



Case Report: Evaluation of Skin Endometriosis Case with ER, CD10 Immunohistochemical Stainings

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Makalenin Alanı: Sağlık

Makale Bilgileri	Öz
Geliş Tarihi 14.12.2022	Endometriozis, endometrial stroma ve bezlerin uterus boşluğu dışındaki yerlere ektopik yerleşimidir. Deri endometriozisi genellikle sezaryen sonrası görülür. Hastalar genellikle menstrüasyonla ilişkili skar bölgesinde ağrı, şişlik ve bazen kanamadır. Bu hastalarda kesin tanı cerrahi eksizyondur. Bu olgumuzda sezaryen ameliyatından 2 yıl sonra kesi bölgesinde şişlik ve ağrı şikayeti ile başvuran hastanın kesi yerinden 5 cm uzaklıkta ağrılı büyüyen kitle tespit edildi. Ultrasonografi ve manyetik rezonans görüntüleme bulguları ile endometriozis ön tanısı ile yatırıldı. Kitle total olarak eksize edildi ve patolojiye gönderildi. Patolojik incelemede endometriozis tanısı doğrulandı. Kadın hastalarda karın ön duvarı kitlelerinin ayırıcı tanısında endometriozis göz ardı edilmemelidir.
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Article Info	Abstract
Received 14.12.2022	Endometriosis is the ectopic location of the endometrial stroma and glands outside the uterine cavity. Skin endometriosis is usually seen after cesarean section. Patients usually have pain, swelling and sometimes bleeding at the scar site associated with menstruation. The definitive diagnosis in these patients is surgical excision. In this case, a painful growing mass was detected 5 cm from the incision site of the patient who applied with the complaint of swelling and pain in the incision area 2 years after the cesarean section. He was hospitalized with a preliminary diagnosis of endometriosis with ultrasonography and magnetic resonance imaging findings. The mass was totally excised and sent to pathology. The diagnosis of endometriosis was confirmed in the pathological examination. Endometriosis should not be ignored in the differential diagnosis of anterior abdominal wall masses in female patients.
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Keywords Endometriosis, Cesarean section, Immunohistochemistry	

INTRODUCTION

Endometriosis is the presence of endometrial tissue outside the uterus (Adamson et al., 2010). It is seen in women of reproductive age in conditions such as pelvic pain, dysmonorrhea, dyspareunia and infertility (Elabsi et al., 2002). It may cause misdiagnosis by mimicking diseases such as tuba-ovarian abscess, diverticulitis, irritable bowel syndrome, appendicitis due to its localization (Agarwal et al., 2008). Some patients are asymptomatic and may be diagnosed incidentally (Akdemir et al., 2014). In summary, although extrapelvic

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endometriosis is rare, it can be found in many tissues of the body and in almost every organ. Often, patients with a history of surgery present with an abdominal mass that grows with pain during menstruation. In this case report, we discussed a case of endometriosis localized in the rectus abdominalis muscle, unrelated from a previous cesarean section incision, with a history of cesarean section.

CASE REPORT

Written informed consent form was obtained from the patient. Written informed consent form was obtained from the patient. A 27-year-old female patient applied to the obstetrics and gynecology outpatient clinic with complaints of pain, swelling at the site of the old cesarean section and a mass in the hand. When the patient's anamnesis was taken, he stated that the pain intensified in this region during the menstrual period. There was no other gynecological complaint in the history taken from the patient. On physical examination, a mass of approximately 3x2 cm was palpated. In the gynecological examination of the patient, it was determined that the uterus and ovaries were normal. In the evaluation of vaginal and rectal touch, no palpable mass could be detected, and parametrial areas were detected freely. In the ultrasonographic evaluation performed on the anterior abdominal wall, a 5.5x5 cm solid-heterogeneous mass was detected. It was reported that the mass was localized to the anterior abdominal wall and was compatible with the endometriotic focus in magnetic resonance imaging obtained in T1 fat-suppressed sequence. After the interview with the patient, it was decided to remove the mass. The mass removed under general anesthesia was sent to pathology. In the pathological examination, the macroscopic evaluation was reported as a mass of 5x5x2.5 cm (Figures 1), With an outer surface covered with adipose tissue, with hemorrhagic-cream-white areas on the cross-sectional surface. In the histopathological findings, the glandular structure of the endometrium in the adipose tissue and the surrounding endometrial stroma were reported together with the diagnosis of endometriosis (Figures 2,3). Immunohistochemical evaluation of sections diagnosed histopathologically; positive staining in endometrial glands with immunohistochemical ER receptor staining and positive staining in endometrial stroma with CD10 staining were observed (Figures 4).

