Umbilical pilonidal sinus mimicking umbilical adenoma
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Citation

Abstract
Pilonidal sinus is a common problem in the sacrococcygeal region, and is rarely observed in other regions like the periumbilical area. We discuss here a case of pilonidal sinus presenting as an umbilical nodule along with the predisposing and differential diagnoses.

INTRODUCTION
Pilonidal sinus of the umbilicus, though a rare occurrence, should be considered in the differential diagnoses of an umbilical nodule as a simple extraction of the hair will relieve the symptoms in most of the cases.

CASE REPORT
A 24-year-old male presented with a three-year history of a painful umbilical swelling with reddish discharge. There was no history of trauma, fever or vomiting. Clinically, a diagnosis of umbilical adenoma was entertained. The swelling was excised and sent for histopathological examination.

PATHOLOGICAL FINDINGS
The specimen received was a skin-covered tissue with attached hair, measuring 2.5 x 4 x 1.5cm. Cut section showed a fistulous tract containing hair with firm grey-white areas.

Microscopic biopsy sections showed squamous epithelium overlying a fistulous tract lined by granulation tissue and chronic inflammatory cells containing hair shafts consistent with umbilical pilonidal sinus. (Fig. 1 & 2)

Figure 1
Fig 1: Sinus with hair shaft surrounded by lymphoplasmacytic infiltrate
DISCUSSION

Pilonidal sinus commonly occurs in the sacral region and involvement of the umbilicus is a rarity, with only few cases being documented in the literature. Patey and Williams documented the first case of umbilical pilonidal sinus in 1956. It is caused by hair penetrating the skin, resulting in a foreign body reaction and development of a sinus lined by granulation tissue. The patient may be asymptomatic initially or present with pain, discharge or bleeding from the swelling. Male sex, young age, heavy hirsutism, deep navel and poor personal hygiene are the most common predisposing factors. Umbilical pilonidal sinus carries a risk of peritoneal extension of inflammation, therefore, it should be included in the differential diagnosis of umbilical nodules and treated more aggressively than its sacrococcygeal counterpart. The major differential diagnoses for umbilical pilonidal sinus include umbilical adenoma, umbilical hernia, endometriosis, metastatic tumor and congenital abnormality which can be distinguished on histopathology.

A conservative management is recommended by many authors for umbilical pilonidal sinus. Surgical treatment is restricted to recurrent cases resistant to conservative treatment.

CONCLUSION

Though umbilical adenoma, umbilical hernia, congenital abnormalities and endometriosis are more common conditions leading to an umbilical nodule, pilonidal sinus should be considered, as a simple extraction of hair in this case will relieve the symptoms in most patients.

References

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