



A RARE PRESENTATION OF EXTRAPELVIC ENDOMETRIOSIS – A CASE REPORT ON PRIMARY UMBILICAL ENDOMETRIOSIS

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ABSTRACT

Endometrial tissue present anywhere other than the uterine cavity is known as endometriosis. These lesions are more commonly seen in pelvic cavity and can also present in extrapelvic areas. When presenting as Extrapelvic endometriosis it can occur in the gastrointestinal tract, nervous system, thorax and can also be seen in cutaneous tissues. Umbilical endometriosis is a very rare benign disorder that can present with umbilical swelling, bleeding or discharge and cyclical pain.

Keywords: endometriosis, umbilical

INTRODUCTION

Umbilical endometriosis is one of the rarest benign disorders that particularly affect child bearing age group of women. It can occur as primary or secondary. Primary umbilical endometriosis can also known as villar's nodule which is a very rare presentation and is not related to previous surgeries, Whereas Secondary umbilical endometriosis occurs more commonly over surgical scars more commonly cesarean section or over laparoscopic scars. The incidence of allexta genital endometriosis is 0.5-1% [1]. Primary and secondary Umbilical endometriosis can present as either subcutaneous or cutaneous lesions [2]. Here we present a case of Extrapelvic endometriosis that was managed in our institution.

CASE REPORT

A female patient aged 40 years, gravida 1 came with complaints of swelling in the umbilical region for 1 year gradually progressive in size, associated with bleeding concomitantly during menstruation for 3 months. No history of dysmenorrhoea, abdominal pain and dyspareunia. On abdominal examination, a firm, non reducible swelling of size 3x2cms was present over the umbilical region (Fig. 1). Ultrasound abdomen revealed a heteroechoic lesion measuring 1.6x1.8x1.9 (TxAPxCC) in the umbilical region.



Fig.1 Umbilical endometriosis presenting as nodule

Further we did MRI whole abdomen which revealed a defect of 1.6 cm in umbilical region with altered signal intensity lesion appeared iso-hypointense on T1, iso- hyperintense on T2 and few areas of blooming and deep infiltration (Figs: 2, 3 and 4). Diagnosis of umbilical endometriosis was confirmed and was planned to proceed with wide local excision with mesh repair.

