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ABDOMINAL WALL ENDOMETRIOSIS

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Abdominal wall endometriosis is an extra-pelvic manifestation of endometriosis, typically occurring after obstetric surgeries like cesarean sections. This article describes a rare case of a nulligravida patient who developed a 2 cm endometriotic lesion in a postoperative scar following laparoscopic surgery for an ovarian endometrioma. The endometrioid formation of the anterior abdominal wall developed at the site of the left trocar insertion when the endometrioid cyst was removed through the expanded left port. Following an unsuccessful 6-month course of dienogest therapy, the patient underwent wide local excision. Histology confirmed fibrofatty tissue with endometriotic foci. This case highlights the risk of "seeding" during the laparoscopic retrieval of endometriotic tissue and underscores the necessity of surgical intervention when medical therapy proves ineffective.

Keywords: *endometriosis, abdominal wall, scar endometriosis, laparoscopy, ovarian cystectomy.*

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Introduction

Endometriosis is the existence of endometrial mucosa outside of the uterine cavity [1]. It is one of the most common gynecological disorders in women of reproductive age.

Here, endometrial stroma and glands are present outside of the uterus [2]. It is estimated in about 10% of women of reproductive age [3]. Endometriosis is an asystematic inflammatory disease that is dependent on estrogen [4]. Endometriosis is the cause of infertility, chronic discomfort, and a decline in the quality of life for many women. It also imposes a substantial monetary strain on the health systems [5].

Endometriosis is commonly found on the ovaries, fallopian tubes and tissues surrounding the uterus and ovaries. Extrapelvic disease is uncommon but cases involving the urinary tract, gastrointestinal tract, and respiratory system have been previously reported [6, 7].

Abdominal wall endometriosis (AWE) is defined as the presence of endometriotic infiltration in any segment or depth of the abdominal wall. It is rare and uncommon presentation of endometriosis [8]. Here, ectopic endometrial tissues get implanted outside the peritoneum including in the subcutaneous fat layer and the muscles of the abdominal wall [9]. While the pathogenesis is unclear, most cases occur at or near the sites of operative scars from surgeries such as cesarean sections and hysterectomies [10]. These are called secondary AWE. However spontaneous AWE occurs in a scarless abdomen and accounts for about 20% of all AWE [11]. Preoperative diagnosis rates are low due to the wide range of clinical symptoms, location of the abdominal mass, and multitude of possible differential diagnosis. Currently, a postoperative pathological confirmation is still necessary for accurate diagnosis [12]. Frequently described localizations for AWE not related to operations are laparoscopic trocar tracts and the navel [13, 14]. With the increase of cesarean sections in the modern world, the incidence of AWE has also gradually increased. Due to the variability of the clinical manifestations of AWE, it's difficult to differentiate from granulomas, hematomas, lipomas and other diseases.

The prevalence of AWE is that it is the most common form of extra-pelvic endometriosis, with an estimated incidence of 0.03% to 3.5% in women with a history of obstetric or gynecological surgeries [14].

When we consider the pathogenesis of AWE, the primary cause is the iatrogenic transplantation of endometrial cells during surgery. While most frequently linked to cesarean sections, it can occur after any procedure where the uterine cavity is entered or endometriotic tissue is handled [13].

AWE is frequently misdiagnosed as an incisional hernia, hematoma, or abscess. It is highly relevant because it can occur even in the absence of pelvic endometriosis, and as seen in this case, can develop in nulliparous women through laparoscopic port-site seeding [13, 14].

Effective management of AWE necessitates a multidisciplinary clinical framework. Historically, therapeutic strategies for endometriosis have integrated hormonal suppression with pharmacological analgesia and surgical intervention. The selection of these modalities is typically dictated by specific patient objectives, primarily the alleviation of chronic pain or the preservation and optimization of reproductive potential [15].

A wide local excision of endometriotic foci is the preferred surgical approach, as comprehensive resection margins are critical to mitigating the 5–9% risk of local recurrence documented in existing clinical literature [16, 17].

