PRIMARY UMBILICAL ENDOMETRIOSIS CASE REPORT

NAYRTON KALYS CRUZ **DOS ANJOS**[1], MESSIAS GONÇALVES **PACHECO JR**[1], JOÃO VICTOR RIBEIRO DOS **SANTOS**[1], THIAGO SANDE **MIGUEL**[1], BRUNA SANDE **MIGUEL**[2], VINICIUS SANDE **MIGUEL**[2], SEBASTIÃO HORTA CÉLIO **COELHO FILHO**[1], LAMARA LAGUARDIA **VALENTE**[3], DANIEL ALMEIDA DA **COSTA**[1,4*]

1. The Medical School at the Center of Higher Education of Valença, Dom André Arcoverde Foundation, Valença-RJ, Brazil; **2.** The Medical School at the Center of Higher Education of Unigranrio; **3**. University of Caratinga, Caratinga-MG, Brazil, PHD; **4**.Lecturer at the Medicine Undergraduate Program at the Faculty of Medicine of Valença, MS

* FAA - Fundação Educacional D. André Arcoverde | Centro de Ensino Superior de Valença. R. Sargento Vítor Hugo, 161, Fátima, Valença, Rio de Janeiro. professordanielfmv@gmail.com

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ABSTRACT

Endometriosis is defined as the presence of endometrial tissue outside the uterine cavity, estrogen dependent and benign, common in gynecological clinic, associated with infertility and pelvic pain. It affects 10-15% of women of reproductive age. The extrapelvic location corresponds to 12%, being the most common cutaneous form. The primary umbilical endometriosis corresponds to 1% of all cases of endometriosis, and this spontaneous appearance. The main objective of this study is to discuss a primary umbilical endometriosis case report and its clinical importance and the correct treatment of this pathology. A case report of a patient treated in the Gynecologic Clinic of the Hospital School Luiz Gioseffi Januzzi (HELGJ) of Valença Medical School in March 2015. In that case, the patient was admitted and treated properly obtaining healing. Ultrasonography, computed tomography and magnetic resonance imaging help define the diagnosis. CA-125 is elevated in advanced cases of endometriosis. Confirmation is by histopathology. Clinical findings and imaging help with the diagnosis. Surgical treatment is therapeutic and diagnosis. The umbilical cutaneous endometriosis is rare (0.5% to 1.0% of cases of endometriosis).

KEYWORDS: Primary umbilical endometriosis, CA-125 elevated, Gynecological clinic.

1. INTRODUTION

Endometriosis is defined as the presence of endometrial tissue outside the uterine cavity, which is a benign, estrogenic, common entity in the gynecological clinic, associated with infertility and pelvic pain, so that it affects approximately 10 to 15% of women in the reproductive period where it is found often a pelvic cavity (27% ovary, 22% tuberoses, 16% sacroiliac ligaments, rectovaginal septum, pelvic peritoneum and intestines 5-25%)[1,2,6,7]. The extrapelvic location affects about 12% of women with endometriosis, the most common being cutaneous form. The cases of primary endometrioses umbilical corresponds to 0.5 to 1% of all cases of endometriose[1'3'].

Endometriosis can be divided into primary and secondary, the first of spontaneous appearance, where several etiologies have been proposed as immunological and inflammatory alterations of the pelvic-peritoneal microenvironment and the migration of endometrial cells through the blood and lymphatic vessels. But none could fully explain its appearance. The secondary one tends to arise after surgical procedures, usually located on the surgical scar of hysterectomies, caesareans, laparotomies and episiotomy, in order to have its etiology attributed to the implantation of endometrial cells in the different tissues after surgeries[1,2,4].

Clinically it presents as a reddish-brown nodule, usually painful with clinical variations in size, with or without bleeding that may or may not coincide with the patient's menstrual period4,7.

Recent studies reveal that there is no definitive relationship between the age of diagnosis and the severity of the disease, nor is there prevalence in different races, so that there is only a small increase in the risk related to early menarche. It is suggested that the risk of onset is higher in those with first-degree relatives (mother and sisters) affected by the disease, thus presenting greater severity in patients with a positive family history. Studies show a relationship between smoking, physical activity and a higher body mass index with the lowest risk for endometriosis, since these factors have anti-estrogenic effects, lower levels of estrogen and irregular and anovulatory cycles, respectively[5].

The main objective of this study is to discuss the clinical importance of primary umbilical endometriosis and its correct therapy.

2. CASE REPORT

S.A. I, black female, 40 years old, living in Valença/ RJ, was admitted to the Gynecological clinic of the HELJG on 03/03/2015, complaining that three

years ago she started having pain with bleeding in the umbilical region concomitant to the period Menstrual period, being diagnosed initially with umbilical endometriosis. Carrier of bronchitis using salbutamol, with obstetric history revealing two pregnancies, two deliveries (vaginal) and no abortion. The patient denies previous surgeries, smoking, alcoholism and allergy to Aminophylline. No family history that may suggest genetic factors for umbilical endometriosis.

