

**LARGE ENDOMETRIOTIC PARIETAL NODULE: A CASE REPORT**

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**ABSTRACT****Summary**

Wall endometriosis is a rare clinical entity whose pathophysiology remains unclear. It most often occurs after gynaecological or obstetric surgery, the etiopathogenesis remains unclear. The clinical characteristic of these types of lesions inconstantly involves a painful swelling during menstruation. However, only histological examination of the surgical specimen can confirm the diagnosis, Treatment is essentially surgical is based on complete removal of the lesion. We report a new case of endometriosis localized to the abdominal wall. which, in the light of a review of the literature, we will emphasize all the features of this entity, including its prognosis, which will enable the practitioner to the importance of early diagnosis and management of this entity - which is never sufficiently parietal mass - and its prevention during any gynaecological surgery.

**KEYWORDS:** Abdominal wall, Endometriosis, Surgery, Case report.**Patient and Observation**

We report the case of a patient, 41 years old, 2 EV/VH in 2008 and 2014, with no particular ATCD CR, on ogino method, consulted for parietal pain at the level of the caesarean scar.

Examination: BMI: 26, BP 11/6 CNC. 5cm long axis mass fixed to the deep plane located opposite the right extremity of the scar.

Echo: 2 heterogeneous masses at the angles of the scar dt 3.6/ 3.5 and left of 2.9/2.13 cm=parietal endometriosis

Pelvic MRI (Fig. 1): subcutaneous mass opposite caesarean scar, measuring

43/80/45 mm, associated with infiltration of the rectus abdominis muscles and peri-lesional fat. The absence of endometriosis in the lesion is suggestive of parietal endometriosis.

Absence of deep endometriosis lesion. Under spinal anesthesia

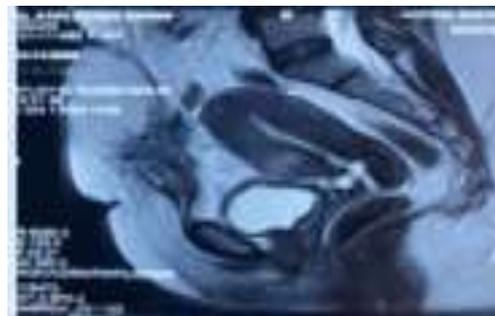
Removal of 6 cm of old Pfann scar

On exploration: Location of a nodule over 10 cm in size, infiltrating the rectus muscles and fascia aponeurosis (figure 2)

Painstaking resection of the nodule, leaving a part attached to the parietal peritoneum and the anterior bladder wall avoiding bladder or digestive tract injury

Difficult closure of the fascia under tension with U-stitches Placement of a subcutaneous suction redon drain

Hemostasis assured Postoperative follow-up was straightforward and progressed well



**Figure 1: Pelvic MRI showing parietal endometriosis.**



**Figure 2: Endometriotic nodule.**

## DISCUSSION

### Introduction:

Endometriosis is defined as the presence of endometrial tissue outside the endometrium to respond to ovarian hormonal stimuli, the most common locations being pelvic ovaries, peritoneum, uterine ligaments, rectovaginal lamina.

Other, rarer, extra-pelvic locations have been described, in particular the bladder, intestine and uterus. bladder, intestine, appendix, umbilicus, hernia sacs, lung, kidneys and abdominal wall.

Abdominal parietal endometriosis is a rare and relatively unknown entity. since it accounts for 1 to 2% of cases of extra-genital endometriosis. surgical or obstetric intervention, even after the menopause. It is a cicatricial endometriosis due to endometrial implantation in a scar. The may take several years to appear, but "rare cases of parietal endometriosis cases of parietal endometriosis can be observed without prior surgery (1), such as the endometriosis lesions described at the umbilicus or abdominal wall".

### Diagnosis:

Its pathophysiological mechanism is explained by the grafting of endometrial cells during surgery, favored by estrogen, thus producing endometriomas Symptoms are catamenial (They appear during menstruation) and may correspond to (In some cases, small nodules can be felt on palpation) and bleeding around the umbilicus (palpation) and bleeding from the umbilicus (Laparoscopic scar). In some cases, however, endometriosis cells may migrate beyond the scars, generating endometriosis. beyond the scars and generate abdominal pain.

Ultrasound is the first-line examination for confirming the diagnosis and assessing size of the nodule and to rule out other parietal pathologies by showing a hypoechoic, hypervascularized mass. CT scans and nuclear magnetic resonance help to orientate the diagnosis, but do not provide certainty, as only anatomopathology anatomopathology provides confirmation.

Treatment can be medical (hormonal) and aims to reduce pain. If this is not sufficient, surgery may be proposed to remove the endometriosis lesions. This surgery may sometimes require the insertion of a prosthesis-type plate, if the resection of the nodule is too extensive and risks causing secondary hernias. Theoretical means of preventing parietal affection exist: particular attention to wall protection with surgical drapes, Appropriate irrigation at the end of surgical procedures.

## CONCLUSION

Parietal endometriomas are rare. Localization on Caesarean section scars is the most common. Diagnosis can be difficult, but should be made in the presence of

parietal tumor on a gynecological or obstetrical scar. The radiological examinations are used to characterize the lesion (Number, location, dimensions, depth) and to search for possible signs of deep-seated disease indicating medical treatment after removal of superficial lesions. Surgery must be extensive to avoid recurrence. The diagnosis is only confirmed by anatomopathological study. Despite the fact that parietal endometriosis obeys the theory of accidental iatrogenic implantation when handling wounds intraoperative, preventive measures have yet to be demonstrated.

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