UMBILICAL ENDOMETRIOSIS

(A Case Report)

by

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In Great Britain and the United States, extrauterine endometriosis either active or quiescent is found in 10-25% laparotomies. In India, it is said to be quite rare, (Jeffcoate, 1972).

Endometriosis may occur spontaneously in the umbilicus with or without any associated intrapelvic endometriosis. A case of the former variety is presented herewith.

CASE REPORT

Mrs. C. P., aged 40 years, Hindu, para 6+0 was admitted in Eden Hospital on 20-12-78 for of pain in and around a small umbilical swelling for about a year. The swelling used to increase in size during her menstrual periods. She was also experiencing lower abdominal pain during that time for the last 6 months.

Past History: She gave a history of removal of chocolate cyst of the right ovary, 3 years back in a peripheral hospital.

Menstrual History: Menarche at 13, L.M.P. 6th Dec. 1978, cycles 28 ± 3 days with a duration of 3-4 days. Dysmenorrhoea ++.

Obstetric History: She had 6 pregnancies of which 4 were normal full term deliveries and 2 were I.U.D. at term. Last childbirth was 10 years ago.

Examination: She was obese, pulse, 78 p.m. regular, B.P. 120/80 m.m. of Hg. Abdominal examination showed healthy longitudinal scar of previous right infraumbilical incision. The distance between the upper and of the scar and umbilicus was 4 c.m. There was a nodular swelling on the left side of umbilicus. The swelling was tender, fixed with umbilicus, bluish in colour and was 2 c.m. in diameter (Fig. 1). Umbilicus was everted. On vaginal examination uterus was of 10 weeks' size, firm, anteverted with restricted mobility. Fornices were tender. Provisional diagnosis of adenomyosis of uterus with umbilical endometriosis was made.

Investigations: Chest X-Ray, blood urea, blood sugar and total and differential counts of blood showed no abnormality. Hb was 8.5 gm%

Laparotomy was done on 31st January 1979. Right paramedian incision was made. There were many adhesions of uterus with intestenes and omentum posteriorly. Right side tube and ovary was absent due to earlier removal. Left ovary contained a small chocolate cyst which was adherent to the posterior layer of the broad ligament anteriorly and pouch of Douglas posteriorly. Uterus was found to be enlarged to 10 weeks' size. Total hysterectomy with left sided salpingo-oophorectomy was carried out. Upper end of abdominal incision was then extended upwards to encircle the umbilicus which was removed. Abdomen was closed in layers with reconstructions of the umbilical depression. She received 2 bottles of blood. The postoperative period was uneventful excepting small stich ahscess. She was discharged after 20 days in good health.

Macroscopic Examination: Uterus showed turkish towel appearance with tiny haemorrhagic spots on the uterine wall, mostly near the fundus and posterior wall. Left ovary contained a chocolate cyst. Cut margins of umbilical nodule showed haemorrhagic spots (Fig. 2).

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Microscopic Appearance: Evidences of endometriosis of ovary, uterus and umbilical nodule were present. No malignancy detected.

Comments

A case of umbilical endometriosis has been presented. Several cases of this condition have been reported (Hawkins and Bourne, 1971). The appearance of small dark blue nodule which enlarges at the time of menstruation and is under increased tension causing a type of extrauterine localised dysmenorrhoea are the usual symptoms.

Menorrhagia is usually associated with this condition but in the present case it was not so. This may happen in many cases (Jeffcoate, 1972). Pelvic clearance operation was undertaken considering the age and parity of the patient.

This type of lesion is difficult to explain unless the theory of coelomic metaplasia is accepted. A tongue of coelom projects in the umbilicus. Another possibility is that this extrapelvic areas of endometriosis may arrive by lymphatic or by vascular embolism (Jeffcoate, 1972).

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References

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See Figs. on Art Paper IV