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A rare case report on rectus muscle endometriosis

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Abstract
Background: Rectus muscle endometriosis is a rare entity. Though it occurs after previous surgeries, it can also occur in patients without scar. A differential diagnosis of extra-pelvic endometriosis must be kept in mind when women of reproductive age presents with mass abdomen which becomes painful during menstruation. CT/MRI can detect lesions and surgical excision remains the definitive treatment.
Case report: We present a case of a 30 year old, P2L2A1, with previous normal deliveries who presented with swelling over left iliac fossa which was painful during menstruation. CECT done showed endometriosis over rectus muscle. She underwent excision of the mass, which showed features of endometriosis in histopathology. She was on followed up for 2 years with no features of recurrence.

Keywords: Extra-pelvic endometriosis, left iliac fossa, excision, histopathology

Introduction
Endometriosis is defined as presence of endometrial glands and stroma outside uterus. The most frequent site of implantation is pelvic viscera and peritoneum. It is predominantly found in reproductive women. Extra-pelvic endometriosis is rare and accounts for 1-2%, which results from vascular or lymphatic dissemination of endometrial cells to many gynaecological and non-gynaecological sites. Endometriosis of abdominal wall represents 0.03–2% of extra genital endometriosis [1]. Various non-gynaecological sites include bowel, lungs, pleural cavity, rectus muscle, umbilicus and surgical sites. Though it commonly occurs after previous surgeries, there are few cases which was reported in women without previous history of surgery.

Case Report
A 30 year old, P2L2A1 who had previous 2 normal deliveries and was not sterilized. She presented with complaints of swelling over lower abdomen, which was more painful during cycles and severe dysmenorrhea before and during cycles with moderate flow. She had regular menstrual cycles. On examination she was found to have a swelling of 3x2 cm over left iliac fossa, which was firm in consistency, immobile and irreducible with tenderness on palpation. CECT abdomen done showed a well-defined irregular homogenously enhancing solid mass of size 2.7x1.7x3.5cm seen predominantly in the muscular plane in the Left iliac Fossa suggestive of endometriosis.

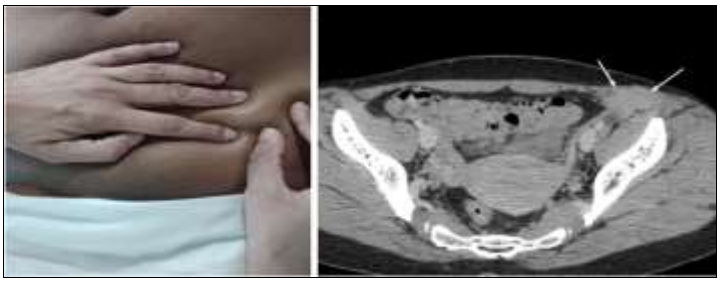

Fig 1: Picture showing mass over left iliac fossa and CECT image showing endometriotic lesion over left rectus muscle

Patient was planned for excision biopsy of the mass. Intra-operatively, a 5x4 cm mass over left lateral wall of rectus muscle noted, same excised. Round ligament and left fallopian tube was found densely adherent to peritoneum over the left lateral wall, below rectus muscle.

Adhesiolysis was done. Specimen was sent for Histopathological examination.

Post-operative period was uneventful. Histopathology was reported as Fibro-collagenous and muscular tissue with endometrial glands and stroma with hemosiderin laden macrophages characteristic of endometriosis. Patient was discharged and followed up.

Patient was discharged on Post-operative day 3 and was complaint with follow up post-operatively for 2 years without any recurrence.

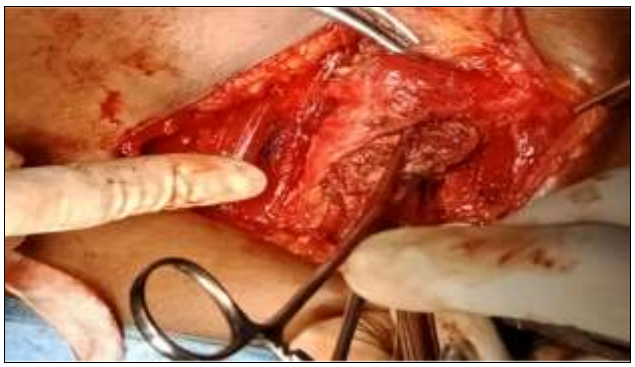

Fig 2: Intra-operative picture of rectus muscle endometriosis

Discussion

Rectus muscle endometriosis is a rare entity. It accounts for 0.03–2% of extragenital endometriosis [1]. The etiopathogenesis of endometriosis is explained by several theories, which includes: the transplant theory - based on tubal reflux of endometrial fragments caused by retrograde menstruation; the theory of coelomic metaplasia- in which there is metaplasia of coelomic epithelial cells which predisposes to endometriosis; and finally, the metastatic theory- suggesting the possibility of hematogenous or lymphatic dissemination [2].

CT scan shows a solid and well circumscribed mass [3]. MRI is beneficial to assess the depth of extension of endometrioma. (4) The sensitivity and specificity of MRI is 90% and 98% respectively for the diagnosis of endometrioma [5].

Medical treatment can be used in cases with big masses, to reduce the size of the mass [4].

The treatment of choice for rectus muscle endometriosis is wide excision of the lesion with negative margins. The surgical margin should include 5–10 mm of the surrounding healthy tissue and care should be taken while removing mass, as there are chances of reimplantation of microscopic remnants of endometrial tissue if mass is ruptured [3].

Thorough washing of the abdominal cavity at the end of intervention (either laparotomy or laparoscopy) helps in preventing recurrence [4].

Conclusion

The Rectus muscle endometriosis is a rare entity. Despite the rare incidence, extra-pelvic endometriosis should be considered as differential diagnosis of a women of reproductive age group who present with characteristic waxing and waning pain over mass in relation to the menstrual cycle. Though Surgical management remains the definitive treatment, proper counselling regarding the nature of the disease and the risk of recurrence should be explained.

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