

## Abdominal wall incision scar endometriosis

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### SUMMARY

*Our aim to publish this case report to remind this rare gynecologic disease to clinicians as a differential diagnose. Our patient was a woman suffering from a painful abdominal mass for about one year. She had two cesarean sections in her history. Ultrasonography revealed a hypoechogenic mass while computed tomography showed an izointense mass with lobulated margins. The diagnosis was confirmed by histopathologically after surgical excision. In conclusion; although abdominal wall endometriosis is seen rarely nowadays, familiarity with its signs and symptoms will increase awareness of this disease.*

**Key words:** Endometriosis, abdominal wall

### ÖZET

#### **Karın ön duvarı insizyon skar endometriozisi: Bir olgu sunumu**

*Bu olgu sunumunu yayınlamamızdaki amaç nadir görülen bu jinekolojik hastalığı klinisyenlere farklı bir tanu olarak hatırlatmaktır. Hastamız yaklaşık bir yıldır ağrılı bir karın kitlesinden yakınan bir bayandı. Hikayesinde iki adet sezaryan operasyonu mevcuttu. Ultrason hipoekojenik bir kitleyi gösterirken bilgisayarlı tomografi lobüle kenarlı izointens bir kitleyi anlatıyordu. Cerrahi müdahale sonrası tanu histopatolojik olarak doğrulandı. Sonuçta bugünlerde karın ön duvarı endometriozisi nadir görülse de, belirti ve bulgularına aşinalık bu hastalığın farkındalığını arttıracaktır.*

**Anahtar kelimeler:** Endometriozis, karın ön duvarı

### INTRODUCTION

Endometriosis is defined as a functioning endometrial tissue outside the uterin cavity (1). It is found in 10-15 % of all reproductive age women, and it is commonly seen in pelvic areas such as ovaries, posterior cul de sac, and pelvic peritoneum (2).

Extrapelvic endometriosis is a relatively rare event although its average incidence represents 8.9 % of all reported cases of endometriosis with a mean age of 35 years. The most common extrapelvic form of endometriosis is cutaneous endometriosis, involving scar tissues occurring after obstetric or gynecologic procedures such as episiotomy, hysterectomy, cesarean section, amniocentesis, and even laparoscopic surgery (3). The incidence of scar endometriosis after cesarean delivery is 0.03-0.4 % (2).

Endometriosis of the abdominal wall is difficult to

diagnose for clinicians; it is often mistaken- as in clinically as in diagnostic imaging- for other abnormal cases such as lipoma, abscess, granuloma, incisional hernia, or primary or metastatic cancer, although a mass in the abdominal wall with symptoms of cyclic pain related to menses and swollen condition together with tenderness before menses is nearly pathognomonic (2,8,10).

### CASE REPORT

Our aim to publish this case report is to draw attention to clinicians cyclic complaints of patients with abdominal wall endometriosis, and also to remind this rare gynecologic disease as a differential diagnose.

A 35-year-old multipara woman, presented with an abdominal mass and a nearly one year history of intermittent pain that becomes more tender a few

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days before and also during her menses at her Pfannenstiel scar. She had had two cesarean sections in 1995 and 1998. She had no history of endometriosis so far and her sistemic examination was normal. Ca-125 blood value was also normal before our surgical excision. On physical examination, she had a painful semi-solid mass that measured approximately 3 cm in diameter and placed 1 cm to the left of her cesarean scar. In ultrasound examination, 20x12 mm hypoechogenic mass with irregular lobulated margins deeply located under the incision scar had been reported (Figure 1).



Figure 1. Ultrasound imaging showed by a black arrow. Marjins of the mass are strongly marked.

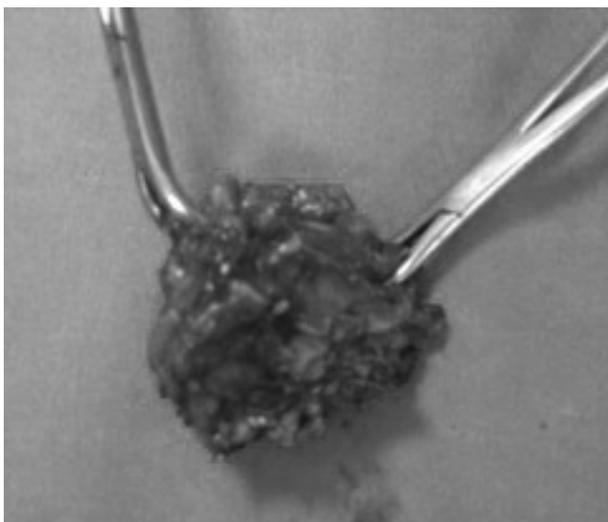


Figure 2. Makroskopik view.

