Late metastatic endometrial carcinoma at the repair site of an abdominal wall incisional hernia

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ABSTRACT

The abdominal wall is a very rare site for endometrial cancer metastases. Its appearance generally indicates advanced cancer with poor prognosis. We report a case of a 55-year-old female who presented with an incisional hernia 4 years after abdominal panhysterectomy for endometrioid adenocarcinoma in 2009. Open hernia mesh repair was performed but on follow-up, she complained of pain and a swelling at the repair site. This was radiologically diagnosed as fibromatosis, but tru-cut biopsy confirmed presence of fibromatosis as well as a metastatic endometrial carcinoma. She was started on neoadjuvant chemotherapy, but had poor response, and therefore, radical excision was performed. She remained well with no metastatic recurrence at 12-month follow-up. This case illustrates late appearance of abdominal wall metastasis from abdomino-pelvic malignancies and highlights the need to exclude the presence of recurrence or metastases prior to surgical repair of incisional hernia occurring after the resection of abdominal or pelvic malignancy.

Case Reports

Spread of endometrial carcinoma (EC) may occur by direct invasion, lymphatic, or hematogenous dissemination. Retrograde spread may also occur through the fallopian tubes into the abdominal cavity.1 Although the anterior abdominal wall has a rich arterial supply and lymphatic drainage, it is an uncommon site of metastatic dissemination of endometrial cancer cells.2 We report a case of an unusual late metastatic EC appearing in the para-umbilical area following an open mesh repair of an incisional hernia. It illustrates the late appearance of abdominal wall metastasis from EC that was surgically resected some years earlier. It also highlights the need to thoroughly exclude the presence of recurrence or metastases prior to surgical repair of any incisional hernia occurring after the resection of any abdominal or pelvic malignancy.

Case Report.

A 55-year-old female underwent abdominal panhysterectomy for EC in June 2009. She also received adjuvant chemotherapy, external beam radiation, and vaginal vault brachytherapy. She presented 3 years later with an incisional hernia in the para-umbilical area, and open mesh repair was performed. This case illustrates the late appearance of abdominal wall metastasis from EC that was surgically resected some years earlier.
Meshikhes et al performed in November 2012. Postoperatively, she developed wound infection with skin edge necrosis, which was treated by regular dressings and antibiotics. Vacuum assisted dressing was also used until the wound healed completely. At 9-month follow-up, she complained of pain and a swelling at the operative site. Clinically, the swelling was confined to the site of repair and slightly tender and irreducible. Routine blood tests were within normal. Computed tomography of the abdomen (Figure 1) revealed right rectus abdominis soft tissue mass with peri-umbilical postoperative changes consistent with fibromatosis. A tru-cut biopsy revealed fibromatosis and therefore, she was treated conservatively. However, the symptoms persisted and 3 months later, a repeat tru-cut biopsy targeting the rectus muscle lesion revealed findings consistent with metastatic EC. Based on this, combined 18F-fluorodeoxyglucose-positron-emission tomography and CT (FDG-PET-CT) scan was performed. This showed increased uptake in the right rectus muscle lesion. The multidisciplinary tumor board recommended chemotherapy, but while on chemotherapy, repeat PET-CT scan (Figure 2) revealed an increase in the lesion size with increased avid FDG uptake (SUVmax: 10.5 versus previously 8.3). Therefore, she underwent wide resection of the abdominal wall metastatic mass (Figure 3). The exploration of the abdomen and pelvis revealed no other metastatic lesions. The resultant defect was reconstructed using a composite mesh. The postoperative recovery was non-eventful and repeat PET-CT scan was negative after 6 months (Figure 2). She remained well at 12-month follow-up with no recurrence or metastases.

Discussion. Abdominal wall metastasis is relatively uncommon, accounting for only 1-3% of all abdominal wall metastases from gastrointestinal or genitourinary malignancies.2 Its presence generally indicates advanced cancer with poor prognosis. Metastatic lesions may appear at any time after treatment of EC and may occur in unusual sites such as abdominal wall, spleen, central nervous system, extra-abdominal lymph nodes, and, less commonly adrenals, appendix, and pancreas.3-6 Moreover, abdominal wall metastases to surgical incisions and port sites after laparoscopic surgery for EC have also been described.7 Park and Hwang8 reported a case of abdominal wall metastasis 8 months after surgical...
References


