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Case Study

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PERINEAL ENDOMETRIOSIS: A CASE REPORT

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ABSTRACT

Endometriosis is the presence of endometrial like tissue outside the uterine cavity, which most commonly affects peritoneal surfaces, ovaries and uterine ligaments. Among the rare localizations of endometriosis on scars, that of the perineum remains exceptional; the origin is often iatrogenic (episiotomy). We report the case of a patient with cyclic pain at the episiotomy scar. With at the examination clinical a mass of 4 cm in diameter at the episiotomy scar. The perineal ultrasound showed a hypoechoic image, heterogeneous, non-vascularized in relation to the episiotomy scar measuring 3.5/3cm. Excision of the lesion was performed and the anatomopathological examination confirmed the diagnosis of endometriosis. The postoperative follow-up was simple, with a 12-month follow-up without recurrence of pain or mass. Through our case and a review of the literature, we insist on the need for clinical diagnosis and treatment in early loading to improve the prognosis of this rare entity.

INTRODUCTION

Endometriosis is the presence outside the uterine cavity, in an ectopic position, of endometrial-type tissue that most often affects the peritoneal surfaces, ovaries and uterine ligaments. Perineal endometriosis is the presence of endometrial tissue in the superficial perineum.[1] Although quite rare, endometriosis can affect the vulva, vagina, recto-vaginal septum or perineal area, usually secondary to obstetric or surgical trauma. Anoperineal endometriosis is the subject of a small literature with a few sporadic articles often from a single clinical case. The first observation of perineal endometriosis was reported in 1923 and that of endometriosis of the anal canal in 1968. We report a case of perineal endometriosis on episiotomy scar, with emphasis on diagnostic means and therapeutic management.

OBSERVATION

We report the case of a 34 year old patient, without particular antecedents, her cycles are regular, primitive gesture pare, a 2 year old child born by low way with episiotomy, complicated by a hemorrhage of the delivery with uterine revision. She consults for cyclic pelvic pain at the level of the episiotomy scar dating back to 9 months. The clinical examination found a 4 cm mass at the episiotomy scar. Perineal ultrasound revealed a heterogeneous hypoechoic, non-vascularized image of the episiotomy scar measuring 3.5/ 3cm. The patient benefited from resection of the mass, performed under spinal anesthesia, we made a biconcave incision around the episiotomy scar with subcutaneous detachment carrying the endometriotic nodule to the pararectal fossa (figure 1). Anatomopathological examination confirmed the diagnosis of endometriosis (Figure 2). The postoperative follow-up was simple, with a good evolution and a 12-month follow-up without any recurrence of the mass or pain.

Figure: resection of the endometriotic nodule

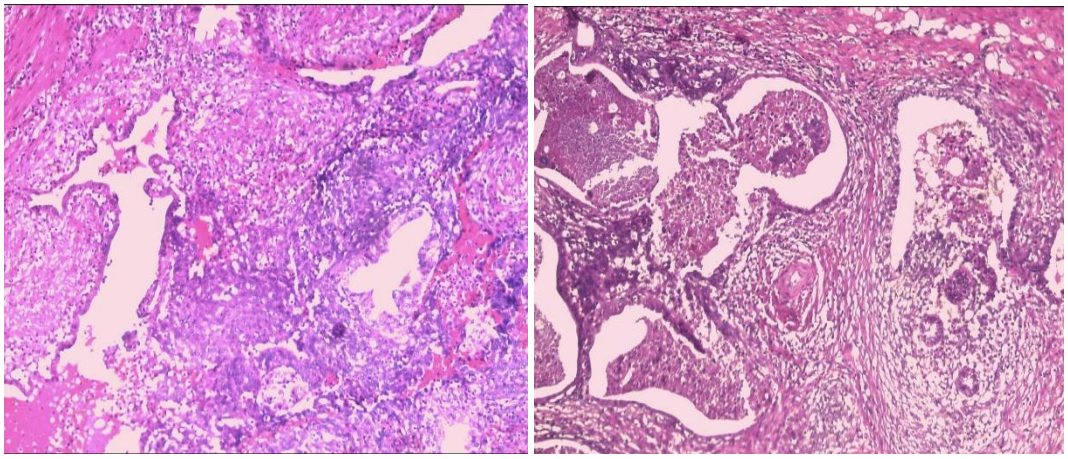

Figure 2: Anatomopathological diagnosis.