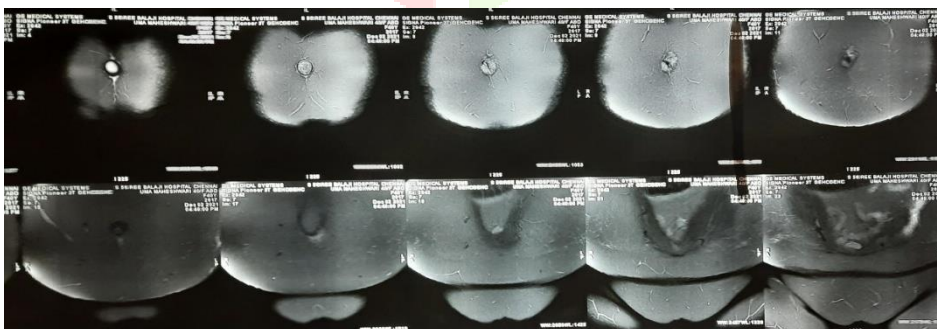


Fig.2 Iso hyperintense lesion

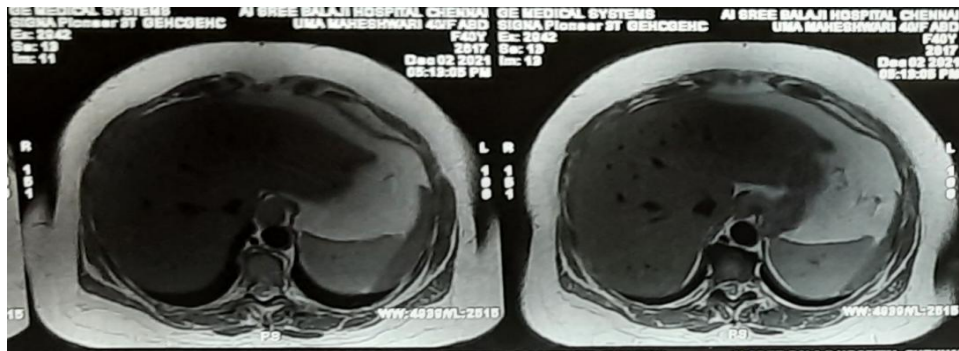


Fig.3 Areas of blooming

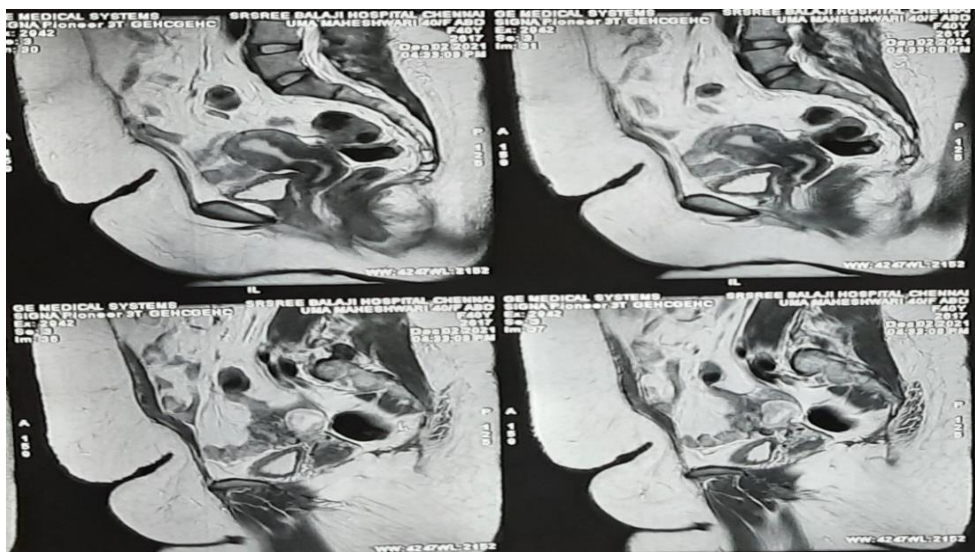


Fig.4 Infiltration of lesion

The surgery was performed with patient in general anaesthesia, mid line incision made including the nodule I umbilical region (Fig.4, 5) and the incision was deepened and peritoneum was opened to look for intraperitoneal extension, bowel or omental attachments, then the umbilical lesion was removed into to (Fig.6) and sent for histopathological examination, prolene mesh was placed subcutaneously. A romovac draining tube was placed. Postoperative period was uneventful, regular wound cleaning and dressing was done and the Drainage tube was removed on post operative day 6 and patient was sent home. Histopathological examination revealed many endometrial glands with stroma, surrounded by reactive fibrosis which was consistent with endometriosis.

