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ABDOMINAL WALL TUMOUR: AN UNUSUAL PRESENTATION OF ENDOMETRIOSIS – A CASE REPORT

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ABSTRACT

The association between endometriosis and abdominal wall lesion is rare. Since its first description by Brew in 1954 only a few sporadic cases have been reported in the literature. We report a case of extensive painfall abdominal wall tumours that occur possibly as a consequence of a previous caesarian section. Symptomatic relief was obtained by analgesics and cold compress to the para umbilical swelling. Surgical exploration of the tumour and histogical diagnosis confirmed the diagnosis of endometrosis, conservative hormonal treatment using danazole therapy led to a remission of disease activity. This case illustrates the uncommon presentation of a relatively common disorder and represents one of the few potentially curable causes of abdominal wall tumour. It also perhaps should serve as a cautious note to surgeaon in applying diligence in the performance of caesarian sections.

KEYWORDS: Abdominal, Wall, tumour, endometrosis.

INTRODUCTION

Painful anterior abdominal wall lesions is common in clinical practice, frequently resulting from trauma, obstructed post-operative incisional hernia and cellulites from infective origin. Umbilical hernias are commoner in children but paraumbilical hernias are commoner in adults, and when obstructed they present as painful abdominal wall lesions. In the absence of these lesions, the occurrence of a painful swelling spreading around the umbilicus with an intact scar suggests the diagnosis of a tumor of the anterior abdominal wall. Endometriosis is an extremely rare cause of anterior abdominal wall painful swelling and in general surgery very rarely seen. Since the first description of ectopic endometrial tissues by Brew in 1954 only a few sporadic cases have been reported in the published literature.

CASE REPORT

A 39 year old – gravida 1 para 1 lady presented severally at Faith Foundation specialist clinic, Calabar with severe painful swelling around the umbilicus of about 10cm in diameter and indurations of the anterior abdominal wall along the midline. The swelling was tense causing the firmness of the inverted umbilicus to be pronounce. She 10 years ago had undergone an elective caesarian section whereby a low midline incision was used. Five years later, she developed this para umbilical swelling which gradually became very tense and tender leading to the suspicion of an obstructed para-umbilical hernia or post operative incisional hernia. She started loosing weight, had a raised ESR but negative abdominal ultrasound findings. She initially refused surgery to relieve the 'obstruction' This therefore necessitated symptomatic relief with suspension of oral feeds, intravenous infusions, bed rest, analgesics and cold compress to the abdominal wall. This episode repeatedly occurred for years but by August 2005, the induration has spread far into both sides of the rectus sheaths of the anterior abdominal wall in a cephalic direction into the epigastrium, causing her severe pains. This episode incapacitated the patient as useful working days were lost. This then necessitated the thinking that surgical exploration of this painful abdominal wall swelling should be carried out. Exploration revealed an intact umbilical scar, intact postoperative scar but haemorrhagic looking tissues within the rectus sheet on both sides of the rectus abdominis. Peritoneal cavity was free of any lesion. The haemorrhagic tissue was "evacuated" maximally and operation wound closed in layers. Specimens were sent for histology and histological report confirm the diagnosis of endometrosis of the anterior abdominal wall. Patient was thereafter placed on Danazol and follow-up on a 3 monthly interval confirm satisfactory clinical response. The "tumour" receded, the painful episodes no longer prevail and patient became fully engaged in her duties. Previous ultrasound scan had shown no masses in the pelvis.

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DISCUSSIONS

The association between endometriosis and anterior wall tumor is rare. Since its first description by Brews in 1954 few sporadic extopic cases outside the peritoneum have been reported but none that affected the anterior abdominal wall. Extra peritoneal locations of endometrosis have been reported affecting the pleural cavity with the development of bloody or serous ascitis in Nigeria. However, all these cases of endometrosis are in women in their reproductive year which typically is applicable to the index patient.

The mechanism of endometriosis of the anterior abdominal wall is poorly understood. Retrograde mensuration with transtubal regurgitation of viable endometrial tissue and subsequent implantation and growth on pelvis viscera and peritoneum is the most widely accepted pathogenic mechanisms for endometriosis. Some authors suggests that rupture of these ectopic endometrial cysts within the peritoneal cavity may lead to serosal inflammation and ascites. This case of anterior abdominal wall endometriosis perhaps may have resulted from the spilling of viable endometrial tissues from the uterus during the processes involved in the caesarian section operation that she underwent.

The diagnosis of anterior abdominal wall endometriosis as in this case is that of exclusion implying that common painful causes of anterior abdominal wall tumours must be excluded. Such conditions are abdominal wall trauma and cellulites, obstructed umbilical and para-umbilical hernias, and obstructed post operative incisional hernia. Imaging modalities such as ultrasonography, computerized tomography may however, assist in making a diagnosis of an abdominal wall tumour. However, in sub-Saharan Africa and other areas of the world where tuberculosis remain a significant health burden, a high index of suspicision is always required. In this patient the elevated ESR, significant weight loss and associated tender abdominal wall swelling justified the need to explore with a high index of suspicion of a neoplasm or obstructed hernia.

Percutaneous peritoneal biopsy and laparoscopy a routine procedure in developed countries is advocated as essential in diagnosis of peritoneal endometrosis (Lesi, *et. al.* 2003). Laparoscopy which afford direct visualization and taking of biopsy have superseded percutaneous peritoneal biopsy. The high cost of the equipment, the infrastructure needed to support the procedure and the technical skills required make access to laparoscopy somewhat limited in many developing countries.

Definitive management of endometrosis consist of surgical removal of the ectopic endometrium coupled with long term combination estrogen progesterone therapy for continued suppression of endometrial activity. Conservative treatment using various hormonal preparations is often adopted to allow for retention of reproductive function (Olive, *et. al.* 1993). The patient in this current report has shown remarkable improvement with recession of her abdominal wall "tumour" with danazole therapy. Long-term follow-up is however needed as recurrence is possible. The tenderness and the pain she experienced pre-operatively was due apparently to the tumour bulk causing extensive stretching of the rectus sheaths of the rectus abdominis, which is itself is not elastic but unyielding.

CONCLUSION

This case exemplifies the challenges faced in the investigation and management of abdominal wall tumours and emphasizes the need for invasive investigative procedure for tissue biopsy. Possibly this should be considered as a differential diagnosis in a woman of childbearing age who previously had undergone caesarian section operations, with or without a pelvic mass. It also means that surgeons should be diligent in the handling of uterine tissue during caesarian section operations to prevent unwarranted spilling of endometrial seedlings to surrounding organs. In sub-Saharan Africa simple surgical procedures to obtain tissue biopsy should be considered before resorting to more potentially hazardous but expensive procedures.

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