For the management of localized scar endometriosis, ultrasound-guided ethanol sclerotherapy has been documented as an effective intervention in select cases, particularly for maintaining abdominal wall integrity and avoiding the defects associated with wide local excision [18].

More recently, High-Intensity Focused Ultrasound (HIFU) ablation has emerged as a viable non-invasive alternative [19, 20]. Clinical data indicates a favorable recurrence rate of 3.9%, with Lee et al. demonstrating that HIFU significantly reduces the incidence of perioperative complications – specifically intraoperative hemorrhage and parietal wall defects – compared to conventional surgical resection [21].

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Pharmacological interventions – including combined oral contraceptives (COCs), progestogens, and gonadotropin-releasing hormone (GnRH) analogues –serve as viable alternatives for patients declining surgical intervention or as adjuvant therapy to mitigate recurrence and suppress residual disease. Furthermore, neoadjuvant hormonal suppression may be utilized to downstage extensive lesions, potentially reducing tumor volume prior to resection. However, it is noteworthy that the robust clinical response to hormonal therapy typical of pelvic endometriotic implants is frequently absent in AWE, which often demonstrates comparative therapeutic resistance [22]. We should note that Surgical Removal is the main therapeutic approach for a patient suffering from AWE.

The overall risk of malignant transformation associated with endometriosis across all sites is estimated at 1%. Data indicate that 80% of these cases originate within ovarian implants, while the remaining 20% involve extra-gonadal sites, including the abdominal wall. Consequently, while primary malignant transformation in AWE is statistically rare, the potential for clear cell or endometrioid adenocarcinoma necessitates vigilant diagnostic screening of atypical or rapidly enlarging masses [23].

Aim of the study. The primary purpose of this research is to perform a comprehensive clinical and diagnostic analysis of a rare case involving AWE localized within a postoperative scar.

This study focuses to present a clinical case of AWE in a patient with no history of pregnancy, occurring specifically at a laparoscopic trocar site, and to evaluate the efficacy of surgical excision following failed medical management due to the patient's resistance to long-term Dienogest therapy. This study also discusses the diagnostic precision of ultrasound (US) and Magnetic Resonance Imaging (MRI) in identifying ectopic endometrial foci. Furthermore, this study seeks to document the surgical management of the condition.

Material and methods

This retrospective, observational and descriptive study included the woman who underwent surgical treatment of AWE at the City Clinical Hospital of Emergency Medicine, Grodno in December 2025. This patient was operated by the surgeon and the cases was confirmed by histopathological examination.

Data collected included patient's history, patient's complaints, clinical presentation, previous surgical/ gynecological/ obstetric history, diagnostic methods, size of lesion and location, type of surgery performed.

The primary material of this study is the clinical records of a female patient presenting at the medical facility in Belarus (2025) the data analyzed include: anamnesis (patient history, surgical and pharmacological), physical examination, imaging data (US scan, MRI), surgical records and pathology (postoperative histological response).

The review of publications was based on studies using key words such as "endometriosis", "abdominal wall endometriosis" based on the results and searched in electronic resources in Belarus and international systems (Google Scholar, PubMed, eLIBRARY) from 2020 to 2026 years.

Case Report

A woman 28 years old went to the gynecological department with complaints of painful formation in the left inguinal region, increased pain and an increase in the size of the endometrioid lesion on the eve of the next menstruation. The above complaints were bothered for 7 months. The patient initially managed medically with Dienogest for 6 months, which yielded no clinical improvement or reduction in the size of the focus. She had undergone laparoscopic surgery for an endometrioid cyst of the right ovary in 2024.

Her general condition is satisfactory and hemodynamically stable.

The first menstruation began at the age of 13. Menstruation is regular, moderate, lasting 5 days, moderately painful in the first days. The duration of the menstrual cycle is 28-30 days. Sex life since the age of 18. There is no history of pregnancy or childbirth. In 2024, she underwent laparoscopic surgery to remove an endometrioid ovarian cyst.

Her gynecological status reveled correctly developed external genitalia, vagina divided by complete septum, two distinct cervices were pink and clean, and bimanual examination shows complete doubling of uterus and both are dense and painless. The appendage area is free and painless on palpation. The vaults are free.

