

# Case Report

## Primary Umbilical Endometriosis

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A 45-year old nulliparous woman presented with umbilical pigmented lesion with cyclical bleeding. The lesion was excised and pathological diagnosis was umbilical endometriosis. The authors reviewed the current literature and discussed the different diagnosis and management of umbilical endometriosis.

**Keywords:** Umbilical endometriosis, Diagnosis, Treatment

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Endometriosis is a very common gynecological disease; however, primary umbilical endometriosis at the extragonadal site of endometriosis is a very rare disease. The authors present one patient who presented with umbilical endometriosis and discuss the pathogenesis, differential diagnosis, and management of umbilical endometriosis.

### Case Report

A 45-year old nulliparous woman presented with a dark brown, painless umbilical nodule for 4 months, and history of cyclical bleeding. The nodule was slightly enlarged. The ultrasonogram showed a subcutaneous nodule at the umbilicus without other intraabdominal abnormality. The authors tried to make a fistulogram to identify the tract of the mass but failed. Surgical removal of the lesion was performed without uneventful post-operative course. The pathological diagnosis was umbilical endometriosis.

### Discussion

Endometriosis is a condition with presence of endometrial tissue (glands and stroma) outside the uterus. It also can be found elsewhere in the body. Endometriosis is a very common gynecological disease with a prevalence rate of about 7% of reproductive age women<sup>(1)</sup>.

Pathogenesis of the endometriosis has many hypotheses, first, it could be related to metaplasia of endometrial tissue, second, it could be a retrograde menstruation and implant shredded endometrial fragments, occurring anywhere, and third, it could be genetic, as many studies have shown that first-degree relatives of women with this disease are more prone to the disease. Other hypothesis suggests that endometrial fragments may travel through blood vessels or the lymphatic system to other parts of the body, or from immune system dysfunctions and environmental influences<sup>(1)</sup>.

Endometriosis lesions are commonly found anywhere in the pelvic cavity: on the ovaries, the fallopian tubes, and on the pelvic sidewall. Other common sites include the uterosacral ligaments, the cul-de-sac, the Pouch of Douglas, and in the rectal-vaginal septum. In addition, it can be found in caesarian-section scars, laparoscopy or laparotomy scars, and on the bladder, bowel, intestines, colon, appendix, and rectum. In rare cases, extragonadal site of endometriosis has been found inside the vagina, inside the bladder, skin, lung, spine, diaphragm, inguinal canal, and brain<sup>(1-4)</sup>.

The most common symptom of endometriosis is pelvic pain. The pain often correlates to the menstrual cycle; however, a woman with endometriosis may also experience pain at other times during her monthly cycle. Other symptoms may include diarrhea or constipation (in particular in connection with menstruation), abdominal bloating (in connection with menstruation) or heavy or irregular bleeding, fatigue, dyspareunia

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and related with infertility<sup>(1,5,6)</sup>. In a case of unusual site of endometriosis, the presentation may vary due to the site of the endometriosis, such as umbilical endometriosis. The clinical presentations of umbilical endometriosis are umbilical pigmented nodule, umbilical weeping especially cyclical bleeding and cyclical pain<sup>(5-9)</sup>.

Umbilical endometriosis, usually associated with pelvic endometriosis and most often found in an old surgical scar, direct seeding after laparotomy or laparoscopy, has been proposed as the pathogenesis<sup>(10,11)</sup>. This has been found in cases of umbilical hernia by implant of endometriosis piece at the defect of umbilical hernia<sup>(3)</sup>.

In rare circumstances, primary umbilical endometriosis, a single endometriosis that implants in the umbilicus and no other site of intrapelvic endometriosis, can be found and lymphatic or venous seeding or persistent the omphalomesenteric duct have been proposed as an etiology<sup>(12-14)</sup>.

Investigation for diagnosis of umbilical endometriosis is no definite diagnostic tool, some reports have shown that MRI or epiluminescence microscopy are useful in improving the accuracy of diagnosis of pigmented skin lesions or in a case of suspected umbilical endometriosis<sup>(15,16)</sup>.

Differential diagnoses for the umbilical nodule are umbilical granuloma, simple inclusion cyst, umbilical hernia, benign or malignant neoplasm of the umbilicus. In a case of umbilical discharge or weeping should be a different condition of pilonidal sinus, urachal cyst, urachal sinus and rare cause as in the presented case is umbilical endometriosis may be the differential diagnosis for umbilical nodule with discharge (Fig. 1). The standard treatment is surgical excision of the endometriosis nodule<sup>(1,6,8,17)</sup>.