DISCUSSION

Perineal endometriosis is a rare entity whose etiology and pathogenesis is not yet clear. Many theories have been proposed to explain this condition as the endometrium implantation theory, the coelomic metaplasia theory, the lymphatic and vascular metastasis theories, the mechanical transplant theory of remnant endometrium in spontaneous or operative delivery, the embryonic rests theory, a recent hypothesis based on the relationship of local immune factors.[2] Perineal endometriotic lesions can be explained by one of these theories. During vaginal delivery associated with episiotomy, endometrial tissue is implanted at the episiotomy site.[3] The theory of angio-lymphatic and mechanical metastasis of endometrial cells during surgery is one among others, which puts forward the explanation of the ethiopathogeny of perineal endometriosis and other ectopic localizations.[4] However, other immunological, genetic and familial factors may be involved in the pathogenesis of this disease.[5] The data collected from the literature and through our experience can explain that perineal endometriosis in our case could be the result of the implantation of endometrial tissue in the perineal region during delivery because the patient underwent an episiotomy with an endometriosis center located in the episiotomy scar.

The diagnosis should be made in the case of any anoperineal pain and/or tumor syndrome in a woman during a period of genital activity.[6] A history of episiotomies and perineal tears of obstetrical origin is often found. Clinical examination generally reveals a bluish, sensitive perineal swelling of variable volume depending on the menstrual cycle. Its blackish-brown content is very evocative,[3] and anoperineal pain is often rhythmic with the genital cycles.[7] Thus, perineal examination should be systematic in all women with chronic pelvic pain, especially if they have had an episiotomy. This examination generally shows the perineal nodule and should systematically look for anorectal locations and the rectovaginal septum. The differential diagnosis of perineal endometriosis arises with the anoperineal abscess. The very rare anal melanoma, often bluish in color, may also be confused with an endometriotic nodule.[6,7]

Endometriosis imaging is based essentially on two tests: ultrasound and magnetic resonance imaging (MRI). In ultrasonography, it takes on the non-specific appearance of nodules that are usually hypoechoic and heterogeneous (depending on their solid and/or liquid component), sometimes hyperechoic (hemorrhagic forms), with external limits that are often blurred and irregular, and of variable shape and size (depending on the amount of blood and fibrosis, the time of the cycle and/or the medical treatment in progress),Some authors have proposed endo-anal ultrasound or echo endoscopy in deep locations.[8]

Pelvic MRI has greater sensitivity (90-92%) and specificity (91-98%) for the diagnosis of endometriosis than other non-invasive imaging techniques.[1,9] MRI is very sensitive to the detection of very small masses and offers excellent differentiation of endometriosis from neighboring tissues. Endometriosis lesions on episiotomy scars are characterized in MRI by a clear hyposignal fibrous thickening on T2-weighted sequences. The appearance is more evocative in the case of stellar and retractile infiltration.[10]

Therapeutic abstention is the rule in asymptomatic forms (30% of endometriosis). The medical treatment is either prescribed alone; it is effective on pain and consists of stopping menstruation with progestins (Danazol) or GnRH analogues; or in addition to a surgical treatment that is limited or incomplete due to the importance of the muscle resection to be performed. The treatment of choice is the surgical resection to be adapted in its modalities according to the age of the patients.[11] It can be performed under local,[12] locoregional or general[11] anesthesia, depending on the size of the nodule.

CONCLUSION

Endometriosis is a rare entity; its physiopathology remains a subject that has fascinated researchers. In our case the etiology can be explained by the grafting of endometrial tissue at the episiotomy site following

uterine revision. Finally, we insist on the principle of treatment which must be an adequate and wide excision to avoid recurrence.

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