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Case Report

Parietal Endometriosis, a Late and Rare Complication of Caesarean Section

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Abstract: Endometriosis is the presence of functional endometrial tissue outside the uterine cavity. It is most frequently found in the internal genitalia. Extra-genital locations are less common. It rarely occurs in gynaecological or obstetric surgical scars, most often following gynaecological or obstetric surgery, particularly with hysterotomy. We report the case of a patient with parietal endometriosis on a Pfannenstiel scar from a caesarean section.

Keywords: Endometriosis, Caesarean section scar, Cyclic pain, A case report.

INTRODUCTION

Parietal endometriosis is a rare pathology. It can occur on all scars in genitally active women, especially after hysterotomy surgery. Its occurrence in surgical scars, particularly caesarean section scars, accounts for 0.03 to 0.4% of all endometriosis [1]. We report the case of a patient with parietal endometriosis on a Pfannenstiel scar from a caesarean section.

PATIENT AND OBSERVATION

Patient Information:

Our patient was 26 years old and had undergone a caesarean section twice, the last time two years previously. She complained of pain in the caesarean section scar, which was punctuated by the menstrual cycle. Abdominal palpation revealed a deep-lying mass measuring 3 cm long, located opposite the left end of Pfannenstiel's scar. Parietal ultrasound revealed a mass with a tissue density of 22 x 18 mm in close contact with the aponeurosis of the rectus abdominis muscle (Figure 1).

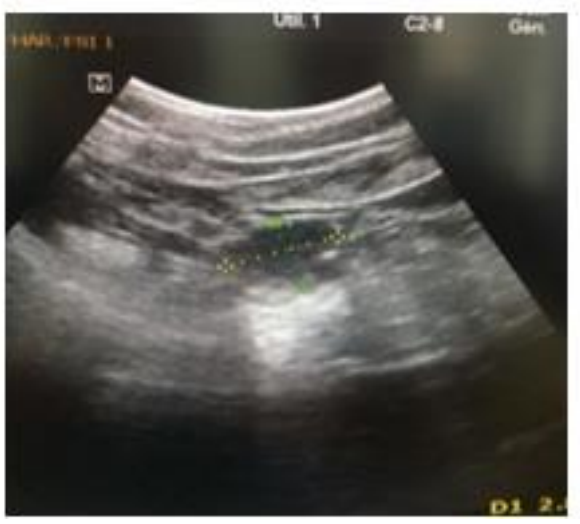

Figure 1 : Ultrasound Appearance

Therapeutic Intervention:

The patient was operated on under locoregional anaesthesia, with an iterative incision at the left end of the old Caesarean scar, identification of the mass by palpation (Figure 2) and excision of the mass (Figure 3), and closure of the wound. Pathological

examination (Figure 4) of the specimen confirmed the diagnosis.