In the case of umbilical endometriosis, the patient presented with an umbilical mass and cyclical bleeding. Surgical excision was performed and pathological diagnosis was umbilical endometriosis. The in-

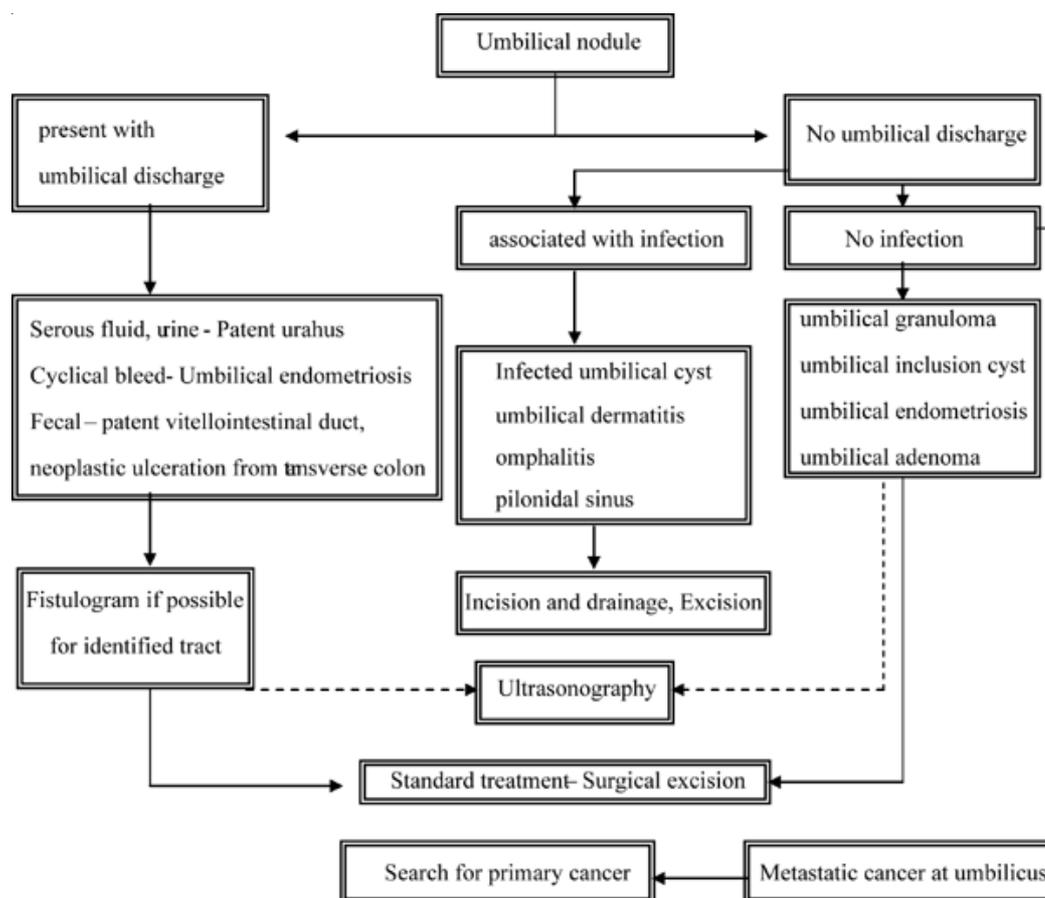


Fig. 1 Scheme for approaching an umbilical lesion

vestigation showed that she had no pelvic endometriosis.

### Conclusion

Umbilical endometriosis is not rare. The case is not significantly important with average interest. It may associate with intrapelvic endometriosis or only primary umbilical endometriosis. The diagnosis is difficult, umbilical endometriosis should be considered as a differential diagnosis in an umbilical lesion. The surgical excision is the standard treatment of this condition.

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## รายงานผู้ป่วย Primary umbilical endometriosis

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ผู้ป่วยหญิงอายุ 45 ปี ไม่มีโรคประจำตัว มาพบแพทย์ด้วยอาการก้อนที่สะดือ และมีเลือดออกสัมผัสกับรอบประจำเดือน ได้รับการรักษาผ่าตัดก้อนออก ผลการวินิจฉัยทางพยาธิวิทยาเป็น Umbilical endometriosis ผู้เขียนได้ค้นคว้ารายงานโรค และวิจารณ์การแยกโรค การรักษาโรคในรายงานนี้