Annals of Mediterranean Surgery 2018; 1 (2) 03-05
https://doi.org/10.22307/2603.8706.2018.02.002
ISSNe: 2603-8706

AMS Annals of Mediterranean Surgery

Case Report

ABDOMINAL WALL ENDOMETRIOMA FAR FROM PREVIOUS SCAR

ENDOMETRIOMA DE PARED ABDOMINAL ALEJADO DE CICATRIZ PREVIA

Luis Ladaria-Sureda[1*]; Juan José Segura-Sampedro[2,3*]; Elías Palma-Zamora[2]; Xavier Francesc González Argenté[2,3]

[1] Department of General Urology, Hospital Universitario Son Espases, Palma de Mallorca, Spain.
[2] Department of General & Digestive Surgery, Hospital Universitario Son Espases, Palma de Mallorca, Spain.
[3]Malignant Peritoneal Disease Research Group, Health Research Institute of Balearic Islands (IdISBa), Palma de Mallorca, Spain.
* Corresponding author: Juan José Segura-Sampedro[2]. Carretera de Valldemossa 79, Palma de Malllorca, 07010, Illes Balears, Spain. Phone 0034-871-205000 segusamjj@gmail.com

Received: 10 March 2018, Accepted: 30 April 2018, Published: August 2018.

Abstract:
Endometriosis is defined by the presence of ectopic endometrial tissue that can respond to ovarian hormonal stimulation. Abdominal wall endometrioma prevalence is about 0.1-1%, the diagnosis can represent a challenge for the surgeon.
We present the case of a 28-year-old woman with a personal history of cesarean delivery 7 years ago who consulted due to pain relating to a mass in her right lateral abdominal wall. Physical examination showed a 2 cm nodular mass at the right lower quadrant, 10 cm away from the Pfannenstiel scar. Palpation was painful and no protrusion was felt after Valsalva or during bipedestation. Ultrasound and CT scan showed a 17 mm nodular mass at the union of oblique muscles and rectus abdominis muscle. With these findings we performed surgery to remove the mass and the specimen analysis confirmed endometrioma.
In our case the seed of this endometrioma probably took place during the previous surgery. Despite the fact that there was apparently no relation with the skin scar, it seems that it could have been sown during the dissection of the abdominal wall while gaining access to the uterus.
Differential diagnosis should be made with lymphatic node and granuloma. Surgery with free margins (more than 1 cm) is the definitive treatment. If needed, synthetic mesh placement can be indicated.

Resumen:
La endometriosis se define por la presencia de tejido endometrial ectópico capaz de responder a la estimulación hormonal ovárica. La prevalencia del endometrioma de pared abdominal es de aproximadamente 0,1-1%, y su diagnóstico puede representar un desafío para el cirujano.
Presentamos el caso de una mujer de 28 años con antecedentes personales de parto por cesárea 7 años antes que consultó por dolor relacionado con una masa en la pared abdominal lateral derecha. El examen físico mostró una masa nodular de 2 cm en el cuadrante inferior derecho, a 10 cm de la cicatriz de Pfannenstiel. La palpación fue dolorosa y no se sintió protrusión tras la maniobra de Valsalva o durante la bipedestación. La ecografía y la tomografía computarizada mostraron una masa nodular de 17 mm en la unión de los músculos oblicuos y el músculo recto abdominal. Con estos hallazgos realizamos cirugía resectiva de la masa y el análisis de la muestra confirmó que se trataba de un endometrioma.
En nuestro caso, la implantación de este endometrioma probablemente tuvo lugar durante la cirugía previa. A pesar de que aparentemente no hubo relación con la cicatriz de la piel, parece que pudo haberse implantado durante la disección de la pared abdominal en el abordaje de acceso al útero.
El diagnóstico diferencial debe hacerse con ganglios linfáticos y granulomas. La cirugía con márgenes libres (más de 1 cm) es el tratamiento definitivo. Si es necesario, se puede indicar la colocación de una malla sintética.

Keywords: Endometriosis; Abdominal wall

Case report

A 28-year-old woman with a personal history of cesarean delivery 7 years ago consulted due to pain relating to a mass in her right lateral abdominal wall. Physical examination showed a 2 cm nodular mass at the right lower quadrant, 10 cm away from the Pfannenstiel scar. Palpation was painful and no protrusion was felt after Valsalva or during bipedestation. Ultrasound and CT scan showed a 17 mm nodular mass at the union of oblique muscles and rectus abdominis muscle (fig. 1 and 2). With these findings we performed surgery to remove the mass. Subsequent anatomopathologic study described it as endometrioma with free margins. The patient was discharged in the same day and had no sequels.

