CASE REPORT

UMBILICAL ENDOMETRIOSIS AND ITS SURGICAL MANAGEMENT

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ABSTRACT: Umbilical Endometriosis is a rare condition with an estimated incidence of 0.5-4% of all patients with extra genital endometriosis.(1) We present a patient who had two prior caesarian sections came with cyclical bleeding from the umbilicus during menstruation and a diagnosis of endometriosis was made by FNAC and confirmed with Histopathological examination of the excised mass.

KEYWORDS: Umbilicus, Endometriosis FNAC.

INTRODUCTION: Endometriosis is a common Gynaec condition and presents mainly with involvement of the pelvic organs. Extrapelvic presentation in almost all parts of the body has been reported in the literature. However primary umbilical endometriosis or secondary to surgery is uncommon and accounts for 0.5 -4% of all extra genital endometriosis.

CASE REPORT: Mrs x 38 years old female para 2 living 2 non tubectomised with previous 2 LSCS last child birth 8 years back came to our hospital with swelling at the umbilicus and cyclical bleeding with pain from Umbilicus during menstruation since 2 years. Initially mass was 1x2 cm and it gradually progressed to present size of 4x4 cm.

(On examination) the swelling measured 4x4 cm firm in consistency tender skin over the swelling stretched and reddish black in colour. No impulse on coughing noted. A vertical LSCS scar approximately 10cm was noted extending from supra pubic region but the upper end of the scar was about 4cm away from the swelling. Fig. 1 and Fig. 2.

This patient was seen by the surgeons and a D/D of umbilical hernia was made and CT scan showed a solid well circumscribed lesion with dense adhesion from peritoneum to the abdominal wall. FNAC from the swelling showed features of umbilical endometriosis hence patient was shifted to us.

Treatment given: Wide margin excision of the umbilical mass done followed by laparotomy to look for endometriotic deposits below the abdominal wall and release of adhesions.

Intra op: Mass was superficial to Rectus Sheath no adhesions and no endometriotic deposits noted in the pelvic cavity. Bilateral Abdominal tubectomy was done as patient opted for it.

Histology of the mass confirmed the diagnosis of endometriosis and revealed the presence of multiple foci of endometrial glands surrounded by stroma with areas of haemorrhage, lymphocytes and plasma cells. No atypia noted Fig. 3 and Fig. 4.

DISCUSSION: Endometrios is the presence of functioning endometrial tissue outside the uterine cavity. The various sites for extra pelvic endometriosis are bladder, Kidney, bowel, omentum,

lymph nodes, lung, pleura, extremeties, umbilical hernial sac and abdominal wall.[2] Umbilical endometriosis was first described in 1886 and since then 122 cases have been reported majority of the cases occurred Secondary to surgical commonly laproscopy scars.[3, 4]

Primary umbilical endometriosis without surgical history is a rare condition[3, 4] some case reports have also described the umbilical endometriosis during pregnancy.[5]

Pathophysiology: Proposed theories are Embryonal rest theory - Endometriosis adjoining the pelvic viscera by wolfian or mullerian remanants. Coelomic metaplasia theory. Migratory pathogenesis theory which explains the dispersion of endometrial tissue by direct extension, vascular and lymphatic channels and surgical manupulation. In our case direct implantation during the previous surgeries or vascular/ Lymphatic spread is the only explanation that can be given.

Patients with umbilical endometriosis are in the reproductive age group and present with discrete bluish purple mass, becoming swollen, painful and bleeding concomitantly with the menstrual cycle. There may be associated symptoms of Co-existant pelvic endometriosis. The mass can range in size from 0.5 to 3 cms but can enlarge to enormous size.[3]

Diagnosis is primarily clinical. MRI is better than CT scan to evaluate patient with suspected endometiosis with a sensitivity of 90- 92% and specificity of 91-98%.[6] Endometriosis appears homogenously hyperintense on T1, weighted sequence and because of high spatial resolution it can detect the plane between muscles and subcutaneous tissue.[6] Serum carbohydrate antigen 125 levels have also been evaluated in patients with endometriosis[1] FNAC helps in the diagnosis.

D/D Umbilical hernia, Pyogenic granuloma, Primary or metastatic adenocarcinoma (sister Joseph nodule), Lipoma.