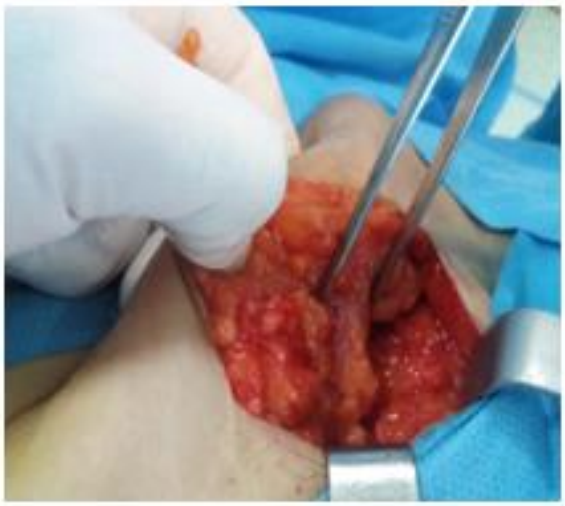

Figure 2 : Identification of the mass by palpation

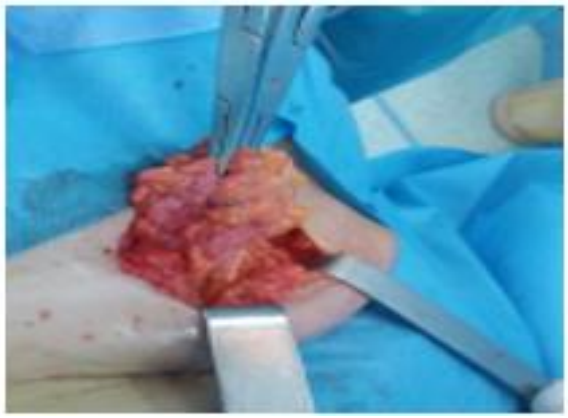

Figure 3 : Excision of the mass

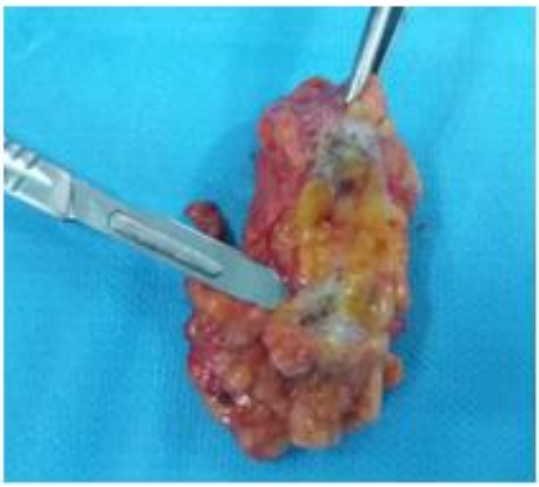

Figure 4 : Macroscopic Appearance

The outcome was favourable, with good healing and disappearance of catamenial parietal pain.

DISCUSSION

Endometriosis is defined as the grafting of endometrial tissue outside the uterine endometrium, and is prevalent in all its forms in up to 10% of genitally active women [2].

It can affect all organs apart from the spleen. It can be found on episiotomy scars and pelvic surgery scars, particularly caesarean sections [3], after laparotomy and also after laparoscopic surgery on trocar orifices [4].

Pathophysiologically, parietal endometriosis can be explained by the theory of implantation by iatrogenic dissemination and grafting of endometrial cells during pelvic surgery [5].

From a diagnostic point of view, there are a number of clinical and radiological arguments; the triad of a history of pelvic surgery, even laparoscopic, a mass opposite the scar, with catamenial pain is very suggestive, even in the absence of any palpable lesion [6], but the diagnosis of certainty remains histological.

Parietal ultrasound is the first-line examination, revealing a mass that is often heterogeneous (haemorrhagic lesions), and specifying its size and its relationship to the fascia and muscle in particular [7].

Needle puncture and microbiopsy are not recommended, as there is a real risk of grafting along the needle path [8].

From a therapeutic point of view, parietal endometriosis is best treated surgically, passing largely outside the lesion to avoid recurrence [9], sometimes necessitating dislocating surgery and parietal reconstruction.

Parietal endometriosis can be prevented by protecting the operating field and the wall, changing gloves during closure, and not using the needle used for suturing during parietal closure.

CONCLUSION

Scar parietal endometriosis should be suspected when the clinical triad is present: history of pelvic surgery, parietal nodule and pain with menstrual periods. It is treated surgically. Surgery must be extensive to avoid recurrence.

Conflicts of Interest: The authors declare no conflicts of interest.

Authors' Contributions

Lounas BENGHANEM: Data Collection, Bibliographic Research and Writing of the Article.
Bouzid ADDAD : Proofreading and Supervision of the Writing of the Article.

Lydia FAÏD : Proofreading and Supervision of the Writing of the Article.
Kamel HAÏL : Proofreading and Supervision of the Writing of the Article.
Radia BENYAHIA : Proofreading and Supervision of the Writing of the Article.

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