Status localis. In the area of the old postoperative scar in the left inguinal region, a dense subcutaneous lesion with a diameter of about 2 cm is palpated, round, well-defined and mobile, painful on palpation.

US (Transvaginal/Soft tissue) of the Inguinal Region shows hypoechoic formation (14×9.1 mm) with uneven but clear contour and detectable signs of peripheral blood flow. Uterine findings confirm complete doubling (Uterus Didelphys).

MRI examination. In the area of the postoperative scar of the left inguinal region, an additional component of the hypointensive signal is determined with a heterogeneous content of hyper-/ isointensive signal on the T2-weighted images (T2-VI), hyperintensive signal T1-weighted images (T1-VI) with limited diffusion with fuzzy walls, measuring 5×15×12 mm (focus of endometriosis). MR signs of complete doubling of the uterus have also been recorded.

As treatment surgery was performed. Under aseptic conditions under endotracheal anesthesia after antiseptic treatment of the surgical field, an incision was made over the old scar in the left inguinal region. A dense, 2 cm endometriotic focus was identified involving the aponeurosis (fascia). Excision of the formation on the anterior abdominal wall was performed with a wide capture of the surrounding tissues. The postoperative period was uneventful, and the symptoms disappeared.

Histopathological analysis shows endometrial glands and stroma surrounded by inflammatory or fibrous tissue. In this patient the histological

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report confirmed confirms fibrous-adipose tissue containing ectopic endometrial glands and stroma within the areas of endometriosis. This confirms the iatrogenic seeding of active tissue into the subcutaneous fat and fascia.

It is recommended that patients undergo a six-month course of outpatient pharmacological therapy utilizing synthetic gestagens as postoperative management protocols for AWE. This extended postoperative regimen is designed to suppress residual microscopic foci, stabilize the local tissue environment, and effectively minimize the longitudinal risk of symptomatic recurrence.

Discussion

Endometriosis is an estrogen-dependent chronic progressive disease characterized by the growth of endometrial-like tissue outside the uterine cavity. About 25% of the patients with endometriosis are asymptomatic.

Most woman suffering from endometriosis have prominent pain. Here patient may experience congestive dysmenorrhea where the pain arises before the menstruation. The women suffering from endometriosis also have ovulation pain specifically during the midcycle period. Other common pain perceptions of women suffering from endometriosis are dyspareunia (pain during sexual intercourse), Chronic pelvic pain, Lower sacral backache, acute abdominal pain and sub fertility. Another common issue in women suffering from endometriosis are menstrual abnormalities such are heavy menstruation and secondary dysmenorrhea.

In our case study, patient who is a female, nulligravida, presented with a painful mass in the left inguinal region at a postoperative scar. She reported that the mass increased in size and became more painful immediately prior to menstruation. The above complaints were bothered for 7 months. She had undergone laparoscopic surgery for an endometrioid cyst of the right ovary in 2024.

AWE characterized by the presence of ectopic endometrial glands or stroma in the abdominal wall is a rare form of extragenital endometriosis.

Scarring endometriosis is most common it is localized in the scar from cesarean section after Pfannenstiel laparotomy. However, endometrioid heterotopias in the postoperative scar can develop after gynecological operations on the uterus associated with hysterotomy or hysterectomy.

Scarring endometriosis after laparoscopic surgery develops at the trocar insertion sites, most often after surgical treatment of pelvic endometriosis. The patient, the clinical case that we describe in this article, developed scarring endometriosis at the trocar injection site after ovarian cystectomy.

For the diagnosis of endometriosis, we can perform hematological investigations, imaging and biopsy. In hematological investigations for endometriosis we check if CA-125 is elevated and also check for anti-endometrial antibodies in the peritoneal fluid and serum. For imaging we perform transabdominal US (TAS) as well as transvaginal US (TVS). Also, MRI imaging is necessary for the identification and confirmation of endometriosis. Clinical data and imaging results may be sufficient to make a diagnosis but in some cases it may be necessary a biopsy including to exclude a malignant neoplasm. In this regard, a fine needle aspiration puncture biopsy may be useful.

