

Abdominal Wall Endometriosis following Caesarean Section: A Series of 3 Cases

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Objective

Endometriosis is a chronic inflammatory condition caused by the presence of endometrial-like tissue outside the uterus. Endometriosis is relatively common, but the development of extra-pelvic lesions is rare. Abdominal wall endometriosis (AWE) is defined as endometrial tissue superficial to the peritoneum. AWE often is misdiagnosed and referred to surgeons for treatment presents as painful swelling and can occur following abdominal surgeries most commonly caesarean section as well as hysterectomy, tubal surgeries, appendectomy, trocar-sites, and amniocentesis. Iatrogenic inclusion of endometrial cells in the surgical wound is thought to be the source of abdominal wall endometriosis which then grows to form the mass. Diagnosis can be challenging as imaging techniques are nonspecific and needle biopsy may confirm the diagnosis. Wide excision is the treatment of choice for AWE as well as for recurrent lesions.

Case Report

We present three cases referred with a painful mass around the previous caesarean section scar. Duration from caesarean varied from 4 to 7 years, with a palpable lump and history of cyclical pain. All were suspected caesarean scar endometriosis clinically but only one on imaging. Surgical excision was performed and histology confirmed endometriosis.

Case One

35 years old referred to Gynaecology with a 3 year history of increasing cyclical LIF pain around previous section scar. Background of 1 vaginal delivery, 2 caesarean sections with the last 7 years prior.
USS - 17x14mm lesion ?endometriosis ? Granulomatous scarring
Excision histology – fibrofatty tissue with deposits of endometriosis
9 months from GP referral to surgery. Asymptomatic at follow-up.

Case Two

28 years old referred to General Surgeons with abdominal lump. Background of 1 caesarean section 5 years prior.
CT - 22x16mm subcuticular lesion closely related to rectus sheath
?scarring ?endometrioma. Biopsy – endometriosis.
Referred to Gynaecology, confirmation of cyclical pain & performed excision.
27 Months from GP referral to surgery. Pregnant when review due.

Case Three

38 years old referred to Gynaecology with painful lump above scar and worsening cyclical pain for two years.
Background of 3 vaginal deliveries and 2 sections with the last 4 years prior. No imaging. Trial of GnRH analogue resulted in constant pain. Requested and agreed for excision.
Histology – fibrofatty mass with multiple foci of endometriosis.
20 months from GP referral to surgery. Asymptomatic at follow-up.

Discussion

Due to the comparatively low prevalence of caesarean scar endometriosis, the evidence to base management is sparse. Literature highlights the difficulties in diagnosis due to the initial presentation of a painful mass resulting more often in referral to general surgeons. There are also the limitations of imaging for diagnosis which although can exclude other differentials, the specific sonographic features of abdominal wall endometriosis should be sought and the findings considered alongside clinical examination and history.

Conclusions

Prompt diagnosis and management requires an increased awareness and clinical suspicion of the presentation to optimise patient outcomes. Surgical excision should ensure clear margins to prevent recurrence.