Abdominal Wall Endometriosis: Case Report

Abdominal Duvar Endometriozisi: Olgu Sunumu

Ozan Turgut[1], Hasan Onur Topçu[1], Ahmet Ay[2]

[1] İskenderun Devlet Hastanesi, Kadın Hastalıkları ve Doğum Kliniği, Hatay
[2] Kırıkkale Yüksek İhtisas Hastanesi, Genel Cerrahi Kliniği, Kırıkkale

ÖZET

Endometriozis temel olarak endometrial dokunun uterus dışında ektopik bir odakta bulunması ile karakterizedir. Kadın genital traktında bulunması, reprodüktif çağda oldukça olağan bir durum olup, en sık jinekolojik organlar ve pelvik peritonda yerleşir. Nadiren de olsa ekstraperitoneal endometriozis, abdominal duvar endometriozisi olarak karşımıza çıkabilmektedir. Abdominal duvar endometriozisli bir olgu ışığında bu nadir antiteyi tartışmayı amaçladık.

Anahtar kelimeler: Endometriozis, ekstraperitoneal, abdominal duvar

ABSTRACT

Endometriosis is characterized by the presence of an ectopic endometrial tissue outside the uterus. It is a usual disorder of women in reproductive age, which is mainly located in the female genital tract. Endometriosis is found most commonly in the gynecologic organs and pelvic peritoneum. Although it is uncommon, extrapelvic endometriosis can form a different mass known as abdominal wall endometrioma. We present the clinical findings, the diagnostic procedures, and the management of a patient with abdominal wall endometrioma.

Keywords: Endometiosis, extraperitoneal, abdominal wall

INTRODUCTION

Endometriosis is characterized by the presence of an ectopic endometrial tissue outside the uterus that can respond to ovarian hormonal stimulation (1). Endometriosis is found most commonly in the gynecologic organs and pelvic peritoneum. Although it is uncommon, extrapelvic endometriosis can form a discrete mass known as abdominal wall endometrioma. Endometriosis of the abdominal wall is a subtype of extrapelvic endometriosis. Common presentation includes palpable mass, cyclic pain during the menstruation, bleeding and discharge. Differential diagnosis includes abscess, lipoma, hematoma, sebaceous cyst, suture granuloma, inguinal hernia, incisional hernia, desmoid tumor, sarcoma, lymphoma and primary or metastatic cancer.

We present the clinical findings, the diagnostic procedures, and the management of a patient with abdominal wall endometrioma.

CASE REPORT

A 29 year-old patient who underwent surgery twice; once for cholecystectomy three years before and once for cesarean one year before presented in our department. The patient had painful attacks during the menstrual period. On physical examination a nodular, fixed formation was found under the pfannenstiel incision. The examination of rest of the abdominal wall and systemic examination of the patient was normal. A nodule established by physical examination was confirmed using ultrasonography. The patient underwent surgery by the initial diagnosis of abdominal wall endometrioma. The surgery was performed and a nodule with 2x2,5 cm size removed with negative margins (Figure 1 and 2). The diagnosis was confirmed pathologically. The risk of recurrence and abdominal wall endometriosis were explained to the patient.

Sorumlu Yazar / Corresponding author
Dr. Ahmet Ay dr.ahmetay@gmail.com

Any medical treatments such as oral contraceptive pill, progestogens and gonadotropin-releasing hormone analogs were not planned with approval of the patient. When followed up 8 weeks after surgery she was found to be asymptomatic and she has been still under follow-up 6 months after the surgery without any symptoms.

