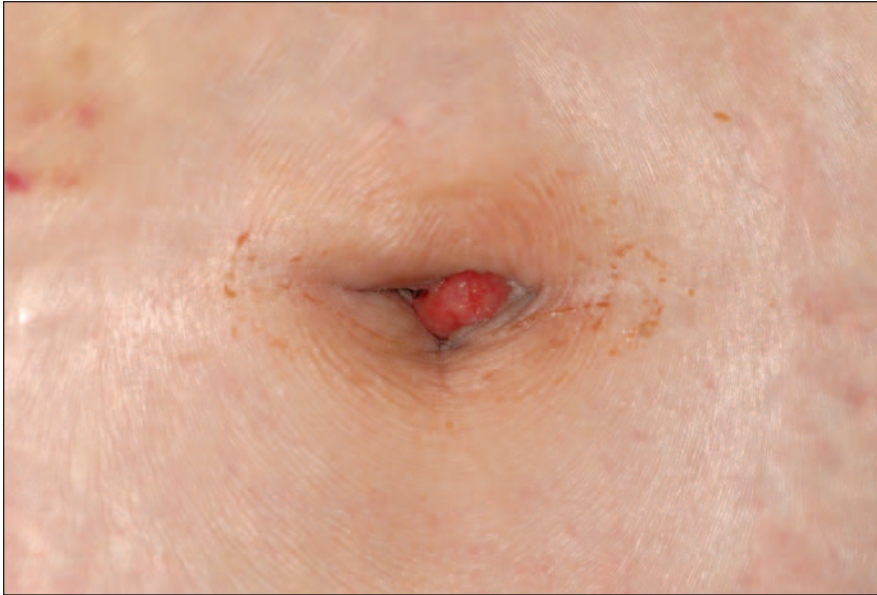


CLINICAL VISTAS BRIEFS

What's your call?

A 62-year-old woman presented with an ulcerated umbilical nodule and vaginal bleeding.



A 15-year-old boy presented with a 4-month history of purple horizontal stripes on his lower back.

See page 930 for diagnoses.

CLINICAL VISTAS BRIEFS

Sister Mary Joseph's nodule

This patient presented with an ulcerated umbilical nodule, profuse vaginal bleeding and a hemoglobin level of 45 g/L. Tumour was visualized at the apex of the vagina; however, biopsy was contraindicated because of bleeding. Biopsy of the umbilical mass revealed metastatic endometrial adenocarcinoma that was strongly positive for both estrogen and progesterone receptors. A CT scan of the abdomen and pelvis supported the diagnosis of umbilical metastasis

(Fig. 1) and showed massive tumour involvement of the uterus and cervix and a left adnexal metastasis (Fig. 2). Urgent radiotherapy successfully stopped the bleeding, and medroxyprogesterone therapy was started.

Sister Mary Joseph's nodule is an umbilical metastasis originating from intra-abdominal or intrapelvic malignant disease. First reported in 1864,¹ it was named after an American nursing Sister who noted an association between the nodules and intra-abdominal cancer during operations when

assisting Dr. William Mayo, founder of the Mayo clinic. The nodule is usually firm, irregular and ulcerated and can be associated with induration, bleeding, discharge and secondary infection. Primary lesions are most often of genitourinary, gastrointestinal or gynecologic origin. Spread to the umbilicus can be hematogenous or via lymphatics, contiguous extension, embryologic remnants, ventral hernia or iatrogenesis.¹ The presence of an umbilical metastasis usually carries an ominous prognosis (average survival time 11 months²).

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Idiopathic striae atrophicae of puberty

A 15-year-old boy presented with isolated horizontal stripes on his back that initially were purple but gradually faded. In the 6 months before presentation, he had gained 11 kg, to a weight of 61.1 kg (50th percentile) and had grown 10 cm, to a height of 173.7 cm (50–75th percentile), which resulted in a body mass index of 20 kg/m² (50th percentile). His medical history was unremarkable, except that he had been born at 33 weeks' gestation and experienced migraine headaches. The boy was otherwise well and had axillary hair for 3 years



Fig. 1: Axial CT scan showing the ulcerated nodule (arrow).

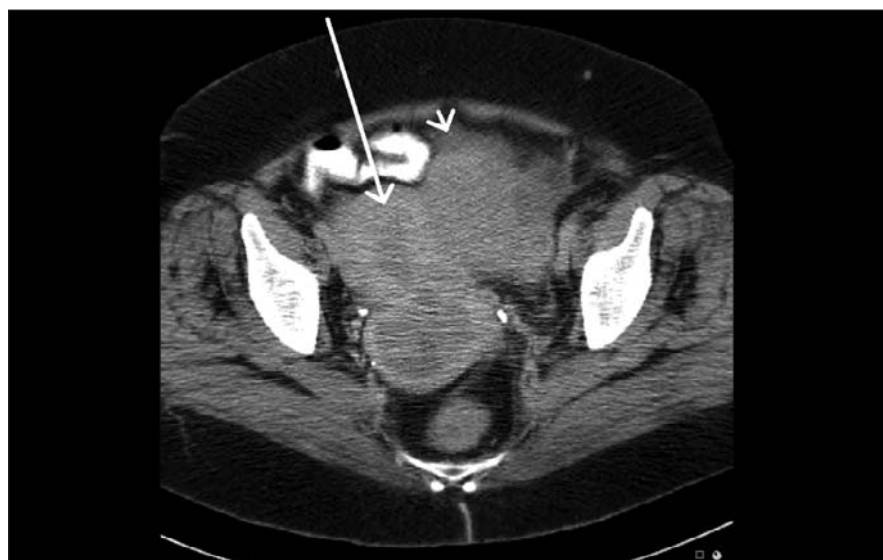


Fig. 2: Axial CT scan showing enlarged uterus (long arrow) and left adnexal mass (short arrow).

and pubic hair for 1 year. His physical examination was unremarkable except for 12 purple linear markings in his lumbar area that felt like a “wash-board.” Blood tests for adrenocortical function were ordered but were not completed by the patient.

Striae distensae (stretch marks) are common in patients who are obese, are pregnant or undergo rapid weight change (e.g., athletes) or who have Cushing’s syndrome or a heritable disorder of collagen tissue (including Marfan syndrome). Striae are also common after prolonged use of topical or systemic corticosteroids. In 1935, Parkes Weber reported an unusual presentation of striae that he called “idiopathic striae atrophicae of puberty.”¹ This form of striae occurs in healthy, nonobese individuals around the time of puberty.

Striae are typically located on the thighs, buttocks, breasts and lower back² and occur in planes perpendicular to the tension of the skin. Isolated striae in the lumbar region in nonobese individuals, as in our patient, are uncommon. Striae typically begin as violet or reddish-pink wavy lines that are slightly raised and, over a period of months to years, fade to barely visible white atrophic lesions with a wrinkly surface.² Striae are rarely seen in children less than 5 years of age. The highest incidence of striae is between 10 and 16 years of age (20%–70%) among girls and between 14 and 20 years of age (6%–40%) among boys.³

Striae may be caused by rapid deposition of adipose tissue or muscular hypertrophy beneath the dermal layer. In striae of puberty, genetic predisposition, periods of rapid growth (“growth

spurts”) and hyperstimulation of the hypothalamic–pituitary axis may all be predisposing factors.²

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