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SECONDARY UMBILICAL ENDOMETRIOSIS, ASSOCIATED WITH PELVIC LOCALIZATION: A CASE REPORT HOSPITAL CENTER, CHU IBNO-ROCHD, CASABLANCA WING SERVICE 10, MOROCCO

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ABSTRACT

Introduction: Endometriosis is defined by the presence of endometrial epithelium with stroma outside the uterine cavity, the prevalence of which is estimated at around 10% of the female population. But extragenital locations are also found in about 0.5% of cases. Observation: A 30-year-old married woman, second gesture and second parent, who presented painful umbilical swelling during menstrual cycles, associated with dyspareunia. This swelling had been evolving for six months, gradually increasing in volume to reach 2 cm long axis. A pelvic ultrasound and pelvic MRI were requested, objectifying the presence of an endometriotic localization at the level of Douglas' cul de sac Comments: Endometriosis is characterized by the presence of functional endometrial tissue outside the uterine cavity. Skin involvement is very rare and represents only 0.5 to 1% in the different series. The isolated umbilical location is exceptional and often unrecognized. The treatment of choice is surgical, it consists of an omphalectomy with an exploration of the abdomino-pelvic cavity allowing other locations to be sought. Medical treatment with danazol or LHRH analogues is recommended before surgery, it would reduce the size of the endometriotic nodule. Local recurrence after complete

surgical excision is rare. For our patient, surgical excision was performed without any recurrence reported with a follow-up of 1 year.

INTRODUCTION

Endometriosis is defined by the presence of endometrial epithelium with stroma outside the uterine cavity, the prevalence of which is estimated to be around 10% of the female population. Endometriosis has a symptomatology punctuated by the ovarian cycle, and preferably develops in the pelvic peritoneum (superficial endometriosis) sometimes infiltrating the wall of the pelvic organs (deep endometriosis): vagina, bladder, rectum, ureter, but extragenital locations are also found in about 0.5% of cases. Umbilical endometriosis has only been very rarely described in the literature, and often occurs in the area of a surgical scar in previously operated women. We report a case of secondary umbilical endometriosis associated with pelvic localization at the level of Douglas' cul de sac, occurring in a patient without any history of abdominal or pelvic surgery, who consulted the gynecology department at CHU IBNO-ROCHD in CASABLANCA in 2020. The patient underwent surgery, resection of the umbilical nodule, and diagnostic laparoscopy, with exploration of an oblong endometriotic-looking lesion which was resected, with simple postoperative outcome. Histological examination of the surgical specimen (Figure 3) confirmed the diagnosis of umbilical and pelvic endometriosis. With nine months of follow-up, no recurrence had occurred.

OBSERVATION

A 30-year-old married woman, second gesture and second parent, who presented with painful umbilical swelling during menstrual cycles, associated with dyspareunia. This swelling had been evolving for six months, gradually increasing in volume to reach 2 cm long axis. It was mobile in relation to the deep plane, of firm consistency, slightly sensitive to palpation (Figure 1). The pelvic examination was normal: uterus of normal size, no latero-uterine mass, otherwise pelvic pain was present during vaginal examination. Pelvic ultrasound and pelvic MRI were requested (Figure 2), demonstrating the presence of an endometriotic localization at the level of Douglas' cul de sac. The patient underwent surgery, resection of the umbilical nodule, and diagnostic laparoscopy, with exploration of an oblong endometriotic-looking lesion which was resected, with simple postoperative outcome. Histological examination of the surgical specimen (Figure 3) confirmed the diagnosis of umbilical and pelvic endometriosis. With nine months of follow-up, no recurrence had occurred.

Figures

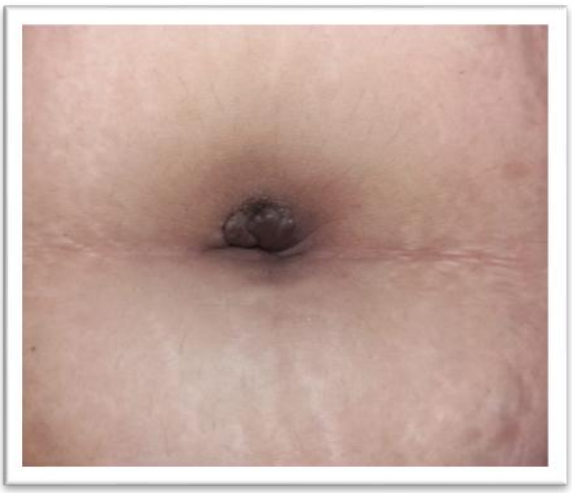

Figure 1: Umbilical nodule.