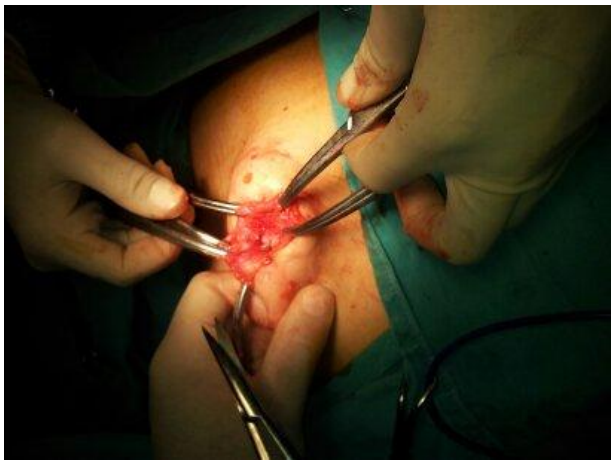

Figure 1- A nodular, fixed mass before its removal

Figure 2-A specimen of the solid mass after its removal

DISCUSSION

Endometriosis, is a common benign gynecologic disorder defined as the ectopic implantation of endometrial glands and stroma outside the uterine cavity. Although endometriosis is usually related anatomically to the uterus and its attachments, extrapelvic endometriosis may occur in 12% of women with endometriosis (1). It occurs most often at the following extra pelvic sites; intestine, skin, including umbilicus and abdominal scars, inguinal region; and the lung (2). Abdominal wall endometriosis occurs most commonly as a secondary process after an abdominal or pelvic intervention such as hysterectomy, cesarean sections, and episiotomy. The precise etiopathogenesis of endometriosis remains controversial, and many theories have been proposed, including cellular immunity, coelomic metaplasia, implantation or retrograde menstruation, vascular and lymphatic metastasis, dissemination, and direct transplantation. Direct transplantation is probably the mechanism responsible for the development of abdominal wall endometrioma following a cesarean section, hysterectomy, appendectomy, laparoscopic trocar tract, or episiotomy.

Symptoms are usually nonspecific, including abdominal pain, nausea, and the presence of an abdominal mass, which may vary in size. All symptoms may sometimes be related to menstrual periods. Some patients apply to the emergency room for severe pain mimicking an acute abdomen, like appendicitis or bowel obstruction. Others may present with nonspecific urinary symptoms, which make the clinical diagnosis even more difficult. These nonspecific symptoms are the reason why most of the cases are admitted to the general surgery units, although this is a disease primarily concerning the gynecologists. It can mimic other lesions of the abdominal wall, such as suture granulomas, abscesses, hematomas, hernias, incisional hernia, lipomas, sebaceous cysts, desmoid tumor, sarcoma, lymphoma, or primary and metastatic cancer. Malignant transformation of abdominal wall endometriosis is (in 1% of cases) very rare (3).

Multiple diagnostic procedures have been used for the diagnosis of abdominal wall endometriosis such as ultrasonography, computed tomography, or magnetic resonance imaging (MRI). However, none of them is specific and the excisional biopsy remains the gold standart method (4).

Management of abdominal wall endometriosis usually includes both surgery and hormonal suppression (5-7). Medical management has been attempted using the combined oral contraceptive pill, progestogens and gonadotropin-releasing hormone analogs. Only short-term success and temporary response can be achieved and recurrence is common after stopping the therapy. Optimal management is by extensive surgical excision with care to remove all affected tissue. Recurrence is rare and usually presents within 1 year and is likely to be a result of inadequate excision.

CONCLUSIONS

Abdominal wall endometriosis is a rare condition, which can be easily overlooked due to the higher frequency of other type of abdominal masses included in the list of differential diagnosis. Endometriosis of the abdominal wall must be considered in the differential diagnosis in women with painful abdominal wall mass. The symptoms do not have always-cyclic attribute and the imaging procedures are not specific for the diagnosis. The extensive surgical excision remains the treatment of choice.

REFERENCES

1. Witz C.A. Current concepts in the pathogenesis of endometriosis, Clin Obstet Gynecol. 1999, 42(3): 566–85.
2. Fujimoto A, Osuga Y, Tsutsumi O, Fujii T, Okagaki R, Taketani Y. Successful laparoscopic treatment of ileo-cecal endometriosis producing bowel obstruction. J Obstet Gynaecol Res. 2001; 27: 221–3.
3. Heaps JM, Nieberg RK, Berek JS. Malignant neoplasms arising in endometriosis. Obstet Gynecol. 1990; 75: 1023–8.
4. Khoo J. J. Scar endometriosis presenting as an acute abdomen: a case report, Aust N Z J Obstet Gynaecol. 2003; 43(2): 164–5.
5. Kaloo P, Reid G, Wong F. Caesarean section scar endometriosis: Two cases of recurrent disease and a literature review. Aust NZ J Obstet Gynaecol. 2002; 42: 218–220.
6. Scholefield HJ, Sajjad Y, Morgan PR. Cutaneous endometriosis and its association with caesarean section and gynecological procedures. J Obstet Gynaecol. 2002; 22: 553–554.
7. Olufowobi O, Sorinola O, Miller SJ, Condie RG. Scar endometrioma: A cause for concern in the light of rising caesarean section rate. J Obstet Gynaecol. 2003; 23: 86.

Yazışma Adresi:

Dr. Ahmet Ay

Kırıkkale Yüksek İhtisas Hastanesi,

Genel Cerrahi Kliniği

Tel: 0531 4687381

E-posta: dr.ahmetay@gmail.com