Rare presentation of asymptomatic endometriosis diagnosed accidently during lower segment caesarean section

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Abstract

Endometriosis is a benign disease defined by the presence of endometrial glands and stroma outside of the uterus and is associated with both pelvic pain and infertility. The ectopic endometrial tissue usually is located in the pelvis but can appear anywhere in the body. The disease exhibits a broad spectrum of clinical signs and symptoms, is prone to progression and recurrence. Here we present a case of a 23 year old women who had a married life of 1 year, presented at term gestation in active labour, emergency LSCS was done for breech presentation with oligohydromnios, intra operatively severe endometriosis, chocolate coloured fluid found in the peritoneal cavity, left ovarian endometrioma was found. Lower segment caesarean section was done, adhesions were released, left ovarian cystectomy was done and peritoneal wash was given.

Key words: endometriosis, lower segment caesarean section, breech, oligohydromnios.

Introduction

Endometriosis is a benign disease defined by the presence of endometrial glands and stroma outside of the uterus and is associated with both pelvic pain and infertility. The ectopic endometrial tissue usually is located in the pelvis but can appear anywhere in the body. The disease exhibits a broad spectrum of clinical signs and symptoms, is prone to progression and recurrence. The pathogenesis and natural history of endometriosis remain poorly understood. The prevalence of asymptomatic endometriosis is 1-7% in women seeking elective sterilization, 12-32% among women of reproductive age with pelvic pain, 9-50% in infertile women, and approximately 50% among teens with chronic pelvic pain or dysmenorrhea[1,2]. The overall prevalence of endometriosis in reproductive aged women probably is between 3% and 10%[1,3]. The mean age at time of diagnosis of endometriosis ranges between 25 and 35 years[4,5].

Case Report

A 23 year old female patient with married life of 1 year, presented at term gestation in active labour. Patient had previously normal menstrual cycles with no history of dysmenorrhea or infertility. Patient had spontaneous conception, presented at 38 weeks of gestation with pain abdomen since 5 hours, there was no history of per vaginum leak or bleed. On examination patient had longitudinal lie with breech presentation, with oligohydromnios, bishop score 7, patient was taken for emergency lower segment caesarean section in view of breech presentation.

Investigation: Ultrasonography showed a single live intrauterine fetus of 36-37 weeks of gestation with breech presentation with oligohydromnios (AFI -5-6 cm).

Intra operative findings: Abdomen was opened with a Pfannenstiel incision, there was chocolate coloured fluid in the peritoneal cavity, there was presence of endometrial tissue over peritoneum, omentum, fundus and body of uterus, bilateral fallopian tubes and ovaries (Figure 1,3), posterior surface of uterus and pouch of Douglas (Figure

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2) and there were dense adhesions, there was a endometriotic cyst of left ovary measuring 3*3 cm. The uterus had features of adenomyosis. Hence it was grade IV endomeriosis or severe endometriosis.

Lower segment caesarean section was done and adhesions were released , endometrial tissue on peritoneum, omentum excised, Pouch of douglas released of the adhesions, consent was taken and left ovarian cystectomy was done.

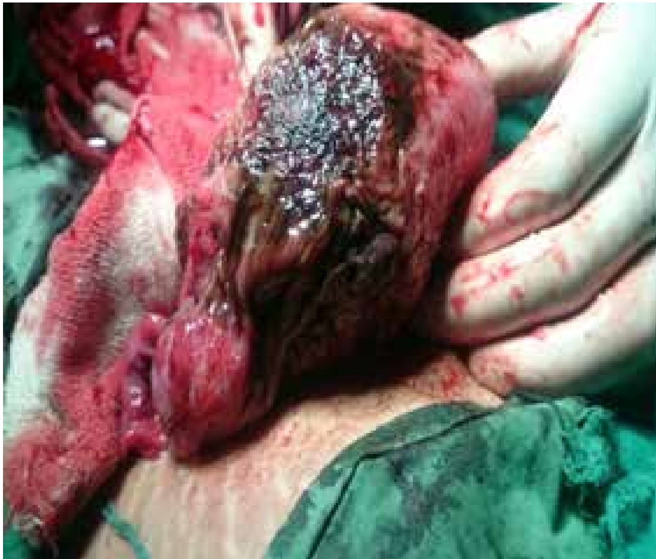

Figure 1. Endometrial tissue over the fundus of uterus involving the fallopian tubes and right ovary.

