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ISOLATED UMBILICAL ENDOMETRIOSIS: A CASE REPORT

Onah HE*, Mgbor SO"  
"Department of Obstetrics and Gynaecology  
" Department of Radiology  
University of Nigeria Teaching Hospital  
Enugu, Nigeria  
Correspondence: H E Onah, PO Box 3709, General Post Office, Enugu - Nigeria  
Tel: +234 (0) 25682, Fax: +234 (0) 251978  
E-mail: h~acin0110infoweb.abs.net

Despite many years of theories, the pathogenesis of endometriosis has remained poorly understood (Novak et al 1974). Classically, it involves the pelvic organs including the ovaries, fallopian tubes, pelvic peritoneum, uterus, urinary bladder, rectum, recto-vaginal septum amongst others. Extra-pelvic sites include the small and large intestines amongst others. The involvement of these extra-pelvic sites often follows surgical implantation of endometrium at these sites during intra-abdominal operations.

Two decades ago, it was thought that endometriosis was rare among Africans (Ekwenlpu 1980, Giwa-Osagie et al 1988). But unpublished clinical observation suggests that pelvic endometriosis may not be as rare in Africans as previously thought. Isolated umbilical endometriosis is rather rare. Although there are some case reports from a number of Caucasian countries (Elkemper 1988, Giwa-Osagie et al 1988). But unpublished clinical observation suggests that pelvic endometriosis may not be as rare in Africans as previously thought. Isolated umbilical endometriosis is rather rare. Although there are some case reports from a number of Caucasian countries (Elkemper 1988, Giwa-Osagie et al 1988), only one case has been reported from Nigeria (Okunola et al 2002). For this reason, we here present one case that we treated recently.

CASE REPORT

P.O.N. was a 24-year old nulliparous woman. She presented to one of us (HE01) on 27th of August 2003 with a 6 month history of bleeding from the umbilicus during menses. Apart from incision and drainage of a right inguinal abscess, she had had no other previous surgery (See Fig 1).

Her menarche was at the age of 14 years. She had a regular 28-30 day menstrual cycle with a 4-day normal flow not associated with dysmenorrhoea. Physical examination revealed a sinus on the right side of the umbilicus with a crust of blood (Fig. 1). There was no other significant finding in the abdomen. Pelvic examination showed normal vulva, vagina and cervix; normal sized anteverted, mobile uterus and free adnexa.

She had an ultrasound examination performed by one of us (SOM), which showed a 19mm x 8mm hypoechoic mass in the paraumbilical region (Fig. 2). The features were suggestive of endometriosis with metastatic deposits and pyomyositis as differentials.

On 29th August 2003, she underwent an excision of the umbilicus. Through the opening in the umbilicus, laparoscopic examination was carried out. There was no evidence of pelvic or other extrapelvic
endometriotic deposits. The surgical incision was closed in anatomical layers. Subsequent histopathology showed endometrial glands of various sizes and shapes characteristically present in the midst of stroma and fibrous tissue. The histology thus confirmed endometriosis. She has been seen three times since the operation and has remained in good health.

DISCUSSION

Umbilical endometriosis coexisting with pelvic endometriosis occurs in a substantial number of cases (Novak). Such coexistence has been explained by lymphatic spread of active endometrium from the pelvic deposits to the umbilicus. However, isolated umbilical endometriosis as seen in the case presented is rare and has been explained by the fact that at the umbilicus, one normally finds remnants of the original coelomic epithelium, which is embryologically capable of endometrial differentiation (Novak et al. 1974).

The case presented is interesting for several reasons. To the best of the authors' knowledge, this is the second case of isolated umbilical endometriosis that is being reported from Nigeria. The patient presented was nulliparous while the first case reported from Ibadan, Nigeria (Okunlola et al. 2002) was multiparous. This suggests that isolated umbilical endometriosis may not have any adverse effect on reproduction. The assumption that endometriosis is less common in Africans than in Caucasians may no longer be valid and requires further evaluation. It was rare in the past probably because Africans used to start reproductive career earlier than Caucasians and pregnancy has a protective effect against endometriosis. It has recently been observed that in the part of Nigeria from where the patient comes, women now start their reproductive career at an average age of 27 years.
years compared to 22 years previously (Onah et al 2002). If this pattern continues, then the prevalence of endometriosis seen in Nigerians is likely to increase even further in the future. Thirsdly, the presentation and treatment of endometriosis remains an enigma. Finally, as shown by the ultrasound report, endometriosis should be considered as a differential diagnosis in umbilical lesions.

REFERENCES


