

## **Abdominal scar- Endometriosis**

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**We report a case of abdominal wall endometriosis which usually occurs in the surgical scar of previous cesarean sections. This condition often presents as a mass with cyclical pain and swelling. The definitive diagnosis was established by histopathological examination. The patient was premenopausal with no history of pelvic endometriosis. The management was adequate excision to prevent recurrence.**

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Endometriosis is the presence of endometrial tissue (uterine internal lining) outside the uterus<sup>1</sup>. The true incidence of endometriosis is not really known, but it is thought that 10-15% of all women in their reproductive age will develop endometriosis and 25-35% of all women who are infertile have endometriosis<sup>1</sup>.

The risk of this disease is seven times greater if a mother or sister had the disease<sup>1</sup>. The cause is unknown but it was attributed to retrograde menstruation theory, hematogenous or lymphatic distribution to other parts of the body, genetic theory, surgical transplantation and dioxin exposure<sup>2</sup>.

Mostly, endometriosis is asymptomatic, some may have extensive disease and have no pain, whereas others with only minimal disease may experience severe pain. Symptomatic cases may complain of dysmenorrhoea, dyspareunia, infertility, fatigue, painful micturition and defecation during periods<sup>2</sup>.

Abdominal wall endometriosis usually occurs after pelvic operations such as cesarean section, tubal ligation and hysterectomy<sup>4</sup>. Endometriosis should be included in the differential diagnosis of women presenting with swellings related to umbilicus, surgical scar, inguinal canal and pelvis, especially if the symptoms are cyclical<sup>6</sup>. Treatment of endometriosis is medical (contraceptive pills, Danazol) or surgical (Laparoscopy and Laser surgical resection)<sup>1</sup>.

### **THE CASE**

A thirty two year old Bahraini lady complained of swelling in the caesarean

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section(LSCS) scar of 3-4 months duration. The swelling was gradually increasing in size and was associated with cyclical pain. The patient had undergone caesarean section 3 years ago.

On clinical examination there was a hard, round mass, 2 x 1 cm with mild tenderness at the right lateral edge of the LSCS scar. The differential diagnosis was implantation dermoid cyst or foreign body granuloma. Excision of the mass was done and the histopathological findings revealed features of endometriosis associated with non specific organizing inflammation. Ultrasound of the pelvic showed no abnormality.

## **DISCUSSION**

The frequency of endometriosis in and around the surgical scar of caesarean section is 0.03%-0.04% to 0.8% in some reports<sup>3</sup>. Diagnosis of scar endometriosis should involve detailed history taking and pelvic examination.

The role of needle aspiration cytology is still controversial. Pre-surgical diagnosis may be difficult as it needs to be differentiated from hernia, hematoma, granuloma and tumours. Sonography and fine needle aspiration cytology can be used but it is usually diagnosed by surgical excision<sup>3</sup> and histopathological examination.

Several prophylactic procedures have been proposed to prevent residual contamination of the wound. Complete surgical excision including the adjacent fascia or skin is the proper treatment<sup>5</sup>.

In our case the definitive diagnosis was established by excisional biopsy. Our patient was premenopausal with no history of pelvic endometriosis. The cause in this case was surgical transplantation. The management was adequate excision to prevent recurrence.

## **CONCLUSION**

**Endometriosis should be included in the differential diagnosis of lumps related to a surgical scar, inguinal canal and pelvis, especially if symptoms are cyclical. Usually surgical excision is adequate management as in our case but selected cases require gynecological referral and further medical therapy<sup>6</sup>.**

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