Longstanding anterior abdominal wall subcutaneous endometriosis after Caesarean section - a case report

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Background

Extrapelvic endometriosis has been described in various locations and endometriosis of the abdominal wall is the most common one.¹ However subcutaneous abdominal wall endometriosis is a rarity. It is often related to a surgical scar. The most common surgery associated with abdominal wall endometriosis is Caesarean section. The reported incidence varies between 0.03%-1%.²,³ One hypothesis is that abdominal wall endometriosis appears following the implantation of endometrial cells into the soft tissue of the abdominal wall after open uterine surgeries like Caesarean sections.

Case summary

An young patient, gravida 1 para 1 , who had emergency Caesarean section abroad 10 years ago presented to our endometriosis centre with history of a 3 cm large 'lump' in the Caesarean section scar which was very painful when having her periods.

Her operation was uneventful. She initially became aware of the mass sometime after her surgery. The client was very slim and noticed that the lump was increasing slightly in size during her periods.

She did not report any other symptoms. No previous history of endometriosis.

The client was not using any hormonal contraception.

Unremarkable medical history. No other surgical history.

On examination there was about 3cm palpable nodule in the superior left aspect of the previous Caesarean section scar. The scar itself was unremarkable and thin. The mass was fixed to the surrounding tissue and was slightly tender.

On bimanual examination the uterus was mobile and free and the mass seemed to slide separately. The ultrasound scan showed suspected 3cm abdominal wall endometriotic nodule, inconclusive whether there was communication with the anterior part of the uterus. No other endometriosis.

Surgical exploration revealed a 3 cm solitary subcutaneous mass fixed to the surrounding tissues and extending to the anterior lamina of the rectus sheet.

The lesion was excised and sent for histology.

The pathology report confirmed the suspected diagnosis of subcutaneous endometriosis.

The true incidence might be higher than the reported one as everyone has a different threshold for pain and sometimes the women can suffer in silence for many years.

Conclusion

Abdominal wall endometriosis should be considered in women with exacerbation of pain and tenderness in the mass during menstruation and history of abdominal pelvic surgery.

On examination there was about 3cm palpable nodule in the superior left aspect of the previous Caesarean section scar. The scar itself was unremarkable and thin. The mass was fixed to the surrounding tissue and was slightly tender.

The treatment of choice is wide surgical excision. It is important not to break the mass during the excision in order to avoid the re-implantation of microscopic endometrial cells.

References