For the diagnosis in our patient, US is considered first-line and MRI for surgical planning (Figure 1). US findings: A hypoechoic formation (14×9.1 mm) with uneven but clear contours and detectable blood flow (IR 0.69). MRI findings in this patient shows a 5×15×12 mm focus in the left inguinal region. It showed a hypointensive signal with heterogeneous contents, hyper/isointensive on T2-VI and hyperintensive on T1-VI, suggesting blood products within the lesion. Imaging also revealed a complete doubling of the uterus (uterus didelphys).



Figure 1 – MRI of AWE in nulliparous women

Currently, the gold standard treatment for scar endometriosis is surgical excision of the node, including the surrounding fibrous tissue. With extensive lesions involving the vagina of the rectus abdominis or the muscle, large defects may form after excision of endometriosis. In these cases, to prevent the formation of postoperative hernias, it is recommended to consider the possibility of reconstructing the abdominal wall using mesh.

As an alternative to surgical intervention, high-intensity focused ultrasound ablation (HIFUA) was proposed, with a recurrence rate of 3.9%

Drug therapy (COCs, progestogens, danazol and GnRH preparations) provides only temporary relief of symptoms.

This patient took Dienogest for 6 months with no effect. Surgical intervention was performed under endotracheal anesthesia; an incision was made over the old scar. A dense, 2 cm endometriotic focus was identified involving the aponeurosis (fascia). Excision of the formation on the anterior abdominal wall was performed with a wide capture of the surrounding tissues to prevent recurrence (Figure 2). The aponeurosis was repaired with continuous PGA sutures.

Histological analysis of our patient in the report confirmed fibro-adipose tissue with areas of endometriosis (Figure 3). This confirms the iatrogenic seeding of active tissue into the subcutaneous fat and fascia.

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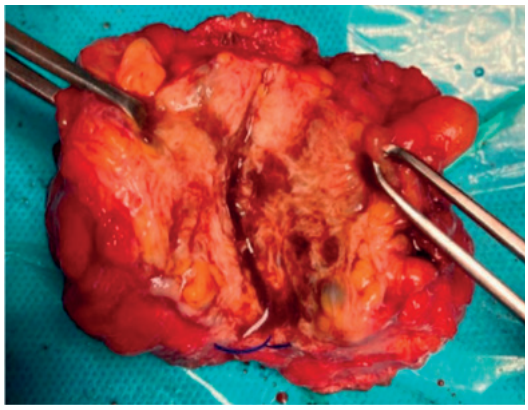


Figure 2 – Intraoperative Image-Excised AWE Mass. The cut surface reveals fibrotic areas interspersed with brownish, chocolate-colored hemorrhagic fluid and cystic spaces-characteristic of endometriotic tissue

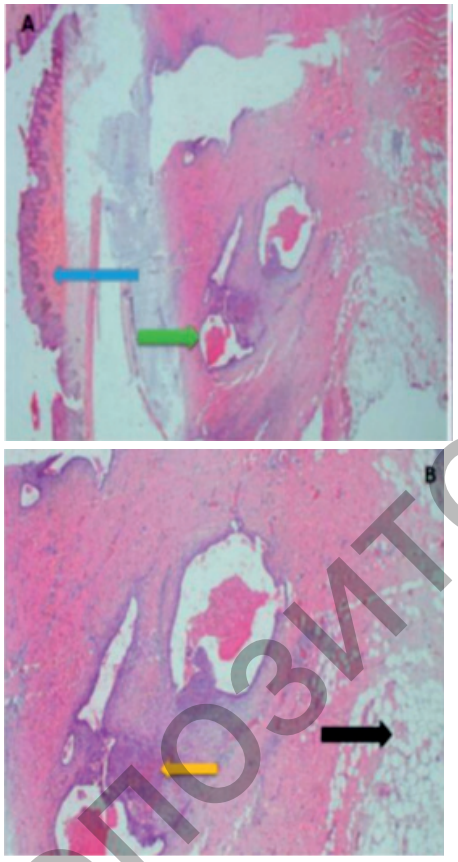


Figure 3 – Histopathology of cutaneous endometriosis demonstrating a normal epidermis and scattered endometrial glands and stroma in the dermis