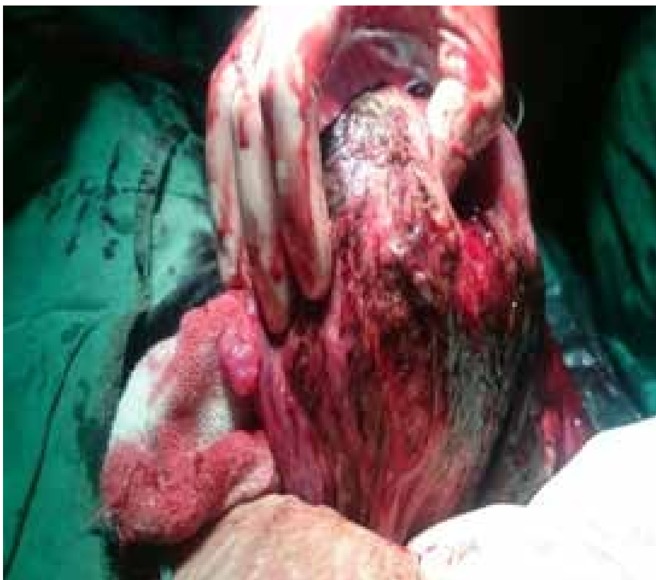

Figure 2. Endometrial tissue over posterior aspect of uterus extending up to pouch of Douglas.

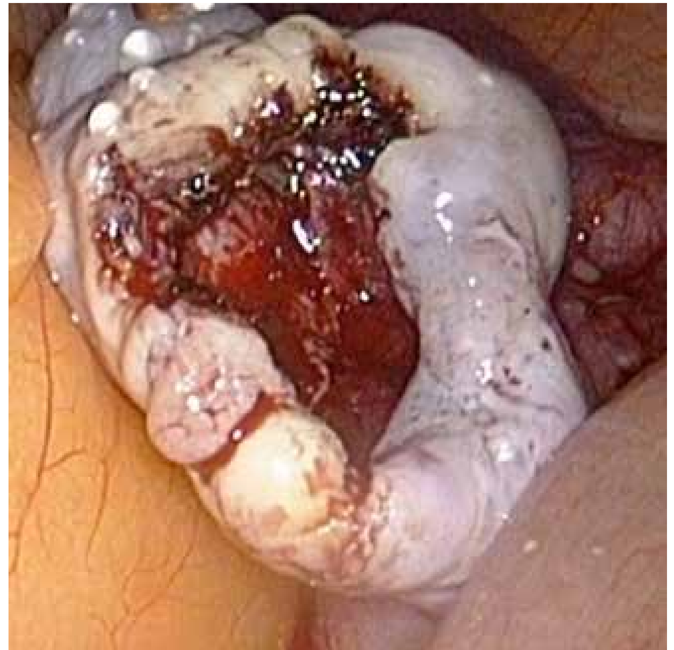

Figure 3. Ovarian endometriosis

Discussion

The age of presentation of endometriosis is usually 25-35 years of age, and patients have chronic pelvic pain with either primary or secondary infertility. Early menarche and short menstrual cycles[6,7], or other cases in younger age group are associated with müllerian anomalies and cervical or vaginal obstruction[8]. In the recent years the etiopathogenesis is also attributed to autoimmune disorder[9]. The severity of endometriosis does not correlate with the number and severity of symptoms; women with advanced disease may have few or no symptoms and those with minimal or mild disease may have incapacitating pain[10]. Laparoscopy with histologic examination of excised lesions is the gold standard for the diagnosis of endometriosis. The classic peritoneal implant is a blue-black “powder burn” lesion with varying amounts of surrounding fibrosis, typically observed on the ovaries and on peritoneal surfaces in the cul-de-sac, uterosacral ligaments, and ovarian fossa[11]. Less commonly, disease may be found in ovarian adhesions, yellow-brown patches, in peritoneal defects, or involving the appendix[11]. Red lesions are highly vascular, proliferative, and represent an early stage of disease. Pigmented lesions represent more established or advanced disease. Studies have shown that it is a progressive disease[12]. Treatment can be medical or surgical depending on the symptoms and time

of presentation. In a young woman with minimal symptoms medical line of management can be tried, similarly a patient who has presented in the perimenopuasal, we can wait till menopause because the symptoms regress after menopause due withdrawal of estrogen and progesterone. Surgical line of treatment will suffice for such patients who are infertile or young and symptomatic. In our patient the patient who was neither symptomatic nor infertile, it was an accidental diagnosis, but the surgical option was still used because patient was young and endometriosis is a progressive disease, and left ovary completely involved. She was advised for exclusive breast feeding for 6 months followed by oral contraceptive[13] to relieve pelvic pain and also as a mode for birth spacing. She was also counselled to complete her family soon as it is also strongly associated with infertility.

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