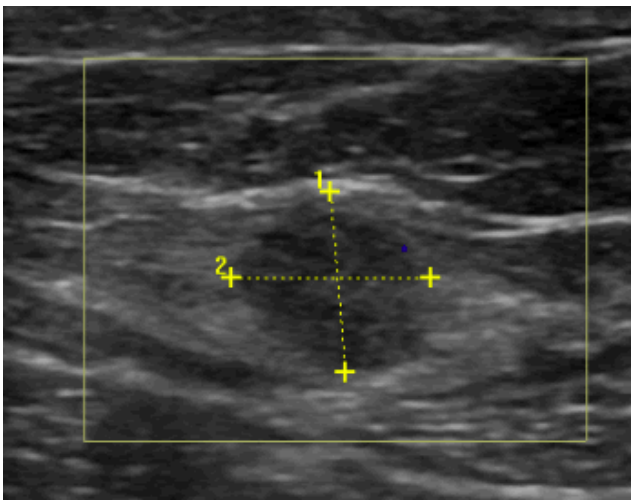

Fig. 1. Ultrasound showed a nodular mass at the union of oblique muscles and rectus abdominis muscle compatible with lymph node.

Discussion

The term endometrioma is given to endometriosis when it forms a discrete mass[1]. Endometriosis is defined by the presence of ectopic endometrial tissue that can respond to ovarian hormonal stimulation. Although the prevalence of endometriosis is not well known, it is said that about 5-10% of women suffer this pathology. Abdominal wall endometrioma prevalence is about 0.1-1%. The clinical picture is normally cyclic pain or abdominal discomfort, usually related to menstruation period, although it has also been described as a painless but gradually enlarging mass[2]. Most cases occur after a caesarean section, because of the seed of endometrial cells, but it may also occur in other surgeries.

In our case the seed of this endometrioma probably took place during the previous surgery. Despite the fact that there was apparently no relation with the skin scar, it seems that it could have been sown during the dissection of the abdominal wall while gaining access to the uterus.

Diagnosis can be achieved with ultrasonography or CT scan and a proper clinical history, but MRI is the most specific image technique. On MRI, the abdominal wall endometriosis may appear isointense or mildly hyperintense to muscle on T1-weighted images and isotense or hyperintense to muscle on T2-weighted images as compared with hypointense on T2-weighted images on ovarian endometriosis. These lesions are frequently enhanced with MRI after administering intravenous contrast agent[1].

Differential diagnosis should be made with lymphatic node and granuloma. Histological confirmation of endometrioma is based on detecting at least two of the three following features: endometrial stroma, endometrial-like glands and hemosiderin pigment. Malignant transformation of abdominal wall endometriosis is exceptionally rare with reported rates between 0.3% and 1.0%. Histologically, the most common malignant neoplasm type is clear-cell carcinoma and the 5-year survival is around 80%[3].

Surgery with free margins (more than 1 cm) is the definitive treatment. If needed, synthetic mesh placement can be indicated[4]. Antigonadotropic treatments (Danazole or Leuprolide) have also been proposed. Although they can alleviate the symptoms

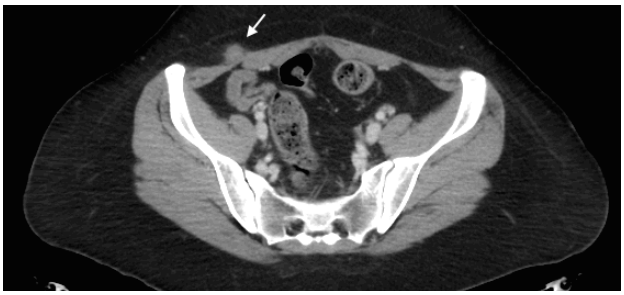

Fig. 2. CT scan revealed a 17 mm nodular mass at the union of oblique muscles and rectus abdominis muscle.

temporarily, their side effects like amenorrhea and dyspareunia make them a second option for treatment, and moreover their benefits have not been proven[5]. Other treatments like targeted radiotherapy have been proposed with conflicting results[5].

Conflict of interests

This work has not received funding of any kind. The authors declare that they have no conflicts of interest in carrying out the work.

References

1. Nissotakis C, Zouros E, Revelos k et al.: Abdominal Wall Endometrioma: A Case Report and Review of the Literature. AORN Journal 2010 91:730-745
2. Khamechian T, Alizagar J, Mazoochi T: 5-Year data analysis of patients following abdominal wall endometrioma surgery. BMC Women's Health 2014 14:151.
3. Heller D, Fitzhugh V: Abdominal Wall Endometriosis: A Rarely Anticipated Diagnosis A 16-Year Experience and Brief Literature Review. The Journal of Reproductive Medicine 2014 59:110-112.
4. Nigam A. Subcutaneous endometriosis: a rare cause of deep dyspareunia BMJ Case Rep. 2014
5. Vinchant M, Poncelet C, Ziol M, et al.: Malignant transformation of abdominal wall endometriosis: case report and literature review. Tumor 2013, 99: e49-e54