An unexpected anterior peritoneal lesion resembling caesarean section scar endometriosis resected laparoscopically.

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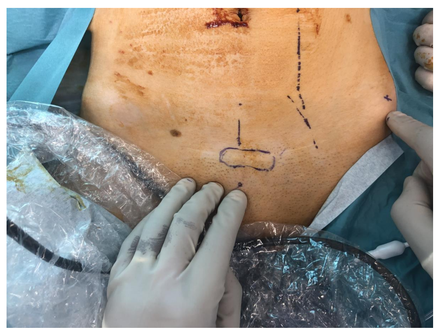
Background

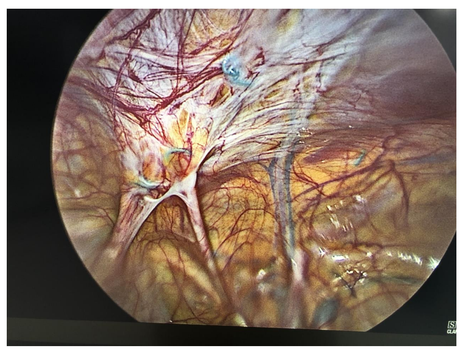
A 40 year old patient presented to our endometriosis clinic with a lump at the site of her caesarean section (CS) scar. She has an unremarkable surgical history apart from a CS 11 years ago in another country. The patient reported cyclical pain at the area of the nodule and scored high for dysmenorrhoea, dyspareunia and bladder pain. On examination, a firm nodule could be palpated underlying her CS scar.

Ultrasound scan of the anterior abdominal wall showed a heterogenous 3cm mass with vascularity and scar endometriosis was proposed as the diagnosis. A further transvaginal ultrasound of the pelvis was unremarkable. In view of the other endometriosis symptoms, diagnostic laparoscopy, treatment to pelvic endometriosis if present and excision of the abdominal wall lesion was scheduled.

Methods

Given the previous CS and low body mass index of 18kg/m^2, entry to the peritoneal cavity was achieved through the modified Palmer's point (8cm lateral to the midline and 3.5cm inferior to the left costal margin). Laparoscopy revealed an anterior peritoneal lesion involving the urachus and medial umbilical ligaments. The lesion had a fibrotic texture and was causing tethering of the above structures. Using an advanced electrosurgical device (Harmonic®, Ethicon) the lesion was dissected off the anterior peritoneal wall. Undissolved suture material was seen during dissection placed there during the CS to close the parietal peritoneum. The lesion was excised completely and did not extend through the rectus sheath. Moreover, undissolved suture material on the visceral peritoneum (uterovesical fold) and a firm left pararectal nodule were noted, the latter of which was resected and sent to histopathology. The procedure was uncomplicated and the patient was discharged the following day.





Results

CS scar endometriosis is a rare entity, albeit well reported. Given the increasing CS rate as well as the improved awareness from clinicians, CS scar endometriosis is often included in the differential diagnosis of women with an abdominal wall nodule and a history of CS. In this case, histology from the laparoscopically resected anterior peritoneal nodule revealed suture granuloma and that from the left pararectal nodule confirmed endometriosis.

Conclusion

CS scar endometriosis should be suspected in a patient with localised pain and a palpable nodule at the site of a previous CS scar. However, in a very slim patient, such a nodule could represent a peritoneal lesion rather than one on the anterior abdominal wall. Laparoscopy should therefore be performed to evaluate the extent of the lesion and to determine how to best access and excise it.

Finally, as clinicians, we should be aware of different surgical techniques and material that might be used in other countries during a routine procedure such as CS. In this case, a foreign body reaction mimicked scar endometriosis.

The authors have no conflicts of interest to declare.