

Az Rastlanılan Karın Ağrısı Nedeni: Endometriozis

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ÖZET:

Amaç: Jinekolojik ameliyatlardan sonrasi ön karın duvarında endometriyotik dokuların gelişebileceğini göstermek istedik.

Araç ve Gereç: Kliniğimize karın ağrısı şikayeti ile başvuran 35 yaşında 3 kez sezaryen öyküsü olan hasta literatür eşliğinde sunuldu.

Sonuç: Geçirilmiş jinekolojik ameliyatı olan ve karın ağrısı şikayeti olan hastalarda endometriozisten şüphelenilmelidir.

Anahtar Kelimeler: Endometriyozis; Ultrasonografi

ABSTRACT:

A rare cause of abdominal pain: endometriosis

Purpose: The development of ectopic endometrial tissue within the abdominal wall results from implantation of endometrial cells during previous gynecological surgery.

Material and Methods: A 35 -year-old patient with a history of three caesarean operations complained of abdominal pain is presented. After imagine studies (MRI), the operation was planned and the cytological diagnosis of a benign lesion, possibly endometriosis, was confirmed by a histological study of the extirpated mass.

Result: The suspicion of endometriosis should arise in case of previous gynecological surgeries in patients with abdominal pain. Endometriosis is an important cause of abdominal pain of patients having history of previous gynecologic surgery. That's why we should always keep in mind the endometriosis who has complaints of abdominal pain.

Key words: Endometriosis; ultrasonography

INTRODUCTION

Endometriosis is the abnormal growth of endometrial tissue outside the uterine cavity. Extrapelvic endometriosis may occur in up to 12% of women with endometriosis (1). Although endometriosis is usually confined to the pelvic region, it has been reported in practically every organ of the female body (2). The development of ectopic endometrial tissue within the abdominal wall usually results from implantation of endometrial cells during laparotomy for gynecological or pelvic surgery (3,4). We present a patient in whom endometriosis was discovered in the rectus abdominis muscle with a (previous?) caesarean section before.

CASE REPORT

A 35 -year-old patient with a history of three caesarean operations complained of chronic abdominal that was worsening at menstruation. A physical examination was performed and a mass (3 by 4 cm) which was solid and fixed 2 cm below the umbilicus. The size and consistency of the mass remained unchanged in the supine and upright position. The laboratory tests of the patient were within the normal range. The ultrasonography showed the presence of a hypoechoic mass within the rectus abdominis muscle which is confirmed by MRI scan (**Fig.1**). In view of these findings operative procedure was started. A wide resection of the mass was performed including the surrounding fibres of the rectus abdominis muscle and the covering fascia (**Fig.2**).

Figure 1: A. Axial precontrast T1-weighted MR image demonstrating hypointens nodular lesion in left rectus muscle. B. Axial contrast enhanced T1-weighted MR image with fat saturation shows nodular contrast enhancement in left rectus muscle.

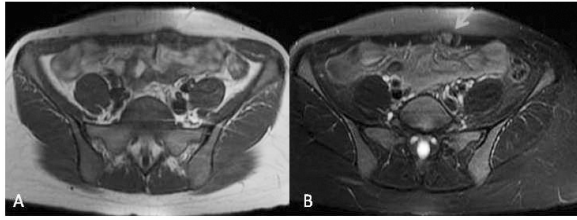


Figure 2 : Intraoperative view of abdominal mass



Mesh graft was placed to cover defective area. The cytological diagnosis of a benign lesion, possibly endometriosis, was confirmed by a histological study of the extirpated mass. After the establishment of the diagnosis the operation was completed with the exploration of abdomen and excluding pelvic endometriosis.

DISCUSSION

The first case of endometriosis was described by Russel in 1899 (5). Since then, ectopic endometrial growth has been reported in almost all organs and systems of the female body, including the urogenital system, omentum, intestine, lungs, pleura, lymph nodes, umbilicus, as well as surgical scars. Although endometriosis in the region of surgical scars is most commonly associated with caesarean section or gynecologic surgery, it has been also described after appendectomy or even inguinal herniorrhaphy. The etiopathogenetic mechanism is probably the intraoperative implantation of endometrial tissue resulting from manipulation by surgeons (6). Abdominal wall endometriosis without a previous surgical history has been reported, but is quite rare (7).

Thorough history and physical examination are essential for the diagnosis of this rare disease. The clinical presentation depend on the location, size and the functional status of the ectopic endometrium (8). Typical symptoms include a tender mass within or adjacent to a surgical scar, most commonly phannenstiel incision. In our case the tenderness of the lesion is usually intermittent and is associated with the menstrual cycle of the patient. The diagnosis of endometriosis is confirmed histologically when two of the following three features are identified: 1) endometrial glands 2) stroma and 3) hemosiderin pigment (9). Although the imagine findings of extrapelvic endometrial implants are variable, MRI is probably the best current imaging modality for the diagnosis (10). Medical treatment with oral contraceptive pills, progestins and gonadotropin-releasing hormone analogs may relief symptoms temporarily. However definitive management is wide surgical excision for the scar endometrioma, which is both therapeutic and diagnostic. The tumor is usually densely adherent to the abdominal fascia, so that a partial resection of the fascia is necessary as in our case.

In conclusion endometriosis can be found in a variety of locations within the body with different complaints. We suggest the including of endometriosis in the differential diagnosis of a symptomatic mass in the abdominal wall in women with a surgical history

REFERENCES

1. Michowitz M, Baratz M, Stavorovsky M. *Endometriosis of the umbilicus. Dermatologica* 1983; 167 : 326-30.
2. Koger KE, Shatney GH, Hodge K, McClenathan JH: *Surgical scar endometrioma. Surg Gynecol Obstet* 1993; 177:243-246.
3. Toullalan O, Baque E, Benchimol D, Bernard JL, Rahili A, Gillet JY, Bourgeon A: *Endometriosis of the rectus abdominis muscles. Ann Chir* 2000;125:880-883
4. Zuber TJ: *Cesarean section scar endometriosis. J Am Board Fam Pract* 1993;6:505-506.

5. Russel WW: *Aberrant portions of the Mullerian duct found in an ovary. Johns Hopkins Hosp. Bull. 1899;10:8-9.*
6. Rizk DE, Acladiou NN: *Endometriosis in a caesarean section scar: A case report. Arch Gynecol Obstet 1996;259:37-40.*
7. Ideyi S, Schein M, Niazi M, Gerst P. *Spontaneous endometriosis of the abdominal wall. Digestive Surgery 2003;20:246–248.*
8. Wolf Y, Haddad R, Werbin N, Skornick Y, Kaplan O: *Endometriosis in abdominal scars: a diagnostic pitfall. Am Surg 1996;62:1042-1044.*
9. Jenkins S, Olive DL, Haney AF. *Endometriosis: pathogenetic implications of the anatomic distribution. Obstet Gynecol 1986; 67:335.*
10. Basu PA, Kesani AK, Stacy GS, Peabody TD. *Endometriosis of the vastus lateralis muscle. Skeletal Radio 2006;35:595-598.*

