Resection of deep endometriosis nodule in psoas and anterior abdominal wall

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SEUD CONGRESS

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INTRODUCTION:

Extraperitoneal forms of endometriosis are rare, but occasionally it may present as a circumscribed tumour called endometrioma or endometriotic granuloma on the abdominal wall.

Although abdominal wall endometriosis most commonly occurs after uterine or fallopian tube surgery, this phenomenon has also occurred after appendectomies and groin plasty.

Foci of endometriosis may involve the full thickness of the abdominal wall or be subcutaneous nodules infiltrating adipose tissue, aponeurosis and muscle.

The most common clinical manifestation in patients with abdominal wall endometriosis is the presence of a hard mass or palpable lump in the abdominal wall.

The diagnosis prior to surgery is made by examination and imaging tests and should include a diagnosis of exclusion of adnexal masses, granulomas or skin cysts.

Diagnostic confirmation is based on anatomopathological examination of the resected specimen.

The best treatment is usually surgery with local resection, which is both diagnostic and therapeutic.

CASE SUMMARY

Woman, 41 years.

Medical background: lumbar hernia. 2 C- sections.

Referred from private clinic for CT scanner finding of right adnexal mass invading psoas muscle and abdominal wall.

Anamnesis: Long term pain in right iliac fossa. Mild dysmenorrhea. No other symptons.

Physical examination: 6cm painfull mass attached to abdominal wall

MRI: right adnexal mass 72x45x51 mm infiltrating psoas, internal oblique and anterior rectus abdominis muscles. Right external adenopathy of 2 cm.

US: right adnexal mass 70x40x45 with Doppler mild vascularization. (1)

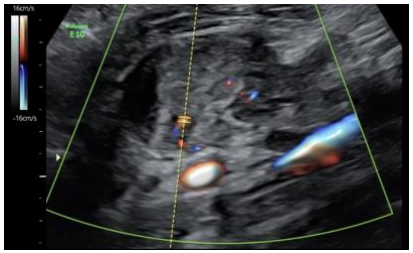
Tumor markers: negative.

SURGERY:

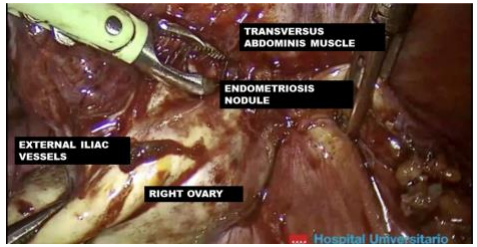
Frozen section. Result: Endometriosis and fibrosis.

Laparoscopic right adnexectomy, complete resection of the abdominal mass.

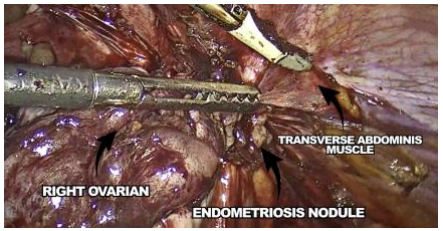
First, we performed right adnexectomy with complete exposure of abdominal mass (2). After, we made exposing and detaching the nodule from the abdominal wall. Disection of iliac vessels. Subsequently we did a detachment of the nodule from the psoas muscle (3). And finally we performed a dissection of fibrotic peritoneum of psoas and extern iliac vessels (4) and the excision of the infiltrating nodule of the psoas (5).



(1). US: Doppler mild vascularization.



(2) Nodule attached to abdominal wall.



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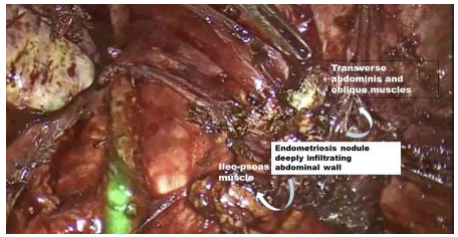
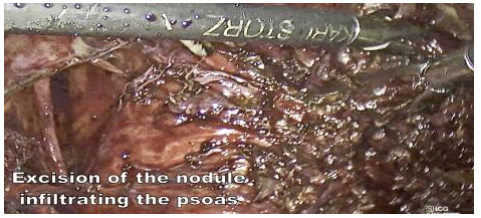


(3) Detachment of the nodule from the psoas muscle .

(4) Right external iliac artery.



(5) Excision of the infiltrating nodule of the psoas .

DISCUSSION

In a patient who ultrasonographically presents with a solid or mixed, well-demarcated mass in the abdominal wall with abdominal pain, especially if it worsens with menstruation and is associated with pelvic surgeries, the diagnosis of endometrioma should be considered. Preoperative diagnosis of certainty can be made by fine needle aspiration (FNA) or by biopsy as in our case, while most imaging tests contribute to its anatomical localization.

To reduce the chance of recurrence, a complete resection with wide margins should be performed to reduce the recurrence rate. In some cases, the nodule deeply infiltrates complex anatomical structures and surgery requires an extensive approach with difficult dissections and wide resections.