a woman with a prior history of surgery on the uterus.<sup>8</sup> Bothersome pain is due to involvement of sensory nerve fibers in deep infiltrating lesions. With classical history and physical examination, no other diagnostic tools are required. However confirmation with USG+Doppler, CT, MRI and Epiluminescence microscopy for superficial lesions to exclude melanoma can be done. FNAC though easy and good but carries the risk of dissemination.

Wide local excision is considered as the gold standard for both diagnosis and treatment.<sup>8</sup> The resection must be complete with clear margins to prevent recurrence and the potential risk of malignant transformation.<sup>8</sup> There were 8 from 33(24%) recurrence in 19 months after excision.<sup>1</sup> In wide excision a narrow incision has high recurrence rate.

**CONCLUSION:** Scar endometriosis though rare, any woman with a positive history and classical findings must be treated in time if interfering her routine. A general physician approach may delay the appropriate diagnosis. With no burden of expensive diagnostic tools but few, recently introduced, less invasive tests at molecular level can thus help a woman cure of her disease at earliest.

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**Fig. 1: Intra operative photograph showing**



**Fig. 2: Intra operative photo showing after excision of scar endometriosis.**



**Fig. 3: Photo showing scar endometriosis specimen**

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