

Correspondence Correspondance

Extrapelvic endometriosis associated with occult groin hernias

Pelvic endometriosis is common in menstruating women and may cause a wide spectrum of gynecologic complaints, including dysmenorrhea, menstrual irregularity, dyspareunia and infertility. Although all endometrial foci in extrapelvic sites show hormonal dependence they may cause unusual symptoms. We report 2 cases of groin endometriosis found in connection with occult hernias to underline the importance of including this unusual condition in the differential diagnosis of inguinal masses.

The first patient, a 35-year-old woman, was referred for removal of a lump located in the right labium majus, presumed to be an enlarged lymph node on the basis of ultrasonographic findings. She had discovered the mass several months after a cesarean section. The mass was characterized by local pain associated with the menstrual cycle. On examination a firm mass, 2 to 3 cm in dimension without fluctuation and covered by normal skin and pubic hair, was felt within the mid-portion of the right labium majus clearly not connected to the suprapubic scar from the cesarean section. The lump was nonreducible and did not modify with straining, coughing or changes in the patient's position. Pressure elicited mild pain. The presumed diagnosis was isolated extrapelvic endometriosis. Since there were periodic changes in the size of the mass according to the menstrual cycle, the woman was scheduled for surgery. At operation, the mass appeared as a bluish-red lump embedded in stiff scar tissue and was connected with a small hernial sac protruding through the lacunar (Gimbernat's) ligament. Histologic examination confirmed the diagnosis of endometriosis. The patient recovered completely and was free of

symptoms at 32-month follow-up.

The second patient, a 30-year-old woman, was referred for evaluation of a painful mass in the right groin. Investigations, including ultrasonography and magnetic resonance imaging, were not diagnostic. Pain, more severe during her menses, never subsided completely and had worsened during the 4 months before presentation. Examination confirmed a hard, nonfluctuant tender mass, 2 cm in diameter, located just above the inguinal ligament. Straining, coughing and changes in the patient's position neither exacerbated the pain nor made the lump more prominent. The mass was not reducible. At operation, the lump, surrounded by stiff scar tissue, was found to be connected to an inguinal hernial sac. Pathological examination of the excised specimen confirmed the diagnosis of endometriosis. The patient recovered completely and was well 14 months postoperatively.

Inguinal endometriosis is rare and may be difficult to recognize. Often it is confused with other more common disorders of the groin, such as lymphadenopathy, hernia, granuloma, neuroma, abscess, lipoma, hematoma, soft-tissue tumour, metastatic cancer and subcutaneous cyst. The majority of cases are believed to be caused by progression of pelvic endometriosis down the round ligament into the inguinal canal.¹

Inguinal endometriosis has been described after gynecologic surgery, and only a minority of cases have been associated with a hernial sac.¹ In both our cases the disorder occurred on the right side. Although the reasons for right-sided predominance have not been identified, over 90% of inguinal endometriosis occurs on the right.² To the best of our knowledge, the association between vulvar (labium majus) endometriosis and lacunar ligament hernia, described here, has never been reported.

Both our patients denied symp-

toms of pelvic endometriosis. Indeed, inguinal endometriosis is not necessarily associated with a pelvic location. Moreover, when it is clinically silent, pelvic endometriosis may not require further investigation or treatment. Accordingly, pelvic laparoscopy was not done in our patients.

The cases of vulvar and inguinal endometriosis we have described may be of interest to the general surgeon who commonly manages patients with groin masses but does not deal often with endometriosis. Hernias associated with endometriosis may not be clinically detectable. Even though no proven explanation can be offered, the scarring reaction that surrounds endometrial foci may reduce tissue elasticity, thus hindering hernia detection on physical examination.

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Coexisting mammary tuberculosis and malignant disease

The coexistence of mammary tuberculosis and breast cancer is