We need to make a special consideration that while AWE typically follows a cesarean section, this patient had no history of pregnancy or childbirth. This case illustrates a specific complication of laparoscopic surgery: the endometriosis developed at the left trocar insertion site. The lesion formed because the endometrioid ovarian cyst removed in 2024 was retrieved through a dilated port, allowing cells to "seed" the abdominal wall layers during extraction.

Based on current clinical guidelines (including the 2022 ESHRE Guidelines and recent 2024–2026 research), the postoperative management of AWE focuses on two goals: ensuring structural healing of the abdominal wall and preventing symptomatic or cellular recurrence. Immediate Postoperative Care & Surgical Recovery include Wound and Fascial Management: For patients with deep lesions (Type III) involving the muscle or aponeurosis, recovery focuses on preventing incisional hernias. If a synthetic mesh was used for reconstruction, strict activity restrictions (avoiding heavy lifting) are typically advised for 4–6 weeks [24, 25].

Medical Management (Hormonal Therapy) including Synthetic Gestagens (e.g., Dienogest) and long-term hormonal suppression is recommended to prevent the development of new foci. Current studies advocate for a minimum of 6 months of treatment to ensure the suppression of any microscopic "seeded" cells [26, 27].

Recurrence is typically monitored via physical examination and US, starting 3 months post-surgery. Any return of cyclical pain or a palpable mass at the scar site requires immediate imaging [25]. Malignancy Screening should be performed, although rare (<1%), the risk of malignant transformation in AWE (e.g., clear cell carcinoma) justifies the recommendation for histological confirmation of all excised tissue and long-term surveillance of the surgical site [24, 28].

This patient was recommended to undergo a six-month course of outpatient pharmacological therapy utilizing synthetic gestagens. This was designed to stabilize the local tissue environment, and effectively minimize the longitudinal risk of symptomatic recurrence in this patient.

Conclusion

Iatrogenic Risk shows that AWE can occur in nulliparous women following laparoscopic procedures if endometriotic tissue is not retrieved using protective bags. Cyclical pain at a scar site should trigger suspicion of AWE, regardless of obstetric history. Wide surgical excision is the treatment of choice, as medical therapy often fails to resolve fibrous abdominal wall lesions. Post-surgical management must include medical rehabilitation. For this patient, postoperative medical rehabilitation on an outpatient basis for 6 months using synthetic gestagens is recommended to prevent recurrence.

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ЭНДОМЕТРИОЗ БРЮШНОЙ СТЕНКИ

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Эндометриоз брюшной стенки, характеризующийся наличием эктопических желез эндометрия или стромы в брюшной стенке, является редкой формой экстрагенитального эндометриоза, но может оказывать значительное негативное влияние на качество жизни женщин. Эндометриоз брюшной стенки чаще всего носит ятрогенный характер и связан с кесаревым сечением. В статье описан редкий случай, когда у пациентки развился рубцовый эндометриоз после лапароскопической операции в месте введения троакара после хирургического лечения тазового эндометриоза (цистэктомия яичника). Оценка размеров очага эндометриоза, местоположения и объема поражения проводилась с использованием ультразвукового исследования и магнитно-резонансной томографии. Несмотря на применение медикаментозной терапии, включающей прием диеногеста в течение 6 месяцев, пациентке было проведено хирургическое иссечение образования на передней брюшной стенке с широким захватом окружающих тканей, что является золотым стандартом лечения эндометриоза рубца. Послеоперационный патогистологический диагноз подтвердил эндометриоз брюшной стенки. Пациентке была назначена противорецидивная медикаментозная терапия в послеоперационном периоде.

Ключевые слова: *эндометриоз, брюшная стенка, рубцовый эндометриоз, лапароскопия, цистэктомия яичников.*

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Conformity with the principles of ethics. The patient gave written informed consent to the publication of his data.

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