DISCUSSION

Endometriosis was first described by Rokitansky in 1860(Douglas et al.,2004). Generally, intrapelvic localized lesions are seen in the ovaries, Douglas space, uterine ligaments, pelvic peritonium, rectovaginal septum, cervix uteri, and inguinal hernia sac, in order of frequency(Medeiros et al.,2011). Extrapelvic-abdominal locations; rectosigmoid, ileum and appendix. Rarely, it can be localized at the surgical scar after amniocentesis, cesarean section, episiotomy and especially abdominal hysterectomies. Other rare settlements; vagina, vulva, bladder, umbilicus, lymph nodes, skin, muscle, lung, pleura, kidney, heart, brain and bone(Gupta et al.,2014).

Endometriotic foci respond cyclically to steroid hormones released from the ovary(Padmanabhan et al., 2013). Implants proliferate under estrogenic stimulation, and the discarded tissue supported by estrogen and progesterone regresses with the involution of the corpus luteum. The spilled material creates a deep inflammatory response that causes fibrosis in the long term(Demiral et al., 2011). The macroscopic appearance of endometriosis depends on the location of the implant, the activity of the lesion, the menstrual cycle day, and the duration of implantation. Lesions may be raised, solid red, black, or brown; Fibrotic scar areas are yellow to white fibrotic scars or pink, clear, or red vesicles. The color of the implant is usually determined by its vascularity, the size of the lesion, and the amount of material spilled. With newer implants, active lesions filled with blood turn red. Older lesions are prone to wrinkled-looking scarring(Toullalan et al. 2000).

In conclusion, it may be difficult to diagnose endometriosis at the scar site clinically and radiologically. The diagnosis is confirmed by pathological examination. The case of endometriosis after cesarean section is very common and may be overlooked during clinical-radiological examination. Before these patients are diagnosed with appendicitis and similar acute abdomen, the differential diagnosis of endometriosis should be kept in mind in cases of dysmenorrhea and palpable mass lesions defined by cyclic pain and/or size change in the lesion area.

Informed Consent Written informed consent was obtained from patients who participated in this study.