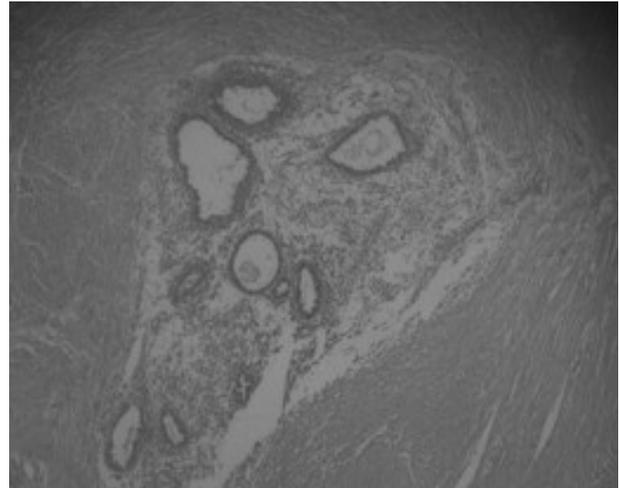


Figure 3. Microscopic image. Endometrial stroma and gland structures in fibroadipose tissue are seen. (From Nurver Ozbay, Pathology Department, by the permission.)

Computed tomography (CT) revealed a 2.5 cm mass with lobulated margins and izointense with a muscle tissue, located next to the left side of the incision scar protruding to subcutaneous fat tissue from anterior abdominal wall.

The mass (Figure 2) was seen located in subcutaneous fat tissue, however partially passing fascial layer through to the rectus muscle in surgery.

The materyal was confirmed to be endometriosis histopathologically by pathology department (Figure 3).

Patient was discharged from hospital on 2<sup>nd</sup> postoperative day uneventfully and was invited to control examination.

## DISCUSSION

The literature emphasizes that scar endometriosis is uncommon; however, it may occur more commonly than believed. Patients may present from months to years after their last surgery. Common presentations include palpabl mass, cyclic pain and bleeding consecutively. Because of clinical suspicion of incisional hernia, patients with abdominal wall scar endometriosis are often referred to general surgeons but not gynecologists (4).

The pathogenesis of abdominal wall endometriosis is best explained by a combination of theories, including metaplasia, venous or lymphatic metastasis and mechanical transplantation (5). The most popular theory is that of mechanical transplantation; during the surgical procedure, viable endometrial cells into scars at the time of surgery (6).

Although therapy with oral contraceptives, progestins, medroxyprogesterone acetate and gonadotropin-releasing hormone agonists has been tried, complete regression is rare with medical treatment. Total surgical excision is considered to be the gold standard for both diagnosis and treatment for abdominal wall endometriosis. Furthermore, fine-needle aspiration biopsy may be used for evaluation of subcutaneous abdominal masses, it is not commonly used for abdominal wall endometriosis as it is not suspected in diagnosis.

Recurs after adequate surgery is not common, as if it occurs, it is likely to be a result of inadequate operation (5).

Malign development from abdominal wall endometriosis has been assigned worldwide, for instance, a report of endometrioid carcinoma unfortunately developing in abdominal wall endometriosis seventeen years after hysterectomy had been reported in 1980 (7).

Postoperative follow-up with a gynecologist is recommended since a concomitant pelvic endometriosis may occur in these cases. Medical treatment after surgery may be added to therapy if it is necessary (8).

Although abdominal wall endometriosis is seen rarely nowadays; cause of increase in cesarean delivery and also other surgical procedures, it may be more common in the future. Familiarity with its symptoms and signs will increase awareness of this disease.

As it is accepted inoculation of endometrium into

the surgical area is the most common cause of abdominal wall endometriosis, it is strongly recommended that the used sponge should be discarded immediately after cleaning the uterine cavity, the suture material used for uterus should not be reused while closing abdominal wall, and finally the surgical area should be cleaned thoroughly and irrigated with saline solution before closure (9).

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