

Subcutaneous Endometriosis Treated with Local Excision: A Case Report

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ABSTRACT

Endometriosis is the growth of endometrial glands and tissues outside of the uterine lining, typically in the pelvis or sometimes in unusual areas such as the bladder or pleura. We hereby, are reporting the case of a young nulliparous woman, with no surgical history, who was admitted for endometrial tissue found in the subcutaneous area of her abdomen and that was treated by complete resection.

Keywords

Endometriosis, Pelvic pain, Surgical scars, Endometrioma, Uterus.

Introduction

Endometriosis is a common benign disorder described as abnormal growths of tissues, histologically resembling the endometrium, located outside of the normal uterine lining, responding to cyclic hormonal fluctuations. Implants are often found on the pelvic peritoneum, also some sites including the uterosacral ligaments, the ovaries or other extra pelvic peritoneal surfaces. Additionally, lesions are rarely found on the rectovaginal septum, ureter, bladder, pericardium, surgical scars and pleura. One pathologic review revealed that endometriosis has been identified on all organs except the spleen [1].

The pathogenesis of endometriosis remains unclear. Many actual theories are debated, explaining the possible origin of endometrial lesions, including coelomic metaplasia, hematogenous or lymphatic dispersion of endometrial cells, the transport of viable endometrial cells through retrograde menstruation, remnant müllerian cells, genetics and also the immunologic dysfunction.

The clinical expression of endometriosis consists of a large spectrum, as some women remain asymptomatic and others complain of frequent symptoms. Subfertility and chronic pelvic pain are repeatedly seen among women, also dyspareunia, dysmenorrhea and less often, dyschezia, dysuria or abdominal wall pain [2]. However, the de novo genesis of the abdominal wall

or subcutaneous endometriomas is still unclear, as most masses seem to be related to prior operations and scars.

These lesions may be diagnosed by variable methods, such as abdominal wall sonography, computed tomography, MR imaging and fine-needle aspiration. Transvaginal sonography can guide the diagnosis if chronic pelvic pain coexists [3].

We hereby, are reporting the case of a young nulliparous woman, with no surgical history, who was admitted for endometrial tissue found in the subcutaneous area of her abdomen and that was treated by complete resection.

Case Presentation

A 33 years old nulliparous healthy woman, with no previous obstetrical or gynecological history and no previous abdominal or pelvic surgeries, was admitted to our department of obstetrics and gynecology, for the management of a pelvic abscess that was diagnosed two months ago. According to the patient, her only complaint was superficial pelvic pain associated with soreness and redness followed by purulent suppuration from the lesion. Her menstrual cycle was completely normal with no dysmenorrhea, except an increased concomitant induration of the abscess that was noted. There were no associated urinary or gastrointestinal symptoms.

General and systemic physical exam did not reveal any abnormality. On abdominal physical examination, a clear pelvic abscess was

seen, with white colored purulent secretions noted on the tip of the wound, along with swelling, pain on palpation and redness. Neither ulceration nor lymphadenopathy were present. Cervical and rectal exams were normal without any other apparent lesions. The abdomino pelvic ultrasound is normal.

After several consultations, many trials of topical emollients were applied, including multiple antibiotics and corticosteroids, followed by repeated oral antibiotics, with no efficient improvement or healing signs.

A surgical resection of the scar was the final decision taken to definitively treat this patient, with wide excision of the margins. The resected piece from the skin and subcutaneous tissue measuring 7 x 2.5 x 1.8 cm was sent to pathology, and no adjuvant therapy was given. The pathology results of the specimen revealed the presence of endometrial inclusions with benign stromal and glandular components along with inflammatory, fibrotic remnants. No recurrences were noted so far, and her wound healed perfectly with no sequelae.

Discussion

In 1903, Robert Meyer was the first to describe the growth of endometrial tissue in a postoperative scar [4]. The presence of endometriosis at the level of scar tissue could be explained by its iatrogenic transplantation on the wound edges during any surgical process, such as caesarean section, hysterectomy, episiotomy, and tubal ligation. Exceptionally, these ectopic lesions can appear in women with no history of endometriosis or surgery [1]. Multiple independent risk factors contain a very high accuracy to reach the diagnosis of ectopic endometrioma, such as mainly localized cyclic abdominal pain, a previous history of laparotomy and the absence of dysmenorrhea [5].

In our case, the symptoms were consistent with those described in the literature: the appearance of a palpable mass (82%), pain (41%) and an increase in size of the mass concomitantly with the menstruation (47%). However, in our study no symptoms of dysmenorrhea were described, and no previous operative scars were noted on our patient.

Ultrasound sonography is not a precise diagnostic tool for an abdominal endometrioma, thus it shows the presence of a mass in the abdominal wall. The latter is imaged as a solid, hypoechoic lesion with internal vascularity and cystic areas [7]. CT and MRI cannot be specific diagnostic methods of an endometrioma, but they can portray the severity of the disorder preoperatively [8]. Sonographically guided FNA has proven to reach the diagnosis accurately [9]. Eventually, a good physical exam along with precise anamnesis and a properly taken gynecological history, will lead us to the correct diagnosis [5].

The therapeutic approach can vary from a simple observation, to

a surgical and/or medical treatment [6]. The definitive curative treatment for abdominal wall endometriosis is the complete resection of the mass [9]. When recurrent lesions reappear, an adjuvant medical therapy should be added after re-excision [10]. Some studies claim the entity of Endometriosis-associated malignant transformation in abdominal surgical scar (EAMTAS) as a very aggressive phenomenon, and the correct treatment is generally extensive surgery and adjuvant chemotherapy and/or radiotherapy [4].

Conclusion

This case report stands out from the literature as an exception due to the absence of surgical scars with no previous interventions that had been done on her abdominal wall. In other terms, our patient presented on her intact abdominal wall an endometrial lesion which was at first masked by the diagnosis of an abscess and treated as such. The standard treatment is complete surgical excision. Therefore, a total wide excision of the mass was done with the particularity of the fact that there was no recurrence observed and no adjuvant therapy given to our patient.

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