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CASE REPORT

Primary Cutaneous Umbilical Endometriosis

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Introduction: Primary umbilical endometriosis a rare case. It is mostly seen in women in the reproductive age group. **Case report:** In this case report, a 38 year old woman is discussed who received antibiotherapy for omphalitis diagnosis established due to many complaints of umbilical secretion but who was diagnosed with primary umbilical endometriosis after histopathological examination. **Conclusion:** Endometriosis must be certainly considered in differential diagnosis in especially inflammatory lesions resistant to noncyclic treatment, determined in umbilical region. **Key words:** Umbilicus, primary, endometriosis.

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1. INTRODUCTION

Endometriosis is functional endometrial tissue found outside uterine cavity (1). It is a common gynecologic disorder that affects 8-15% of women in reproductive period and 6% of women in premenopausal period. It is frequently seen in vulva, vagina, cervix, ovarium and pelvic peritoneum and less frequently seen in extra pelvic regions (2). Umbilical endometriosis is a very rarely seen case and incidence is stated to be 0.5-1% (3).

2. CASE REPORT

In this case report, a 38 year old woman who complained from umbilical secretion and mass for approximately 10 months, is discussed. In the anamnesis of the patient, it is stated that antibiotherapy was accomplished 7-8 times with omphalitis diagnosis due to

her complaints but the same complaints started again after healing. The history of the patient informed that complaints were not related to menstrual period. 2-3 cm nodular lesion with hyperemic serohemorrhagic secretion in umbilicus was determined during the physical examination of the patient. 25 x 15 mm collection area was determined in umbilicus in the ultrasonography (USG) performed for lesion. There was no history about a surgical intervention. Surgical excision was performed after the patient was informed and the consent of the patient was taken. The preoperative hemogram, biochemistry and coagulation examination was normal. The existing lesion was excised totally together with umbilicus under spinal anesthesia. It was determined during surgical excision that there was no fascia defect and that there was no rela-



Figure 1. Postoperative Incision Area.

tion between lesion and intraabdomen. Postoperative incision area is presented in Figure 1.

In the histopathological examination of excision material, hemorrhage regions were monitored macroscopically in 2.5 cm high tissue sample containing 4 x 2 cm skin ellipse and tissue section. Microscopically, endometrial glands and endometrial stromal tissues at various sizes, some showing cystic dilatation was observed in sections in the tissue samples covered with hyperplastic epidermis, in dermis and subcutaneous tissue. Wide hemorrhage areas were determined (Endometriosis

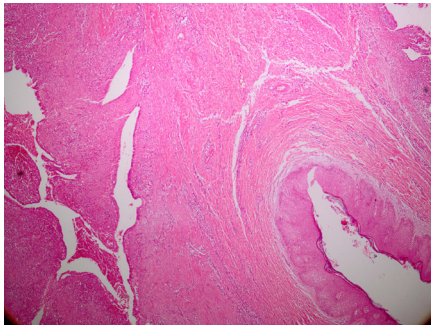


Figure 2. Histopathological Imaging ($\times 10$, H&E).

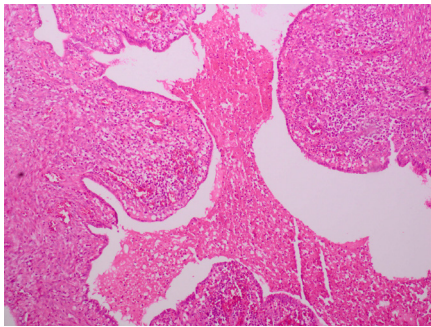


Figure 3. Histopathological Imaging ($\times 40$, H&E).

externa). Histopathological images are shown in Figure 2 and Figure 3.

Another focus was not determined in the patient with the abdominal USG performed upon identification of primary endometriosis as a result of histopathological examination.

3. DISCUSSION

Endometriosis is generally a benign and chronic disease that frequently affects women at reproductive period. It may be rarely seen in male patients who take hormone therapy for a long time. 88% of the cases are seen in ovary. Cutaneous endometriosis constitutes less than 5.5% of all cases and it is seen approximately at 35-38 years of age (4). Cutaneous endometriosis develops frequently on the scar area after surgery (5). In this case presentation, the patient had no history of surgical intervention and primary umbilical endometriosis was diagnosed.

Endometriosis may be classified as secondary (scar) and primary (spontaneous). While pathogenesis of spontaneous endometriosis is not clear, the pathogenesis accepted in scar endometriosis is the implantation of endometrial tissue to skin (4).

Primary umbilical endometriosis is a rarely seen case (%0.5-1) (3). Malebranche et al. (6) stated that 81 umbili-

cal endometriosis cases were reported in the world between 1953 and 2008. The most common symptoms are dysmenorrhoea, menorrhagia, pelvic pain, dyspareunia, infertility and intestine disorders (7). It appears clinically as nodular, red-blue-brown-black lesion from a few mm to a few cm. The most characteristic symptom is cyclic pain together with palpable mass (8, 9). However, characteristics clinical findings and symptoms may not be observed all the time. Therefore, in differential diagnosis suture granuloma, pyogenic granuloma, polyp, nevus, epithelial inclusion cyst, desmoid tumor, hemangioma, lipoma, abscess, folliculitis, omphalitis, hernia and gastrointestinal adenocarcinoma metastasis must be considered (6, 10). Nonspecific symptoms like noncyclic oedema, inflammation and seropurulent secretion were seen in the patient presented in this case report. Firstly omphalitis was considered due to nonspecific symptoms found in the patient. However surgical excision was performed because symptoms and lesion did not regress despite antibiotherapy. As a result of histopathological verification, primary endometrial endometriosis could be diagnosed. In other words, endometriosis was not considered in differential diagnosis because atypical symptoms existed in the patient.

Clinical suspicion in diagnosis, detailed anemnesis and findings of examination are very important. However final diagnosis is established histopathologically. Dermoscopy, magnetic resonance imaging (MRI) and USG are imaging methods supplementary to diagnosis (11). Fine Needle Aspiration may be used in diagnosis however the results are inadequate. But the risk of faulty and inadequate surgical intervention may be decreased by establishing diagnosis pre-surgery (2, 12). Concentration of serum CA 125 may rise above 260 u/ml but it is nonspecific for the diagnosis of endometriosis (12, 13, 14).

Gonadotropin Releasing Hormone Agonists, danazol and oral contraceptive drugs may be used in order to prevent the symptoms in treatment and to decrease the lesion diameter pre-surgery (15). However the definitive treat-

ment is surgical excision at the end of menstrual cycle (16).

Prognosis is extremely good. Recurrence rate is very low after adequate surgical excision. Malign transformation risk is stated to be %0.3-1 in scar endometriosis (17).

4. CONCLUSION

Primary umbilical endometriosis is a rarely seen case. Although it appears generally together with nodular lesions with cyclic pain, atypical symptoms may be seen also. The inference drawn from this case presentation is that umbilical endometriosis must certainly be considered in differential diagnosis and diagnosis must be confirmed histopathologically when inflammatory lesions that are noncyclic, refractory to treatment, are determined in umbilical regions.

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