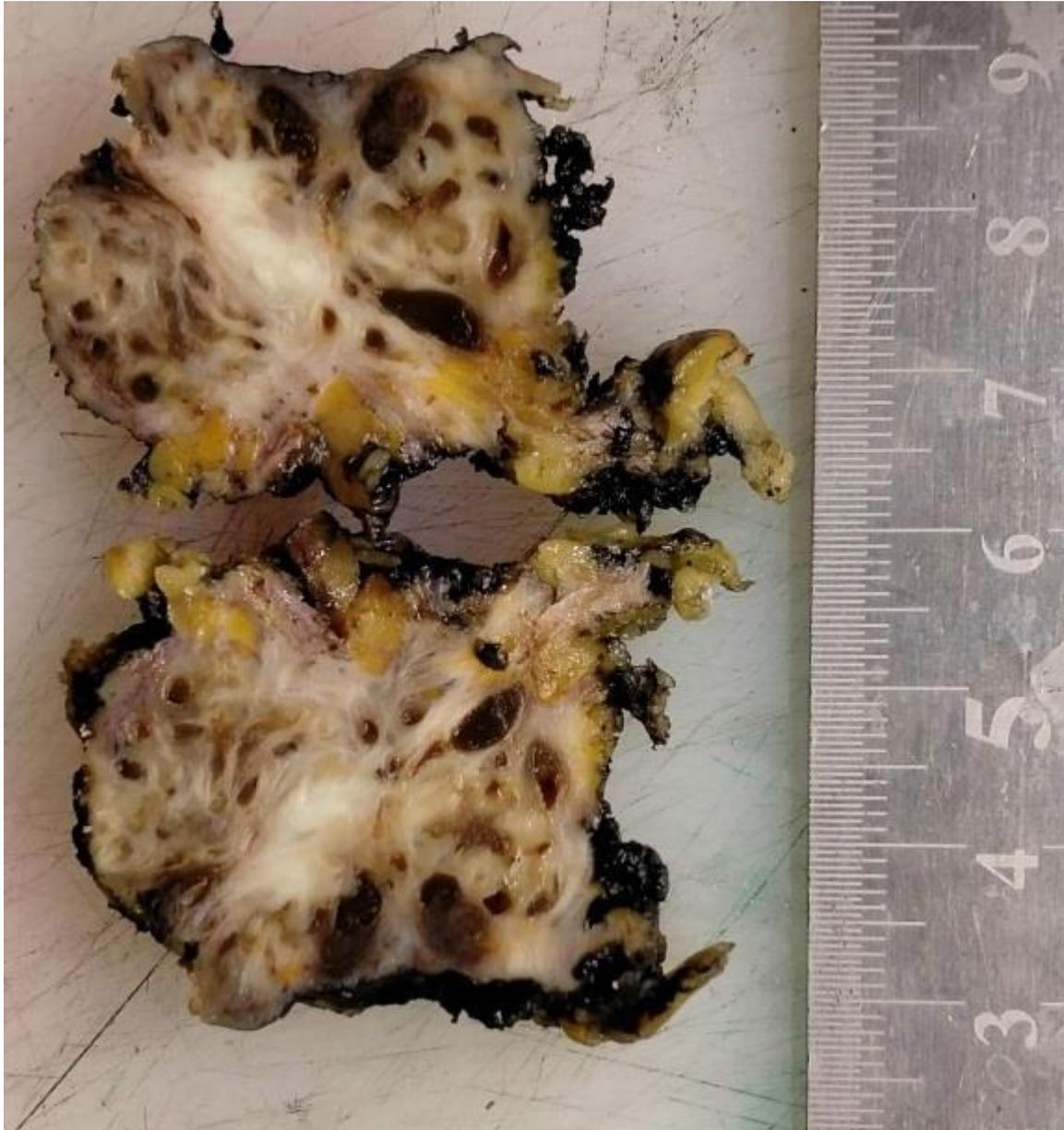


Figure 1: The cut surface is densely fibrotic, there are bleeding areas in between.

