

Endometriosis in a Caesarean section scar

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ABSTRACT

Scar or incisional endometriosis is a rare condition and often difficult to diagnose. The symptoms are non specific and often confused with other pathologies. Rarely endometriosis occurs in an abdominal wall scar after a caesarean delivery. A case of 37 year old woman is presented who developed endometriosis at the caesarean section scar done four years back. A clinical diagnose of endometriosis was made. The mass was removed completely and histopathology of the surgical specimen revealed endometriosis.

KEY WORDS: Endometriosis, Caesarean section.

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INTRODUCTION

Endometriosis is the presence of endometrial-like tissue outside the uterine cavity, which induces a chronic inflammatory reaction. It can occur in various pelvic as well distant sites outside pelvis.

Extra pelvic endometriosis has been described almost everywhere in the body including the central nervous system (CNS), lungs, pleura, kidney, and bladder.¹ Abdominal wall endometriomas often develop in previous surgical scars. The reported incidence is 0.03-1.7 percent² while the incidence of abdominal wall endometriosis following caesarean section which is said to be a rare entity is quoted to be 0.03-0.47%.³⁻⁶

The etiology of abdominal wall endometrioma is thought to be a result of transportation of endometrial tissue during surgical procedures and subsequently stimulated by estrogen to produce

endometriomas.⁷ If present in the scars, the patients may present with non- specific symptoms such as abdominal wall pain at the time of menstruation and a palpable subcutaneous mass near surgical scars.

Clinical examination may reveal a painful nodule. Preoperative diagnosis is difficult to make and sometimes the diagnosis is made after excision only. Diagnostic methods available are computed tomography, magnetic resonance imaging, ultrasound, and fine needle biopsy.⁸ All have been used with varying degrees of success precision and accuracy to establish the diagnosis of scar endometriosis. Most of the Imaging techniques are nonspecific and vague and needle biopsy may confirm the diagnosis. Wide excision is the treatment of choice for abdominal wall endometrioma as well as for recurrent lesions.⁹

We present a case of abdominal wall endometriosis, which developed in the scar of Caesarean section.

CASE REPORT

A 37 year old woman Para 4+0 came to the outpatient department of the Kharader general hospital with the complaints of pain and swelling at the scar of lower segment caesarean section which she had undergone three years back due to fetal distress. All her previous deliveries were normal vaginal deliveries except the last one. She started to develop pain at the site of scar two years back, the pain was initially mild and dull but gradually increased in intensity with time. Along with the pain she noticed

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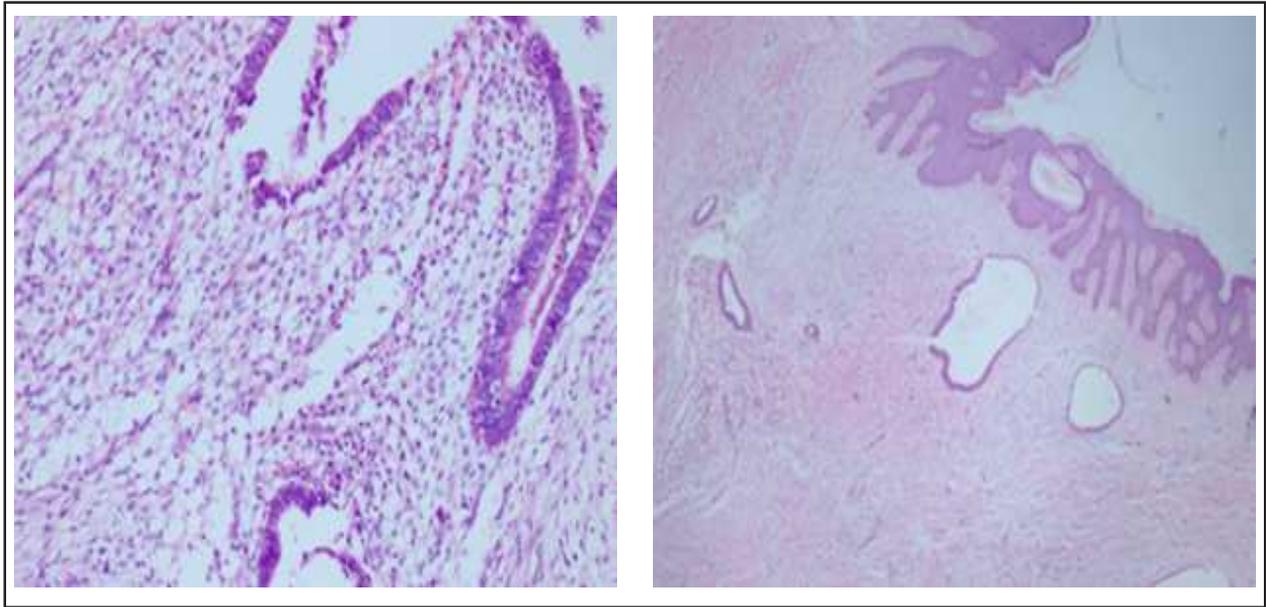