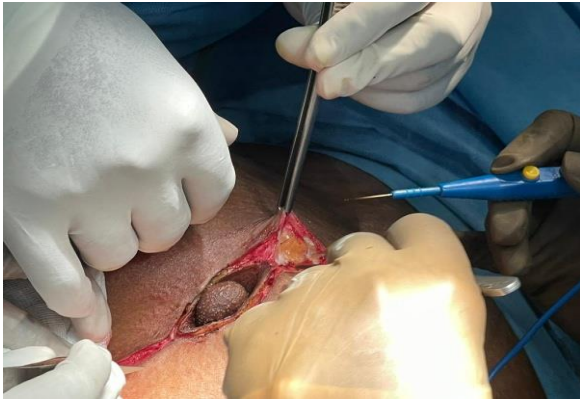


Fig.4 Mid line incision



Fig.5 Dissection of surrounding structures

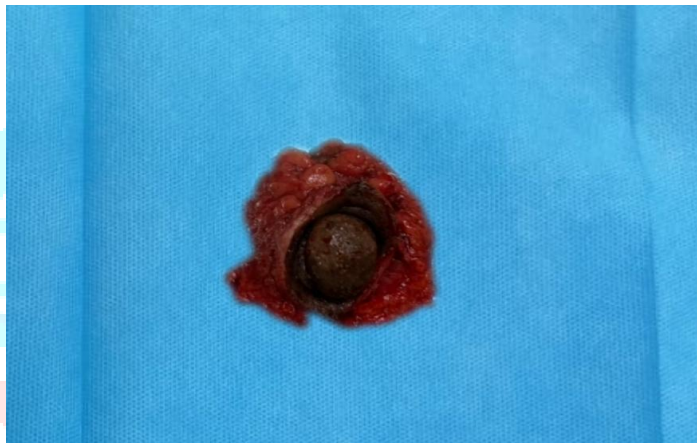


Fig.6 Excised umbilical nodule

DISCUSSION

Endometriosis occurs rarely and accounts for 10-15% in reproductive age group women [1]. Commonly occurring sites of endometriosis are the pelvic organs mostly the ovaries, fallopian tubes, utero-sacral ligament and pelvic peritoneum. Endometriosis occurring in extrapelvic areas is uncommon and can occur in various sites like bladder, liver, kidneys, lungs, ureters, diaphragm, bowel, extremities and abdominal wall [3,4]. Of all endometriosis cases less than 5.5% accounts for cutaneous endometriosis [5,6]. It is very rare to get umbilical endometriosis without any previous surgical history. Secondary umbilical endometriosis can occur due to spread of endometrial cells during surgical procedures. However, the cause of occurrence of primary umbilical endometriosis is unclear. There are several theories of spread that are believed to cause umbilical endometriosis, the theory of embryonic remnant, the theory of retrograde menstruation, migration theory, coelomic metaplasia theory or combination [7]. The Sampson's theory which is widely accepted at present, states that retrograde flow of menstrual discharge from endometrial tissue through the fallopian tubes gives rise to endometrial implants. The theory of embryonic rest describes that presence of cell rests of the müllerian and wolffian duct system can give rise to differentiated endometrial tissues, coelomic metaplasia theory states

that the ovaries, peritoneum, and the Mullerian system arise embryologically from coelomicmesothelium and due to certain stimulus either traumatic, inflammatory or hormonal, the metaplastic changes occurs leading to endometrial tissue formation in the cells of peritoneum; the migration theory states that through vascular and lymphatic routes dissemination of endometrial cells from uterus even in sites far away from the pelvis can occur, leading to implantion and proliferation. Familial and immune system disorders can also play a role in the occurrence of endometriosis [8]. The diagnosis can be made clinically, based upon symptoms presented by the patients. Ultrasound, magnetic resonance imaging (MRI) or CT scan can be used to assess the extent and depth of the lesion. The differential diagnosis of umbilical hernia, pyogenic granuloma, metastatic adenocarcinoma (Sister Joseph's nodule), cutaneous endosalpingosis, residual embryonic tissue and nodular melanoma must be taken into consideration as differential diagnosis. The risk of malignant transformation is rare but there are reported cases [9,10]. There is no standard treatment for endometriosis some prescribe progesterone, gonadotropin-releasing hormone analogues or danazol, it relieves symptoms like bleeding and pain, but they donot cure endometriosis, so surgical excision with margins of atleast 5 mm in depth and diameter is the treatment for complete cure [11,12]. Umbilical endometriosis being rare disease is easy to diagnose by all differential diagnosis must be considered while examining umbilical lesions. Complete excision and histopathological examination is recommended for conclusive diagnosis.

CONCLUSION

Primary umbilical endometriosis is a nonmalignant disorder that occurs in women of reproductive age group. Although diagnosis can be made based of its clinical features,it is always a good practice to confirm the diagnosis by histopathological examination, but the chances of recurrence is a worrying factor for both patients and surgeons.

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