

A CASE REPORT OF AN EPISIOTOMY SCAR SITE ENDOMETRIOSIS: IN SAUDI ARABIA

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ABSTRACT

A rare disorder known as perineal scar endometriosis develops when endometrial tissue is discovered outside of it. This tissue is located in the perineal region, which is the space between the external genitalia and the anus, in cases of perineal scar endometriosis. The quality of life for a woman can be greatly impacted by this ailment, which can be extremely painful. Since perineal scar endometriosis can resemble other perineal masses like abscesses or hematomas, its diagnosis might be difficult. When women appear with perineal masses, especially those who have had previous pelvic procedures, healthcare providers should be highly suspicious of endometriosis. For those who have perineal scar endometriosis, early detection and treatment can help reduce symptoms and enhance quality of life. The successful identification and treatment of endometriosis in this patient is a testament to the collaborative efforts of the healthcare team involved. Delaying diagnosis or confusing them with other diagnoses like perineal abscess, like in our case, can lead to increased morbidity resulting from anal or rectal involvement, recurrence, malignant transformation, and other complications of this condition, and it is very important to identify the margin by doing an MRI to assess the exact location.

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Introduction

Endometriosis is an estrogenic-dependent chronic inflammatory disease characterized by the presence of a functioning endometrial gland or stroma outside the uterine cavity, and it represents 10–25% of cases mostly developed in women of reproductive age. Episiotomy scars are rare and can sometimes be misdiagnosed by mimic diseases such as Bartholin cysts, as in our case [1].

An extremely uncommon condition, perineal scar endometriosis at the episiotomy scar site occurs in about 0.03–0.15% of cases [1, 2]. Though it is documented in the literature, only half of the cases have the standard clinical triad of this illness, which consists of a history of episiotomy, a painful nodule at the scar site, and cyclical pain [3, 4]. Thus, radiography is essential for both the critical preoperative assessment and the diagnosis of instances with unusual presentations [3].

The recommended imaging modality is magnetic resonance imaging (MRI) because of its excellent contrast resolution. In addition to diagnosing, it may precisely define the disease's extent and how it relates to surrounding structures [1, 3, 5]. A delayed diagnosis may result in higher morbidity due to involvement of the anal sphincter or the rectal system; thus, early identification is essential [3, 5]. The other problems with this illness are malignant transformation and recurrence [1, 5].

Clinical History

The case of a 27-year-old female from the Philippines who presented with a perineal mass and associated discomfort is indeed a complex and intriguing one. The patient's complaint of a perineal mass accompanied by dull aching, particularly during sitting and linked with her menstrual cycle, is significant. The patient denied any discharge or redness and did not experience rectal or urinary symptoms. Obstetrical history, including a previous episiotomy during a normal vaginal delivery, is pertinent

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to understanding her current presentation. She had been previously diagnosed with a Bartholin gland cyst and received antibiotic treatment without relief.

The physical examination revealed the presence of two firm nodules at the site of the episiotomy scar, accompanied by mild tenderness upon palpation. Importantly, there was no evidence of redness or discharge. The ultrasound revealed the absence of intrapelvic endometriosis.

A comprehensive range of laboratory investigations, including CBC, coagulation studies, chemistry panel, and tumor markers, all fell within normal ranges.

The provisional diagnosis of endometriosis, based on the clinical presentation and findings, was followed by a planned local excision. A successful surgical excision under spinal anesthesia was done, without evidence of invasion or significant hemorrhage.

The histopathology report revealed the presence of skin and fibrous tissue with focal endometrial-type stroma, glands, and hemorrhage, consistent with endometriosis, serves as a definitive confirmation of the diagnosis.

Results and Discussion

Endometriosis is one of the common gynecological cases that can affect childbearing females after obstetric or gynecological procedures [6]. The first case of endometriosis was discussed in 1860 by Rokitansky [7]. It's known as abnormal endometrial tissue outside the uterus and can be present with many symptoms as cyclic pain, dysmenorrhea, menorrhagia, and infertility. The classical triad is an Episiotomy scar from vaginal delivery, a painful mass or nodule at the site of the scar, and cyclic pain during menstruation. It can be an asymptomatic mass with no other findings. Generally, it can be found in many different sites inside and outside the pelvis mostly in the ovaries as an endometrioma or in the pelvic peritoneum, rarely, it can occur in surgical scars commonly as a cesarean section or episiotomy incision such as the case presented [8, 9].

Late stages of perineal scar endometriosis can cause injury to the rectum or anal sphincter, two nearby structures, which can cause severe morbidity and persistent pain for patients [5]. As a result, early diagnosis is essential, and MRI is useful for both preoperative illness assessment and diagnosis [3].

A clinical diagnosis of perineal scar endometriosis can be made if the traditional triad of symptoms listed in the literature is present [6]. Nevertheless, imaging is helpful in the diagnosis because this typical triad is only observed in 50% of cases [3]. For perineal endometriosis, the asymptomatic window after surgery may extend to more than eight years. In roughly 25% of cases, associated pelvic endometriosis is observed [9].

In cases of perineal scar endometriosis, the US is frequently the first imaging modality used. Trans-perineal US imaging uses a linear probe with a high frequency of 7.5 MHz. Peripheral vascularity may be observed, and there may be a hypo-echoic or anechoic lesion at the scar site with fine internal echoes [5]. Being a non-invasive imaging technique, MRI is highly helpful for preoperatively determining the local extent of disease and for making diagnoses [8].

For perineal scar endometriosis, surgical excision with well-defined, wide margins is the preferred course of treatment [10]. Recurrence is possible. Therefore, the lesion must be completely removed [8]. According to Jeyaseelan *et al.*, the only method to stop a recurrence is to completely remove the lesion with a large margin. Leuprolide, an analogue of gonadotropin released after surgery, is another medication that can be used to stop recurrence [11]. Although uncommon, malignant transformation is possible. Cytology should therefore be carried out in every instance [5].

Conclusion

The successful identification and treatment of endometriosis in this patient is a testament to the collaborative efforts of the healthcare team involved. Delaying diagnosis or confusing them with other diagnoses like perineal abscess, like in our case, can lead to increased morbidity resulting from anal or rectal involvement, recurrence, malignant transformation, and other complications of this condition, and it is very important to identify the margin by doing an MRI to assess the exact location.

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