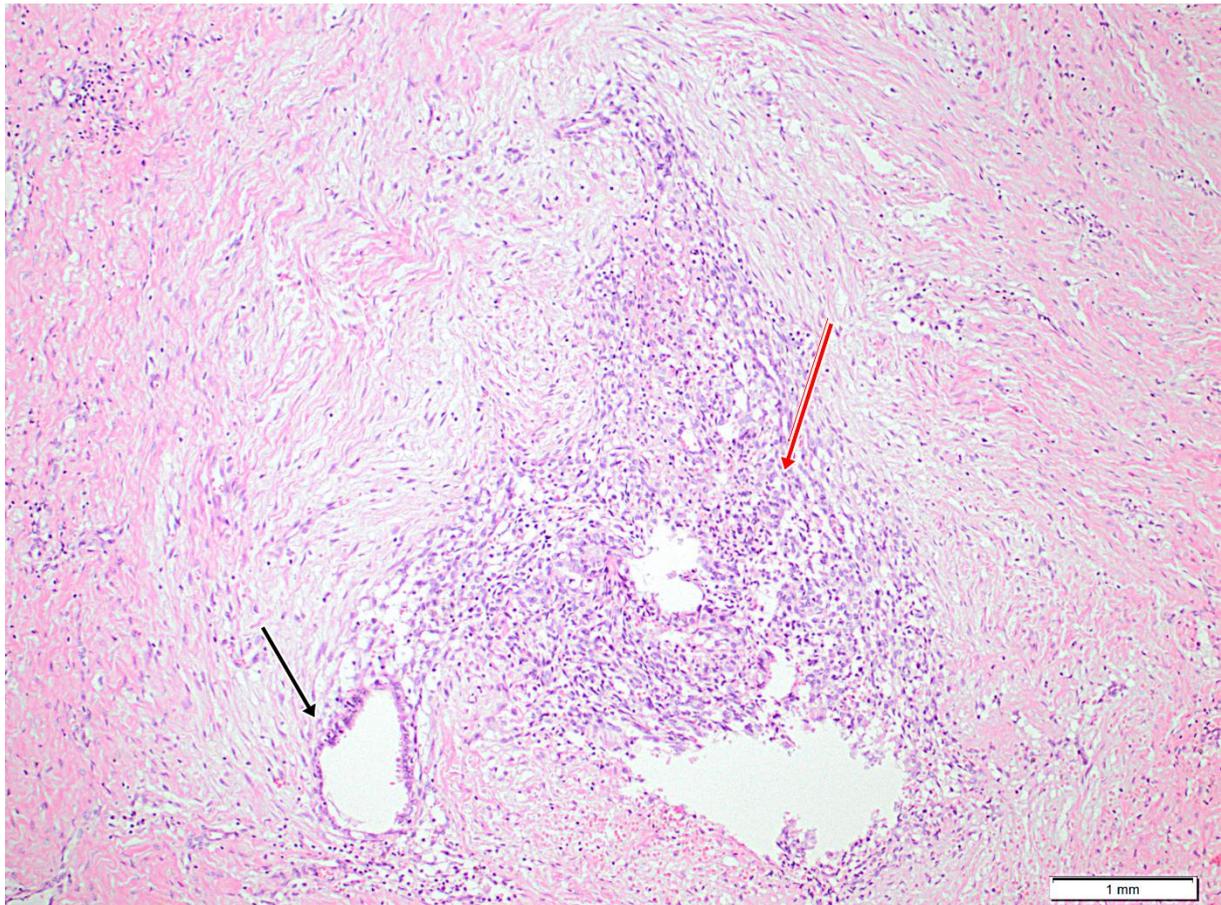


Figure 2: The area marked with the black arrow is the focus of endometriosis, and the area with the red arrow shows dense inflammatory cells. Intense adhesions and inflammation are seen in foci with endometriosis (HE, X200).



Figure 3: The area marked with the black arrow is the focus of endometriosis. There is a purulent structure in the middle (HE, X200).

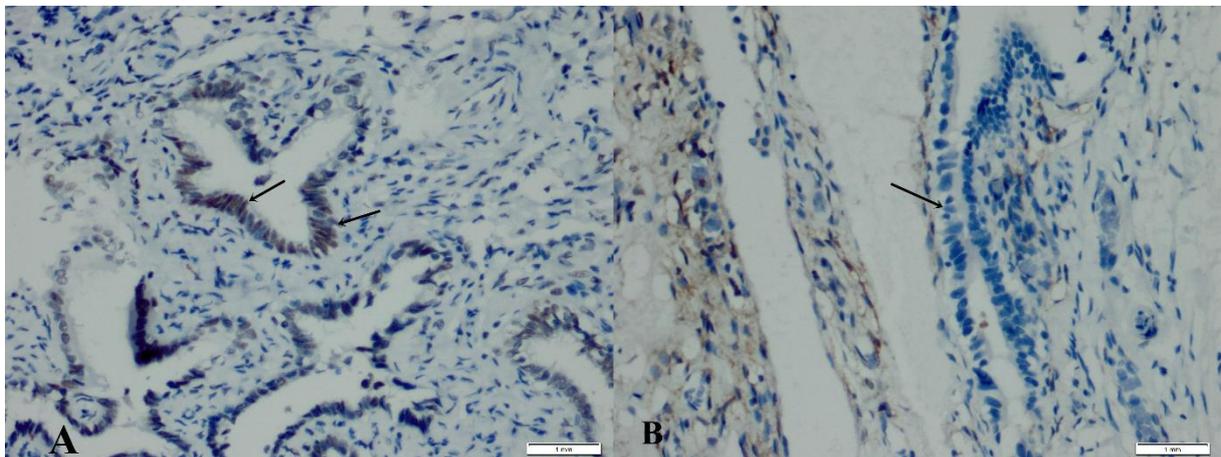


Figure 4: A: ER receptor immunohistochemical staining was found to be positive in endometrial glands (IHC,X400). B: CD10 immunohistochemical staining showed positive staining in peripheral stroma but not in endometrial glands (IHC,X400).

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