

Umbilical Mass Due to Endometriosis: A Rare Localization

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Abstract

Objective: Endometriosis is rarely seen in the anterior abdominal wall. Cyclic pain and previous gynecological operations help us in preoperative diagnosis. Although it is most frequently seen in the phannensteil incision line, it may be atypically located far from the incision. Here, we describe atypical localized endometriosis operated for umbilical mass in our clinic.

Case Presentation: The patient who was 45-year-old, gravida three, parity three, had a history of myomectomy four years ago due to a phannensteil incision for myoma uteri. The patient's USG showed an echogenicity of approximately 22×14 mm in size under the skin. The operation was performed to exclude the mass in the umbilical region. Histopathological diagnosis of the mass was reported as findings consistent with endometriosis.

Conclusion: The history of the patient's gynecological operation is typical. However, localizations outside the incision line are atypical. It should be kept in mind that endometriosis may occur even in patients with cyclic pain and previous gynecological surgery.

Keywords: Abdominal wall endometriosis; Atypical location; Umbilical mass

Introduction

Endometriosis is a disease caused by the presence of functional endometrial tissue outside the anatomical location of the uterus. It is located in the sacrouterine ligaments, rectovaginal septum and pelvic peritoneum, which are the most common ovaries [1-3]. The majority of cases of extrapelvic endometriosis are scar endometriosis after hysterectomy, cesarean section and episiotomy [4,5]. Rarely, cases of endometriosis after amniocentesis and laparoscopic procedures have been reported, as well [6,7]. Anterior abdominal wall endometriosis presents with various presentation and treatment methods. Considering the increase in cesarean rates, it is thought that these cases will be encountered more. In the literature, diagnosis and treatment have been emphasized more, but there are not many recommendations for preventive measures

[8]. Firstly, in 1975, it was reported that endometriosis foci may be present in or around the incision scar in patients undergoing cesarean or gynecologic surgery [9]. It is reported that in 0.03-0.4% of the cases, it can be seen around the incision scar or the abdominal wall [3,10]. In this study, a case who was operated due to a mass in the umbilical region but whose histopathological diagnosis was reported as endometriosis is presented.

Case Report

A 45-year-old patient with a gravity three and parity three had complaint of swelling in the navel for three years. However, he was admitted to the General Surgery Outpatient Clinic of our hospital with complaints of increased swelling in the navel and growing cyclic pain for 6 months. He had a history of laparoscopic cholecystectomy 5 years ago and myomectomy for myoma uteri 4 years ago. Physical examination of the patient revealed a 2 cm mass in the umbilical region (Figure 1).



Figure 1: Preoperative appearance of the mass.

The patient's ultrasound showed a reduced echogenic tissue of approximately 22×14 mm under the skin. Excisional biopsy was planned. The patient received 3mL (15 mg) of Havy Marcaine (MARCAINE® SPINAL HEAVY ampoule containing 0.5% injection solution, Astra Zeneca İlaç San.ve Tic. Ltd. Şti.). The patient underwent spinal anesthesia and after adequate block formation, a 7-8 cm longitudinal incision was performed to excise the mass in the umbilical region (Figure 2). The patient was taken to PACU (Postoperative Care Unit) postoperatively and anesthesia follow-up started. There were no problems. The patient followed in clinic was discharged on the first postoperative day. Polyclinic was recommended and the sutures were removed on the 10th postoperative day. There were no complications. Histopathological diagnosis of the mass was reported as consistent with endometriosis.



Figure 2: Mass removed with umbilicus.

Discussion

We know that endometriosis affects approximately 15-44% of women of reproductive age today [3]. Dysmenorrhea, dyspareunia and infertility are the most common symptoms of endometriosis [3, 11, 12]. Abdominal wall endometriosis is very rare.

The most common cases present to the physician with complaints of abdominal wall mass and abdominal pain [10,11]. Although endometriosis is a gynecological problem, especially as in this case, most of the patients usually apply to general surgery because of differential diagnoses such as hernia, abscess and malignancy. Most of the cases are young and they present with the complaint of a painful and tender mass which occurs cyclically a few years after the surgery. In our case, the menstrual cycle increased and the mass was enlarged. Although history and physical examination support the diagnosis, the definitive diagnosis is made only by histopathological examination [10-12].

Although endometriosis has been reported to occur after pelvic surgeries such as caesarean section, hysterectomy and myomectomy as in this case, it may develop spontaneously, as well. As in this case, abdominal wall endometriosis may not always accompany pelvic endometriosis, especially pelvic endometriosis is known to occur in only 13-24% of cases with abdominal wall endometriosis [3,13]. It is accepted that abdominal anterior wall endometriosis is caused by iatrogenic auto-transplantation of endometrial cells during surgery [12]. It can also be seen in lymphatic and hematologic spread. In differential diagnosis, neuroma, hernia, hematoma, lymphadenopathy, lymphoma, desmoid tumors and sarcomas in the abdominal wall should be taken into consideration [3,10,11]. Although imaging methods such as ultrasonography, computed tomography and magnetic resonance imaging are not diagnostic, they give detailed information about the location, size and density of the mass [3,10,14]. Since ultrasound is both radiation-free and cost-effective in these cases, it should be the first choice in imaging, but computed tomography and magnetic resonance imaging may be more useful for surgical planning. Incisional biopsy should not be performed because it may cause endometriosis to spread [2,3].

Surgical excision is an effective treatment in abdominal wall endometriosis. Preference of the most comfortable anesthesia for the patient during surgery is very important in reducing postoperative complications, early mobilization and early oral start. In this case, surgeon and anesthesiologist compliance is also prominent. Therefore, we preferred spinal anesthesia, which is a regional anesthesia method, because this patient was suitable.

To prevent recurrence, the mass should be totally removed with at least 1 cm of intact tissue [3,9,12]. If residual tissue is not left postoperatively, no additional treatment is needed [14]. Medical treatment (combined oral contraceptives, progestins, danazol, gestrinone, GnRH analogs and anastrozole) for atrophy of ectopic endometrial tissue is preferred primarily in patients with pelvic endometriosis. Non-steroid anti-inflammatory agents can be used for symptomatic treatment [9,11,12]. In conclusion, gynecologic operations should be questioned well in female patients presenting with abdominal wall mass and endometriosis should be considered.

Imaging methods should be used for differential diagnosis. In the treatment, surgical excision should be performed with 1 cm intact tissue as in our case.

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This case report had no involvement sponsors.

Conflict of Interest

The authors have no conflict of interests to declare.

Ethical Approval

This case report is exempt from ethical approval by our institution.

Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request.

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