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Case Report

UMBILICAL PIGMENTATION: AN UNIQUE PRESENTATION OF OCCULT MALIGNANCY

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ABSTRACT
An umbilical metastasis form occult or clinically asymptomatic visceral malignancy is very rare, incidence being 1%-3% of all metastatic malignancies. A 60 years old post cholecystectomy female presented with indurated hyperpigmented lesion at umbilicus with short duration of presentation. Fine needle aspiration cytology revealed carcinoma (FNAC). The diagnosis of metastatic carcinomatous deposits made on FNA was further supported by computed tomography abdomen. This entity is also known as Sister Mary Joseph Nodule traditionally, usually presents as a nodular swelling. Here, we are reporting a case of occult malignancy with unusual clinical presentation. In the today's time of high technology, emphasis also has been given to the role of FNAC as one of the baseline investigations helping in clinical management with immediate results, hence, further management of the patient.

Keywords: *Sister Mary Joseph, Cholecystectomy, FNAC*

INTRODUCTION
The umbilical metastasis usually presents as nodular swelling as suggested by Albano EA (2005). The brown pigmentation of the umbilical area has a long list of diagnosis other than metastatic deposits. This kind of presentation is unique in itself.

CASES
A sixty years old post cholecystectomy female presented with a discharging hyperpigmented skin lesion at umbilical region. On examination lesion was measuring 7 x 4.5cm in size, with in duration and irregular margins. The lesion started as a tiny plaque which was slowly increasing in size over the four months with itching, ulceration, fissuring and increased regional pigmentation (Figure 1). Patient had history of cholecystectomy five years back, now the patient was clinically asymptomatic except discharging umbilical sinus. USG abdomen showed mild thickening of parieties in sub umbilical area. The patient was advised for FNAC. On aspiration, syringe was immediately filled with blood raising clinical suspicion of either vascular pathology or skin lesion lined with granulation tissue. On examining the smear, smear was hyprercellular with singles and group of atypical large cells with high nucleocytoplasmic ratio, hyperchromatic, pleomorphic nuclei focally arranged in glandular pattern (Figure 2 & 3). Further CT abdomen performed, revealed an infiltrative soft tissue mass measuring 48 x44 x 58 mm, involving the parieties, omentum and transverse colon in the umbilical region with focal thickening measuring 12.0 mm in the periampullary region with prominent common bile duct and post cholecystectomy status of the gall bladder.

DISCUSSION
Umbilical diseases comprise large number of lesions including both benign and malignant. Benign lesions comprise 57% of all cases and rest being malignant comprising 43% of cases. The malignant lesions usually include both primary and secondary metastatic deposits to umbilicus (Albano and Kanter, 2005). Cutaneous metastasis is observed in approximately 0.7 to 10.4% of the cases only (Lookingbill *et al.*, 1993). Amongst malignant umbilical tumours, incidence of primary malignancies including squamous cell carcinoma, basal cell carcinoma, adenocarcinoma and sarcoma is only 17% and incidence of

secondary metastases is around 83% (Dodiuk-Gad *et al.*, 2006, Khan and Cook, 1997; Piura *et al.*, 2006). In case of all intra-abdominal or pelvic malignancies, the incidence of umbilical metastasis is very low comprising of 1%–3% only. The most common underlying primary site can be gastrointestinal tract, gall bladder, pancreas, genitourinary system and metastases from unknown primary visceral malignancy (Piura *et al.*, 2006). In men most common primary site is gastric carcinoma and in women it is ovarian carcinoma. The presence of cutaneous metastatic nodule itself is ominous clinical sign and associated with poor prognosis and such cases if diagnosed early will affect the clinical management of the patient (Khan and Cook, 1997). As described earlier, umbilical metastasis presents as a firm irregular nodule with size varying from 1 cm to 1.5 cm, occasionally reaching up to 10 cm in diameter (Dodiuk-Gad *et al.*, 2006). In the present case, clinical presentation was unique as diffuse pigmentation only. The possibility of pigmented skin lesions was ruled out due to short duration of onset (Ragi *et al.*, 1988). Keeping in view discharging sinus possibility of granulomatous omphalitis was also kept in mind, on the other hand endometriosis can also present like a chronic discharging sinus umbilicus (Jafferbhoy *et al.*, 2013). And it was ruled out clinically due to menopausal status of the patient and lack of history of cyclical bleeding or pain. But FNAC procedure ruled out all the possibilities with diagnosis of carcinoma within a short time and helped in the early management of the occult malignancy. After further radiological investigations patient was diagnosed as a case of adenocarcinomatous deposits from upper GIT.

Figure 1: Clinical Presentation of Umbilical Lesion

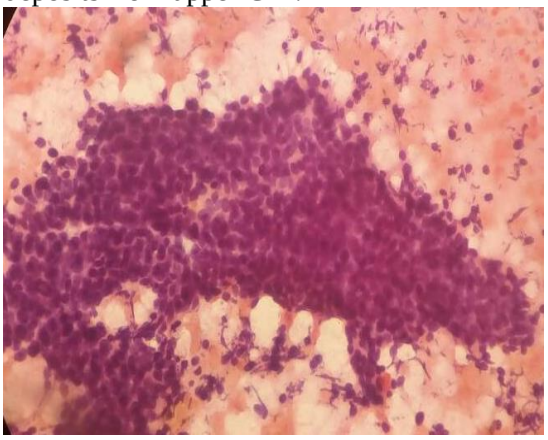

Figure 2: Papillae and Clusters of Atypical Epithelial Cells, Focally Arranged in Glandular Pattern (H & E Stained Cytological Smears 10X)

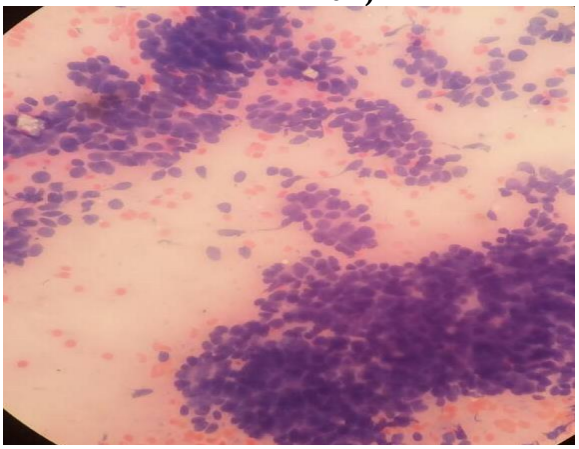

Figure 3: High Power View of Atypical Cell Clusters with Nuclear Overlapping, Crowding, Hyperchromasia Irregular Nuclear Membrane and Scant Cytoplasm (H & E Stain 40X)

Conclusion

Case Report

Umbilical metastasis is rare from visceral organs and usually presents as umbilical nodule. The current case report showed a case of umbilical cutaneous metastasis with unique clinical presentation of pigmented skin lesion.

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