Management is always total wide Excision which is diagnostic and therapeutic at the same time. Medical management with the use of GnRH analogues (Leuprolide acetate) has been tried but there is only partial relief of symptoms and does not ablate the size[7] moreover because of the side effects like amenorrhoea, weight gain, hirsuitism and acne compliance is unlikely. Treatment should be individualized depending on the severity of patients symtoms, age and desire for pregnancy

Follow up and prevention: Follow up of endometriosis patient is important because of the chances of recurrence which may require re-excision. Malignancy risk is about 21.3% in cases of endometriosis at extragonadal sites and 4% cases in scars after laparotomy.[8]

Good technique and proper care during caesarean section may help in preventing endometriosis. It has been suggested that at the end of Surgery especially on the uterus and tubes, the abdominal wall should be cleaned thoroughly and irrigated vigorously with high jet solution before closure.[9]

CONCLUSION: Extra pelvic Endometriosis should be thought of in case of swelling associated with pelvic surgeries, early diagnosis and surgical excision is the main stay of treatment.

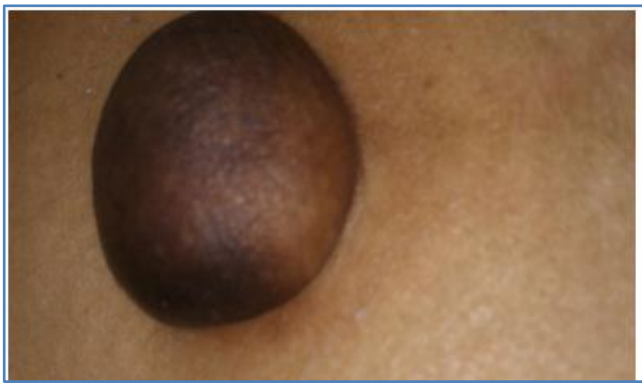

FIGURE 1

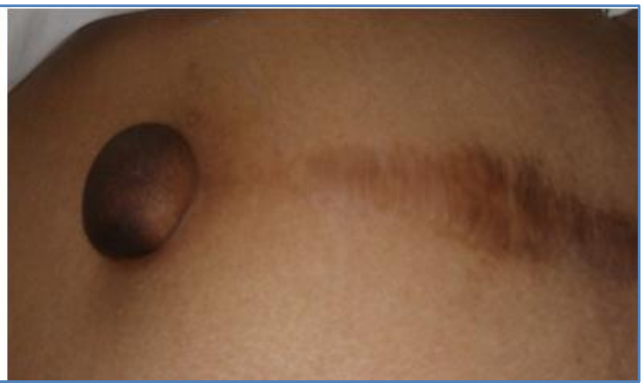

FIGURE 2

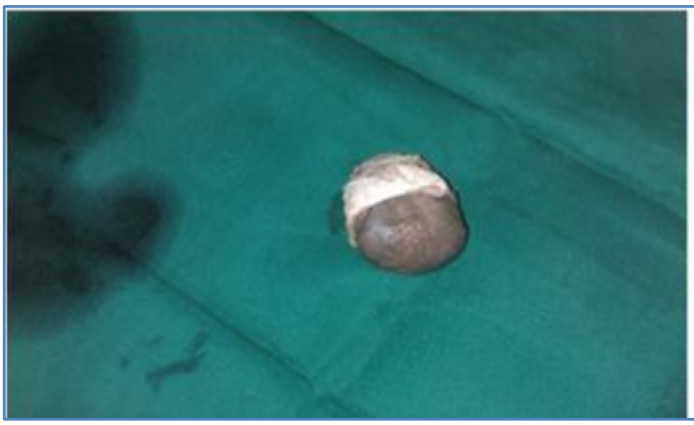

FIGURE 3

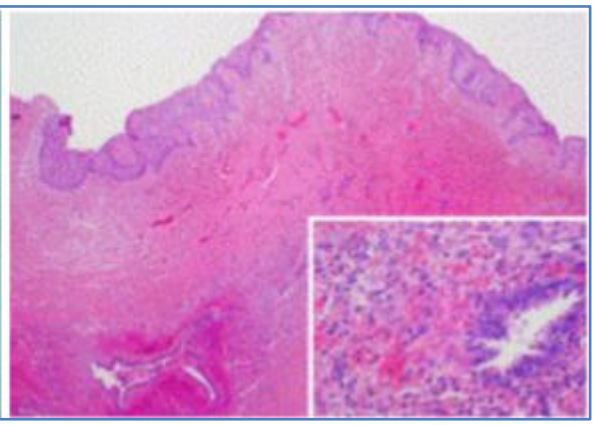

FIGURE 4

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