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Case Report

Umbilical Endometriosis Associated with Para umbilical Hernia: A Case Series

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Abstract

Extrapelvic endometrioses in almost all parts of the body have been reported in the literature. However, umbilical endometriosis that is spontaneous or secondary to surgery is rare, but its diagnosis is difficult and a differential diagnosis of endometriosis should be considered when an umbilical swelling presents in a woman of reproductive age. Reported herein is a case of umbilical endometriosis one of which was spontaneous with menstruation from the umbilicus and the other one occurred following a previous history of myomectomy for a uterine fibroid. Both cases had an associated para-umbilical hernia.

Keywords: *Endometriosis; Paraumbilical Hernia; Recurrent Hernia*

Introduction

Endometriosis is a condition in which endometrial stroma and glands are found outside the uterine cavity. Extrapelvic endometriosis is less common than the pelvic type, but it has been described in almost every area of the female body including the bowel, bladder, lungs, brain, umbilicus, and surgical scars [1]. Umbilical endometriosis represents 0.5% to 1% of all cases of extrapelvic endometriosis. It usually occurs secondary to surgical scars, but very rarely presents as primary umbilical endometriosis [2]. The ectopic endometrial tissue develops into lesions that respond to the cyclic hormonal stimulation in the same way the uterine endometrial tissue does. The response includes intrauterine proliferation, secretory activity and mucosal sloughing [3].

Case Report

A 35-year-old lady came to the surgical clinic institution, Saudi Arabia. complaining of a pigmented and painful umbilical swelling gradually increasing in size for the last one year approximately (14 months) prior to presentation. The pain was sharp, intermittent, aggravated by menstruation, sitting for a long time and walking, relieved slightly by lying down and sometimes interfering with daily activities. She also complained of occasional constipation. There was no history of associated anorexia, weight loss, dysphagia, heartburn, regurgitation, nausea, vomiting, dyspepsia, change in stool color, or urinary symptoms. She has no past similar history.

Past surgical history: myomectomy for a uterine fibroid 2 years ago.
Past medical history: nil.
Gynecology history: menarche at the age of 12 years with regular menstrual cycles.
Social history: single, unemployed and smokes argila once a day for about 15 years.
Family history: irrelevant.
There is no history of any known allergy or blood transfusion.
Drug history: nil.
Systemic review: nil.

On examination preoperatively

The patient looking well oriented, overweight, not in distress, connected to IV cannula.
Head and neck: within normal except for the scar of the previous subtotal thyroidectomy.
Chest: equal bilateral vesicular breathing, no added sounds.
Cardiovascular system: on auscultation audible S1+S2 no added sounds and no murmurs.
Vital sign: Temperature: 37, Pulse: 71 bpm, Blood Pressure: 128/83, SPO2: 96%
Abdomen: On inspection, there was pigmented umbilical swelling about 1 X 2 cm, no scars, symmetrical abdomen movement, no sinus or fistula, no stoma, no distension, no dilated veins and no visible pulsation. On palpation: soft, lax, slightly tenderness, no palpable mass, no organomegaly, gallbladder not palpable, no expansile pulsation and negative expansile cough impulse. On auscultation: normal bowel sound with no bruit sound.

She was admitted on 1/10/2015 and had excision of the umbilical swelling and primary repair of an underlying paraumbilical hernia confirmed intraoperatively in the same day procedure unit.

Postoperatively, she developed a minor superficial wound infection which was treated by opening and draining the wound followed by subsequent daily dressing changes until it healed. Otherwise, she's been fine postoperatively after more than a year of follow up.

Discussion

Umbilical endometriosis constitutes 0.5 - 1 % of all endometriosis cases [4], Only a few cases of endometriosis associated with an umbilical hernia have been reported here some of them;

In 2000, a case report of endometriosis in the scarless abdominal wall of a 33-year-old woman. She had a 2-year history of intermittent umbilical pain associated with a mass and an underlying umbilical hernia. The mass increased in size and pain prior to menstruation. Physical examination revealed a 2 X 1-cm, round, firm, cherry red nodule at the umbilicus with an underlying umbilical hernia. Postoperative histological analysis showed endometriosis. Subsequent laparoscopy showed no evidence of pelvic endometriosis [5].

In 2001, a 43-year-old woman who had experienced umbilical pain that occurred during menses for several months. She had no other symptoms suggestive of endometriosis. She had a caesarean section 9 years earlier. Physical examination revealed a lower midline scar and a tender, irreducible umbilical hernia with skin discoloration. Histologic analysis showed a focus of endometrial tissue within the lower dermis [6].

In 2012, a surgeon reported a case of a 48-year old multiparous woman she had for two and half years a painful nodule in the umbilicus associated with cyclic pain in the nodule but there was no history of umbilical bleeding or discharge and no menstrual disturbances or constipation or infertility to suggest pelvic endometriosis. The nodule was excised and the histopathological diagnosis was umbilicus endometriosis [7].

While in 2015, surgeons reported a case of endometriosis in 47 years old women with a history of 2 normal deliveries and with no history of any abdominal pelvic surgery and no cesarean section, came complaining of cyclical umbilical pain for four months associated with menorrhagia and chronic constipation. On examination there's was suprapubic mass and umbilical swelling reducible, suggestive of umbilical hernia which was confirmed by ultrasonography. An ultrasound suggested multiple intramural fibromyomas largest being 7.5 x 7.9 cm along with bilateral ovarian endometrioma [8].

The differential diagnosis of all premenopausal women who present with umbilical swelling and pain should include endometriosis. Magnetic resonance imaging is the best modality for evaluating extrapelvic endometriosis in cases which aren't an emergency [9].

Up to 50% of these patients have concurrent pelvic endometriosis, which can lead to infertility and reseeding of endometrial tissue to extra-pelvic sites. Therefore, making an appropriate diagnosis and ruling out concurrent pelvic endometriosis is extremely important. If endometriosis is suspected or diagnosed, referral to a gynecologist for further assessment is recommended.

Conclusion

Endometriosis can rarely present a diagnostic challenge to the general surgeon evaluating an umbilical swelling. The importance of considering endometriosis in the differential diagnosis of any premenopausal woman who presents with a painful umbilical swelling with or without bleeding during menstruation and regardless of whether the pain correlates with her menses is highlighted in the cases discussed here.

Conflict of Interest

There is no any financial interest or any conflict of interest exists.

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