On physical examination, globose abdomen, flaccid, peristalsis present, painless to the superficial palpation and without signs of peritoneal irritation. In the umbilical region, painful bulging was observed at palpation, adhered to the deep plane and of hardened consistency of about 4.5 cm in diameter. The same caused architectural deformities of the umbilical scar. Deep palpation did not reveal visible myelias, pulsatile masses without specific semiologic signs of other abdominal pathologies. Pelvic ultrasonography via transvaginal, abdominal wall ultrasonography, abdominal radiography, computed tomography of the abdomen and pelvis were requested for diagnosis. The first imaging examination revealed no alterations in the pelvic organs, thus discarding the focus of endometriosis in this cavity. The second showed subcutaneous and muscular tissue of normal aspect, without signs of rupture with hypoechoic and heterogeneous image located in the topography of the umbilical scar suggestive of endometriosis. The radiography did not show specific signs. The tomography showed diastasis of rectus abdominis muscles measuring about 3.5 cm in the supra umbilical region. From these evidences, the patient was referred for surgical risk, in order to be classified as ASA-I (a normal healthy patient). Shortly thereafter, elective surgery for umbilical focus excision was proposed.

Thereafter, the treatment was instituted and the diagnosis was confirmed through the surgical procedure and evaluation of operative times (1-antisepsis, 2-mid incision in the umbilical region, 3-divulsion of subcutaneous tissue, 4-evidence of endometrioma and Local fibrosis with resection of the same, 5-revision of hemostasis, 6-synthesis of the aponeurosis, 7-synthesis of subcutaneous cellular tissue, 8-synthesis.

Postoperative was revealed without intercurrences. On discharge day the patient was asymptomatic, with good general condition, normal cardiovascular, respiratory and abdomen.

3. DISCUSSION

Studies reveal that there is no definitive relationship between the age of diagnosis and the severity of the disease, nor is there prevalence in different races, so that there is only a small increase in the risk related to early menarche. It is suggested that the risk of onset is higher in those with first-degree relatives (mother and sisters) affected by the disease, thus presenting greater severity in patients with a positive family history. Studies show a relationship between smoking, physical activity and a higher body mass index with the lowest risk for endometriosis, since these factors have antiestrogenic effects, lower levels of estrogen and irregular and anovulatory cycles, respectively, of the skin)[1,3,5].

In the mentioned case, the female patient with primary umbilical endometriosis was admitted and treated through surgery where she was cured. Cases of primary umbilical endometriosis, because they are not associated with endometrial manipulation or direct contact with retrograde menstrual flow, gain prominence and theories that contemplate changes in the immune and pelvic microenvironment, especially lymphatic and haematological transports, especially to explain the Cases involving umbilical scar, as well as metastasis by retrograde flow, permanence of Mullerian endometrial tissue and metaplasia of mesenchymal pluripotential cells[1'2'].

It is known that environmental changes that may lead to the onset of endometriosis, such as exposure to 2,3,7,8-tetrachlorodibenzo-p-dioxin (TCDD), known as dioxin. TCDD activates genes that develop transcription of proinflammatory cytokines, with continuous stimulation and increased secretion of IL-1, IL-6, IL-8, TNFα, INFγ and VEGF, which are present in the natural course of endometriosis[1],[2].

The patient used salbutamol for the treatment of bronchitis, which is of continuous use and carries allergy to aminophylline. The genetic factor is very important in the onset of the disease, even the cited patient having no suggestive genetic factor [5"].

The primary umbilical form accounts for 1% of all cases of endometriosis, and thus is the most prevalent. Other sites may be affected, such as the perineum, articular regions, pericardium, pleura and central nervous system, being these rare[3,4,6].

It is characterized by a nodule of variable size, having color ranging from red to blue or black. It is almost always cyclical in nature, and there is an increase in volume and pain in the premenstrual and menstrual periods. Ultrasonography, computed tomography, and nuclear magnetic resonance help to assess the extent and define the diagnosis. CA-125 is elevated in advanced endometriosis2.

The confirmation is through histopathological examination, being obligatory the presence of two typical components of endometrial tissue, columnar epithelium glands and endometrial stroma. After removal of the endometrial focus the fragment was sent for histopathological analysis. The association of the clinical data with the imaging findings helps in the diagnosis.'3 Treatment is always surgical with complete excision and umbilical reconstruction, thus being both therapeutic and diagnostic[1],[3,8].

4. CONCLUSION

Umbilical cutaneous endometriosis is a rare pathologic entity representing 0.5% to 1.0% of cases of

endometriosis. It should therefore be remembered as a differential diagnosis of lesions in this region in women of childbearing age, especially in those where the symptoms are related to the menstrual period.

5. ACKNOWLEDGEMENTS

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