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Images in Surgery

CESAREAN-SECTION SCAR ENDOMETRIOMA

ENDOMETRIOMA EN LA CICATRIZ DE CESÁREA

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A 26-year-old woman (G1, P1) presented with cyclic pain and abdominal mass during menstruation at the right lateral edge of the Pfannenstiel scar for thirteen months. The patient had a history of one pregnancy with an uncomplicated caesarean section five years prior. On physical examination, there was a palpable mass located in the lower abdominal wall just lateral and superior to the right extent of the Pfannenstiel incision scar. The area of induration was approximately 3x2cm to palpation and was tender. Transabdominal ultrasonography (US) revealed heterogenous hypoechoic lesion in the subcutaneous region of the lower abdomen. Contrast-enhanced abdominal computed tomography (CT) demonstrated an oval hyperdense soft tissue mass in the subcutaneous fat of the left lower abdominal wall, measuring 2.9 x 2.1 x 1.6 cm with involving rectus sheath (Fig. 1 A). The mass was surgically excised with clear margins and prosthetic mesh was used to close this defect in the rectus sheath. Endometrial glands and stroma were found within the abdominal wall mass on pathologic examination (Fig. 1C). An immunohistological study was positive for CD 10 in the surrounding cytogen stroma (Fig. 1D). These findings confirmed the diagnosis of Abdominal Wall Endometriosis (AWE). The postoperative course was uneventful. No obvious recurrence or subjective symptoms were observed postoperatively or reported in the 3-year follow-up period.

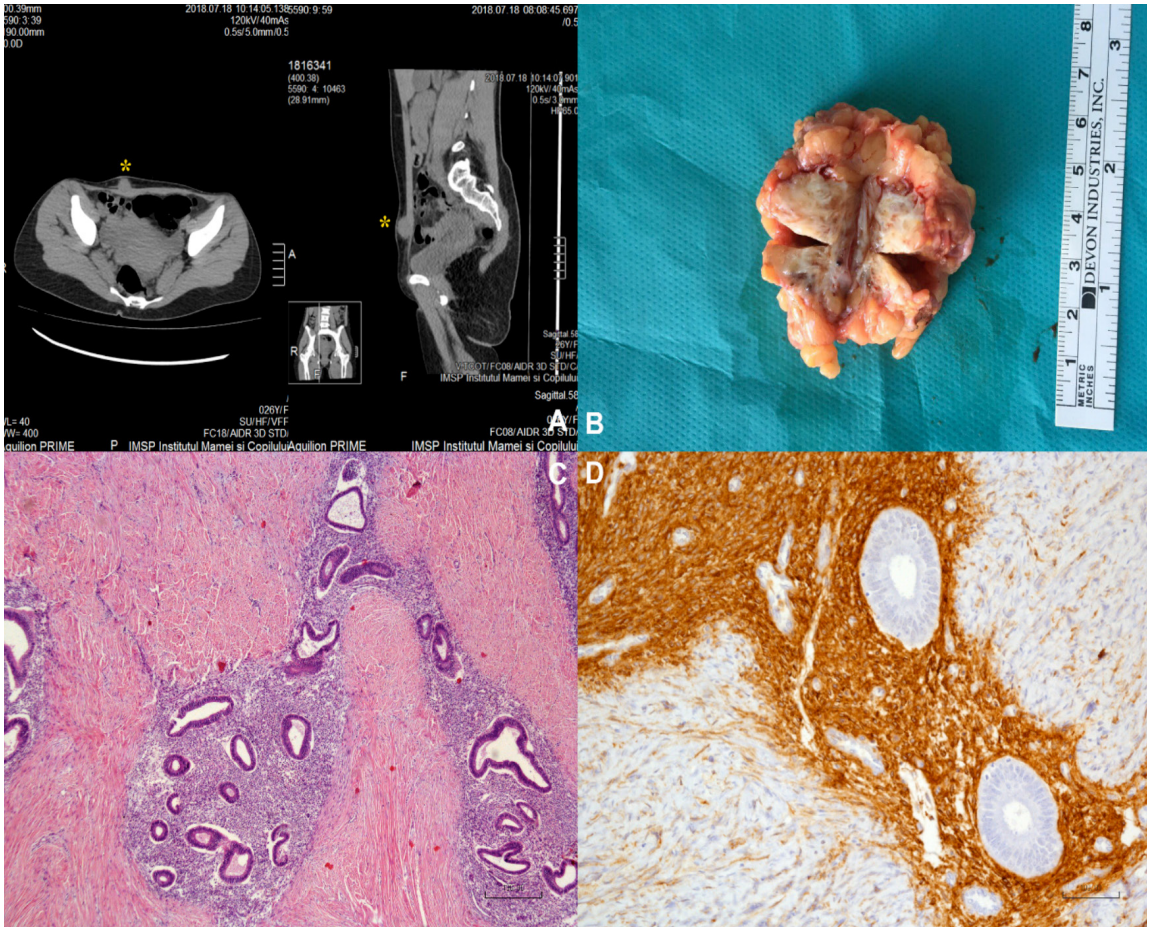

Figure 1. (A) Axial and sagital abdominal CT images revealed a soft tissue mass (asterisk) abutting her anterior rectus sheath (B) Gross appearance of a cut-open specimen. (C) Histopathology of the specimen showing multiple endometrial glands and stroma (H&E staining, magnifcation x 40) (D) Immunohistochemical staining demonstrated CD positivity in stroma confirming the diagnosis of abdominal wall endometriosis (magnification x200)

AWE is a rare type of endometriosis defined as endometrial glands and stroma located within the abdominal wall [1]. Abdominal wall is a rare location for endometriosis, with a reported incidence of parietal endometriosis of approximately 0.03 to 0.4% [2, 3]. AWE occurs most often secondary to obstetric or gynecological surgeries and seems to be related to iatrogenic transfer of the endometrial tissue at the level of the surgical scar [1, 2]. Ultrasound is first-line imaging for diagnosis of AWE [3]. CT and magnetic resonance imaging of the abdomen provide useful information for choosing the best method for closing the fascia defect during operation, as they reveal the extent of the disease and the involvement of the fascia of the rectus muscle [1, 3]. The most definitive treatment of AWE appears to be wide surgical excision including the surrounding fibrotic tissue with negative margins [1–3]. Following surgical excision, more than 90% of patients experience complete symptom relief [1]. Malignant transformation of AWE is rare with an estimated incidence of 0.3% – 1.0%, but carries a very poor prognosis [4].

Author's Statement

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- Conflict of interest: All authors declare no conflict of interest.
- Declaration of patient consent :The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given her consent for her images and other clinical information to be reported in the journal. The patient understands that her name and initials will not be published, and due efforts will be made to conceal her identity, but anonymity cannot be guaranteed.
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