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Case Report

Post-Caesarean Section Parietal Endometriosis: About A Case

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Abstract

Wall endometriosis is a rare clinical entity whose pathophysiology remains uncleaI to ccurs most frequently after gynecologic or obstetric surgery. We report the case of à patient with cyclic pain at the caesarean section scar. Clinical examination showed à 4cm mass in the right iliac fossa. Tomodensitometry revealed a tissue density mass (45mm onthemajor axis). Hence, the decision to performa wide excision of the lesion. Anatomo-pathological examination confirmed the diagnosis of parietal endometriosis. Postoperative sequelae were simple with a follow-up period of 20months with no recurrence of the mass or of the pain. Our study highlights the characteristics of this disease to allow the health practitioner to understand the importance of diagnosis, of early treatment of this disease as well as of the possibility to prevent it during each gynecologic or obstetric surgery.

Keywords: Endometriosis, abdominal wall, parietoplasty.

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INTRODUCTION

Endometriosis is described by the presence of endometrial tissue functional outside the uterine cavity. Its most important location frequent seat at the level of the internal genital organs. The others extra-genital locations are less frequent. Its occurrence in level of scars from gynecological or obstetrical surgery is rare (0.03-0.4%). We report the case of a patient with an endometriosis of the abdominal wall on scar of Pfannenstiel. This case is reported because of its rarity and the unusual nature of its location.

PATIENT AND OBSERVATION

This is a 36-year-old patient, fifth gesture fifth parity, three living children who have twice been treated with a the last Caesarean section, the last one three years ago, which complains of pain in the caesarean section scar with development of a mass increasing in size associated with pain rhythmed by the menstrual cycle. The abdominal examination puts in evidence a mass of 4cm of large axis fixed to the deep plane sitting facing the right end of the scar of pfannenstiel (Figure 1).

Computed tomography shows a mass density tissue not enhanced by the contrast medium measuring 30 x 45 mm making intimate contact with the straight muscle of the abdomen, evoking a desmoid tumor, in this sense a wide excision of the mass was performed (Figure 2).

In view of the importance of the loss of parietal substance a parietoplasty was performed by interposition of a plate of Polypropylene 15x15 cm between the two deep muscle planes constituted by the internal oblique muscle and the transverse and superficial plane constituted by the external oblique. Anatomopathological examination of the resection specimen revealed that it is a site of endometriosis of the abdominal wall.

The immediate postoperative follow-up was simple with a resumption of feeding the next day and an outing under analgesic treatment.

The patient reported a disappearance of dysmenorrhea in the weeks following surgery. A control at 3 months then every 6 months was carried out without any recurrence on a 20-month setback.

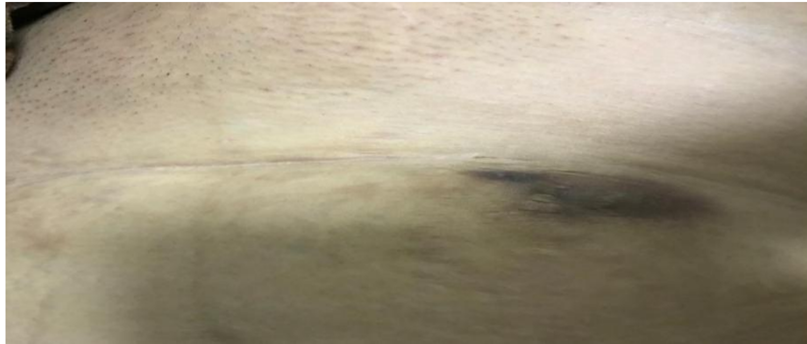

Fig-1: Endometriotic mass on the right side of the pfannenstiel scar

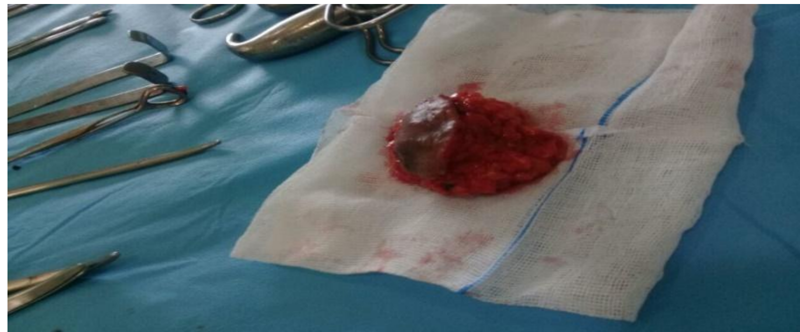

Fig-2: Operating piece after resection

DISCUSSION

Endometriosis is the ectopic implantation of tissue endometrial. Its abdominal location has been identified at the level of different sites including the rectus abdominis, the umbilicus, and the trocar ports. Scarring parietal endometriosis is an a fairly rare entity whose initial diagnosis is not easy. Its pathophysiological mechanism is explained by a graft of endometrial cells during the favoured surgical procedure by estrogen producing endometriomas.

The most frequent modes of revelation are the discovery of a palpable mass increasing in volume, painful that can be associated with skin changes in relation to the scar. The catamenial character, i.e. the exacerbation of these signs during menstruation is an important part of the diagnosis. It has been found in our patient's home. The ultrasound confirms the origin typical intramuscular parietal wall of the recovered mass clinically, the scanner and nuclear magnetic resonance allow to orient the diagnosis without giving any certainty because only anatomopathology allows for the confirmation.

The treatment of these lesions is based on surgical removal, which must be as wide as possible in order to remove the entire mass.

This surgery can be disastrous and may require reconstruction parietal with parietoplasty, which was the case in our patient.

Prevention in case of laparotomy is based on washing of the abdominal cavity and the scar at the end, and the change of gloves for the time of the intervention parietal closure, whereas in laparoscopy, the extraction of the pieces in a protective bag and the abundant washing of the pelvic cavity should be systematic. These measures are part of good surgical practice, although their benefit has never been proven.

CONCLUSION

Parietal scarring endometriosis is a rare pathology, but whose diagnosis must be mentioned in particular in the case of women who have undergone gynecological surgery, or obstetrical to open sky and presenting with pain associated or not with menstrual disorders. The treatment is essentially surgical.

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