

## Extra-Gonadal Endometriosis with Unusual Presentation: A Case Report

Alzahrani Majdi Saleh<sup>1\*</sup>, Almoanna Mazin Saleh<sup>1</sup>, Alsulami Jaber Dhahyan<sup>1</sup>, Alkhadyde Khalel Ibrahim<sup>1</sup>, Alrubayyi Maram Saad<sup>2</sup> and Alaamri Atheer Methqal<sup>2</sup>

<sup>1</sup>Medical Intern, Umm Al-Qura University, College of Medicine, Makkah City, Saudi Arabia

<sup>2</sup>Medical Student, Tabuk University, College of Medicine, Tabuk City, Saudi Arabia

**\*Corresponding Author:** Alzahrani Majdi Saleh, Medical Intern, Umm Al-Qura University, College of Medicine, Makkah City, Saudi Arabia.

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### Abstract

Endometriosis is a typical gynecological condition and gives predominantly association of the pelvic organs. However umbilical endometriosis is extraordinary. This case report was experienced at the surgical clinic. we report a 49 years old multigravid woman presented with umbilical swelling and pain during menstruation for last 6 year with cyclical bleeding from the umbilical region with an offensive odor, menorrhagia, and constipation. The patient had regular menstrual bleeding since the time of menarche. The patient had no past history of endometriosis, dysmenorrhea or dyspareunia. Physical examination showed a fleshy dark red nodule, slightly tender paraumbilical swelling with bloody discharge through the umbilicus. The umbilical endometriosis which was spontaneous with menstruation from the umbilicus. This case had an associated para-umbilical hernia. Surgery approach was done and the patient was asymptomatic at the follow-up visit i.e. 24 months after surgery.

**Keywords:** Endometriosis; Paraumbilical Hernia; Extra-Pelvic Endometriosis; Menstruating Tumor

### Introduction

Endometriosis may be a condition within which mucosa stroma and glands are found outside the cavity. Extrapelvic endometriosis is a is less common than the pelvic kind. However, it's been represented in nearly each space of the feminine body together with the intestine, bladder, lungs, brain, umbilicus, and surgical scars [1]. umbilical endometriosis represents 0.5% to a quarter of all cases of extrapelvic endometriosis. it always happens secondary to surgical scars, however terribly seldom presents as primary umbilical endometriosis [2]. The ectopic mucous membrane tissue develops into lesions that reply to the cyclic secretion stimulation within the same method the female internal reproductive organ mucosa tissue does. The response includes intrauterine proliferation, secretory activity and tissue layer shedding [3].

### Case Report

A Forty-nine-year-old female, known case of hypertension on olmesartan and captopril, complaining of an umbilical swelling that increases gradually in size for 6 years associated with bleeding out of the umbilicus during her menstrual periods with an offensive odor, menorrhagia, and constipation.

She still having heavy periods even after partial excision of the mass at another hospital about a year prior to her presentation to our surgical clinic. She underwent subtotal thyroidectomy 2 years prior to her presentation for a multinodular goiter. She was a Hookah

smoker once a day for about 15 years but quit recently. She is a housewife and a mother of four children, all of them were delivered normally. Her menarche was at the age of 12 years and her periods were regular. She has no family history of the same condition, no known allergy or blood transfusion.

### 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 sound.

Cardiovascular system: on auscultation audible S1+S2 no added sounds and no murmurs.

Vital sign: Temperature: 37°C, Pulse: 71 bpm, Blood Pressure: 128/83 mmHg, SPO2: 96%

Abdomen: On inspection, there was pigmented umbilical swelling about 1×2 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, positive cough impulse with fleshy dark red nodule. On auscultation: normal bowel sound with no bruit sound.

All blood Investigation were normal, liver function test was normal, creatinine and BUN were normal.

She was admitted on 28/3/2015 from the surgical clinic for elective surgery. Primary suture repair of a para-umbilical hernia and excision of the umbilical tumor was done on 29/3/2015. The nodule was excised, the histopathology confirmed the diagnosis of endometrioma which was completely excised. She was discharged in a good condition on 4/4/2015. She had an uneventful postoperative period. She is still asymptomatic after almost 2 years of follow-up.

### Discussion

There are a number of theories regarding the cause of endometriosis. None have been proven, nor does any one theory explain all the different manifestations of the disease. The retrograde menstruation theory, which states that endometrial tissue refluxes through the fallopian tubes during menstruation and implants at ectopic sites, would explain the high percentage of cases occurring in the pelvis. In addition, this theory could also explain the development of umbilical endometriosis [4-9].

The presence of distant extra-pelvic sites is better explained by the metaplasia theory, which proposes metaplastic conversion of coelomic epithelium (multipotential cells) into endometrial tissue, often stimulated by inflammation. Other theories include hematogenous or lymphatic transport of endometrial cells.

It has been suggested that the umbilicus acts as a physiologic scar with a predisposition for developing endometriosis. Umbilical endometriosis has been well described in the literature, occurring either spontaneously or following laparoscopic procedures in which the umbilicus was used as a port site through which a trocar had been introduced. There is no specific blood test to diagnose endometriosis. Surgical resection is the standard management for umbilical endometriosis [2].

Only a few cases of endometriosis associated with an umbilical hernia have been reported.

In 1994, Yu and associates described their experience with a 30-year-old woman who had an 18-month history of cyclic umbilical pain and bleeding.

A 1.5 X 1.5 X 1.0-cm lesion was found in the umbilical area, adjacent to a small umbilical hernia. Histologic analysis of the lesion revealed endometriosis with chronic inflammation, fibrosis, and hemosiderin [4].

In 2008, Sari and colleagues reported a 29-year-old woman who was referred for repair of an umbilical hernia. She had a history of a tender umbilical mass gradually increasing in size and sometimes associated with right lower quadrant abdominal pain for 7 months. The mass had changed in color from reddish-pink to bluish-gray. She had a caesarean section 5 years earlier to deliver twins. Physical examination revealed a 2 X 2-cm, irreducible, tender umbilical hernia with dark skin discoloration. Surgical exploration revealed an umbilical hernia which was repaired and a firm dark-gray lesion which was identified within the tissue and excised. Histologic analysis revealed endometriosis with chronic inflammation and reactive fibrosis. The endometrial tissue was adjacent to the peritoneal lining, but not within the hernia sac itself. Subsequent pelvic ultrasonography showed no evidence of pelvic endometriosis [7].

In 2012, A Singh 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 with no history of umbilical bleeding, discharge, menstrual disturbances, constipation, and infertility. She had past history of laparoscopic cholecystectomy two years previous. The nodule was excised and the diagnosis was umbilicus endometriosis by histopathology examination [8].

In 2014, Stojanovic M and colleagues reported a case of a patient with “spontaneous umbilical endometriosis associated with a large umbilical hernia, treated by surgical excision and mesh repair of the abdominal wall”.

Up to half of these patients have a pelvic endometriosis, which can lead to infertility and with seed the endometrial tissue to extra-pelvic sites. Therefore, making an appropriate descion with rule out the pelvic endometriosis is very important. If endometriosis is suspected referral to a gynecologist for further assessment.

### Conclusion

Endometriosis still one of the challenge to the general surgeon in evaluating and diagnosis of umbilical swelling preoperatively. Its very importance to the surgeon considered endometriosis one of the differential diagnosis specially in childbearing women who presents with a painful umbilical swelling with or without bleeding with her cycle. When the diagnosis is made on clinical situation, although still difficult, no further treatment needed only wide surgical excision is the only option.

### Conflict of Interest

The authors declare that they have no conflicts of interest.

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