Incisional endometriosis: a report of 3 cases

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CASE REPORT

The 3 patients presented between September 2006 and May 2007. Each patient had had a cesarean section; otherwise, their medical histories were not significant. The 32-year-old woman had undergone surgery 5 years, the 22-year-old 3 months and the 30-year-old 12 months before presentation. Each patient described a sharp, rarely radiating pain at the site of the mass, occurring most often a few days before their menses. None had a history of endometriosis. On physical examination, each patient had a firm mass and restricted mobility along the right superolateral aspect of the cesarean section scar. The masses measured about 3 × 2 cm in the 32-year-old woman, 1 × 1 cm in the 22-year-old and 2 × 2 cm in the 30-year-old. Other findings from physical examination were normal in all patients. Each patient underwent surgical excision. All 3 masses extended from subcuticular tissue but not through the fascial layer, and they were easily excised. The histopathology report for each specimen confirmed a diagnosis of endometriosis (Fig. 1 and Fig. 2). Each patient recovered uneventfully.

DISCUSSION

Incisional endometriosis is an underappreciated phenomenon in general surgery. The literature indicates that cesarean section scar endometriosis is very rare; however, it may occur more commonly than believed.

In most patients, surgical scar endometriosis involves a painful mass that becomes swollen and more tender before menses. In the literature, the mean size of masses has been 3.1 (range 1.5–4.8) cm. Patients may present from months to years (mean 21 mo) after their last obstetric/gynecologic surgery. In our patients’ cases, presentation occurred 5 years, 3 months and 12 months after surgery, respectively.
It is hypothesized that failure to close the parietal and visceral peritoneum with sutures at the time of cesarean section may markedly increase the postoperative occurrence of an endometrioma in the incision scar. Furthermore, endometrial tissue can be transplanted and survive at ectopic locations.1

Therapy with oral contraceptives, progestins, medroxyprogesterone acetate and gonadotropin-releasing hormone agonists has been tried with minimal success.2 In some patients, the effects can be relatively long-lasting, but complete, permanent regression of endometriosis is rare with medical therapy. For cutaneous endometriosis, total surgical excision is considered to be the gold standard for both diagnosis and treatment. Resection must be complete with clear margins to prevent recurrence.

CONCLUSION

Cesarean section incisional endometriosis is very rare and difficult to diagnose. In addition, it is an underappreciated phenomenon in general surgery, so it may be more common than reflected in the literature. Familiarity with its signs and symptoms will increase awareness of this disease. Endometriosis should be included in the differential diagnosis of abdominal scar lesions following gynecological operations. A mass involving cesarean section scars with symptoms intensifying before each menses is almost pathognomonic. Medical treatment may decrease symptoms for some time; however, to provide both diagnostic and therapeutic intervention, surgical management is the best choice.

References


Fig. 1. Endometrial stroma and gland structures in fibroadipose tissue in a 30-year-old woman (hematoxylin and eosin stain, original magnification ×400).

Fig. 2. Endometrial stroma and gland structures in fibroadipose tissue in a 32-year-old woman (hematoxylin and eosin stain, original magnification ×400).