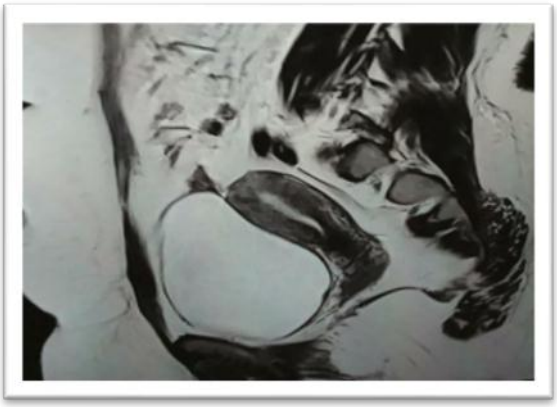

Figure 2: oblong lesion at the CDS of Douglas-fir, with T2 hypersignal enhanced after injection of gadolinium, it attaches the uterus to the rectum measuring 7.4x6mm.

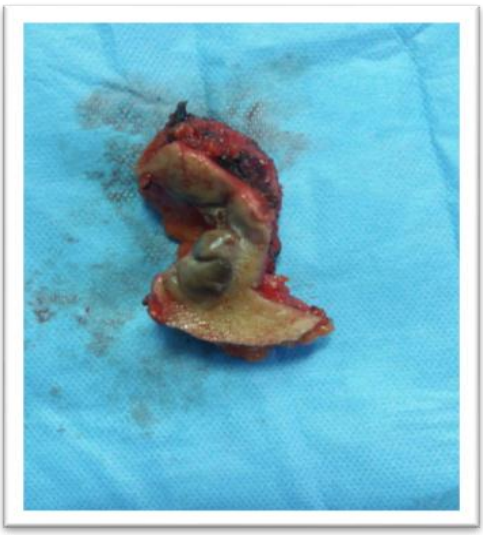

Figure 3: omphalectomy.

COMMENTS

Endometriosis is characterized by the presence of functional endometrial tissue outside the uterine cavity.[1,2] Skin involvement is very rare and represents only 0.5 to 1% in the different series.[2,3] The isolated umbilical location is exceptional and often unrecognized. Cutaneous endometriosis usually occurs after surgery or obstetrics, as is the case with our patient who had 2 cesarean sections.[4] Endometriosis is said to be secondary with a history of abdominopelvic surgery, as in the case of our patient.[2,3] It occurs in women of childbearing age and presents as a sensitive swelling of varying size depending on menstruation, with a bloody discharge punctuated by menstruation.[1,2] The differential diagnosis of umbilical endometriosis is made with umbilical hernia, pyogenic granuloma, hemangioma and melanoma. But it is above all an umbilical metastasis of an abdomino-pelvic tumor called Sister Marie-Joseph's nodule that this diagnosis must be differentiated.[1,5] The definitive diagnosis of umbilical endometriosis is made by pathological examination showing an appearance similar to that of the ectopic endometrium, with the presence of endometrial glands bordered by a columnar epithelium and endometrial stroma made up of small round cells.[3] The extension workup is based on the history, pelvic examination, and pelvic ultrasound or pelvic MRI. Laparoscopy is reserved for symptomatic cases as is the case for our patient accusing dyspareunia, laparoscopy is done for diagnostic and therapeutic purposes.[3] The treatment of choice is surgical, it consists of an omphalectomy with an exploration of the abdomino-pelvic cavity allowing the search for other locations.[1,3] Medical treatment with danazol or LHRH analogues is recommended before surgery, it would reduce the size of the endometriotic nodule. Local recurrence after complete surgical excision is rare.[1,6] For our patient, surgical excision was performed without any recurrence reported with a follow-up of 1 year.

Conflict of interest: The authors declare no conflict of interest.

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Consent

Written informed consent was obtained from the patient for publication of this research study. A copy of the written consent of each patient is available for review by the Editor-in-Chief of this journal on request.

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