Figure-1 & 2: Section of endometriosis show both well-developed glands and stroma in fibrofatty tissue. (Hematoxylin-eosin stain)

a small lump at the left lateral edge of scar for the last one and half year. The swelling also got bigger in size and became more painful especially during periods. She was also noticing change in the color of the swelling at different time of the month and some oozing of blood from the swelling during periods.

On examination, she was a healthy looking woman in good health. There was soft to firm mass about 4x3 cm size at the outer border of the scar. The mass was red in color and tender to touch. Rest of the scar looked normal. Sonographic examination of the abdominal scar showed a hypo echoic mass, with internal echoes, infiltrating the subcutaneous fat, extending up to the sheath of the rectus abdominals muscle. Initially she was kept on continuous oral contraceptive pills to relieve her symptoms and to see the changes in the lump. On subsequent visits the scar was seen to be slightly decreased in size and her pain was relieved. On the basis of history, clinical examination and behaviour of the lump with oral contraceptive pills a presumptive diagnosis of endometriosis was made. The lesion was removed surgically under general anaesthesia. It was found extended from skin up to the external oblique aponeurosis. The histopathology of the surgical specimen revealed presence of endometrial glands and stroma suggestive of endometriosis.

DISCUSSION

Extra pelvic endometriosis is rare. However, it should be suspected in any woman of childbearing age complaining of a cyclic painful nodule in a scar from a previous obstetric or gynaecologic procedure. This condition is often confused with other surgical conditions¹⁰, such as inguinal hernia, incisional hernia and abdominal wall tumor.⁹ The endometriotic lesions are hormone dependant and tend to bleed with each menstrual cycle, becoming more congested and larger in size, with patients feeling cyclical pain and discomfort. Time interval between operation and presentation has varied from three months to 10 years in different series.¹⁰

The diagnostic methods described such as transvaginal ultrasonography and computed tomography may be useful in case of lesions on the abdominal wall, or if the nodule is large, but give no specific results. MRI enables very small lesions to be detected and can pick the presence of hemorrhage in the endometriotic lesions. Fine needle biopsy can be used to identify endometriosis before surgery. The diagnosis is frequently made only after excision of the lesion. Scar endometriosis can be treated medically by hormones such as progesterone but the success rate is very low with high recurrence rates.⁷ Wide excision is the treatment of choice for abdominal wall endometrioma as well as for recurrent lesions.⁹

CONCLUSION

An abdominal wall endometrioma needs to be considered in the differential diagnosis of any woman of reproductive age presenting with a painful abdominal wall mass and a history of uterine surgery via an abdominal incision.

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Dyslexia: The faceless threat of patient safety in clinical chemistry laboratories

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The Greek word dyslexia means poor language. The World Federation of Neurology defines dyslexia as “a disorder manifested by difficulty in learning to read despite conventional instruction, adequate intelligence and socio-cultural opportunity”.¹ Dyslexia can be either hereditary or acquired with prevalence rates ranging from 5 to 10 percent to 17.5 percent.^{2,3} The hallmark of dyslexics is transposing letters and or numbers (i.e., reading the relative formula of the genius Albert Einstein as 2CM=E).

The impact of dyslexia on reading and writing letters, numbers and symbols in the blood banking field was previously reported.⁴ Since the numbers and abbreviated letters are vital elements in the field of practical clinical chemistry, hence, the aim of this communication is to nudge the laboratories and medical schools about the possible dyslexic’s

reading and writing problems in clinical chemistry laboratories:

1. Transposing absorbencies letters in the Beer’s law Ast / At.
2. Substituting the number “6” for “2” and vice versa while reading and writing the standard concentration of total protein.
3. Difficulties in calculation of $\Delta A / \text{min}$ in CK assay. First, adding absorbencies in place of subtraction. Second, difficulties in ordering absorbencies.
4. Reading LDH test as HDL.

Flagging of laboratory errors and improving the patient safety is a priority with all medical laboratories. Therefore, all sources of errors should be minimized or eliminated. Screening and identifying dyslexics’ problems among medical students and staff are important hub mechanisms to minimize such errors.

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