Navel piercing during pregnancy: A cautionary tale for the family physician, the obstetrician and the midwife

Piercing du nombril durant la grossesse : le généraliste, l’obstétricien et la sage-femme doivent rester vigilants

Navel piercing is usually performed above the umbilicus by women to enhance beauty and attractiveness. According to a British national survey, 9.5% of the women would have such piercing [1]. It is therefore far from being rare for a midwife or a gynaecologist to have a young parturient woman with such piercing nowadays.

Tissue tearing usually occurs as the jewellery get accidentally snagged or pulled and the tissue gets ripped [2]. As pregnancy causes great abdominal distension, maintaining a navel piercing during that period may carry the risk of migration, rejection or striae/stretch mark development [3]. A navel ring may also impede the growing uterus [4]. Besides, we observed cases of rejections of abdominal microdermal implants during pregnancies [5]. Therefore, the question of navel piercing removal during pregnancy has to be discussed at the beginning of the pregnancy with the parturient. It should be stressed that a "prophylactic" removal may not prevent a patient from developing stretch marks at the piercing site, due to the stress rupture related to gravid distension [6]. However, it does not seem obvious to everyone that a navel piercing should be taken off when the skin start to stretch on that area. The hereby figures (figure 1) is an unaesthetic scar as the consequence of spontaneous rejection of a navel piercing that was kept until 48 hours before delivery. During her first pregnancy, at the age of 26-years-old, this patient noticed that the skin over the piercing began to stretch under the abdominal distension. However, she sought advice for her piercer who changed the jewellery by another larger one. Unfortunately, it did not prevent from tearing and the piercing was rejected through the bridge of skin.

Removal of body jewellery for procedures, in elective or non-emergency health care especially, always raises concerns among patients about maintaining patency of the piercing tract. Indeed, the delay of staying open after removal is variable and unpredictable [7]. The patient does not always perceive the risk of maintaining the jewellery, while the physician may overstate the necessity of its removal [7]. However, our observation supports such necessity before the end of pregnancy, especially if tissue begins to stretch [8]. The fact that the piercer chose here to maintain the piercing illustrates that there is no consensus among piercers. Besides,
this peculiar situation is not always mentioned in piercing guidebooks for the public [9]. Therefore, midwives and obstetricians play an important preventive role. As soon as the first consultation, the parturient should be warned of the potential risks and know that she may have to remove her piercing within the next upcoming months. Fortunately, various retainers, such as intravenous catheter, can be placed to keep the hole open [7,10] if the parturient fears for a premature closing of the piercing hole. Of note, some body jewellery retainers are commercially available but may come apart more easily and are not encouraged in this context [7]. Such "issue" may appear trivial for some readers. However, the remaining scar may be disabling from an aesthetic point of view for any young woman, where as it could be avoided simply and easily.

Disclosure of interest: the authors declare that they have no conflicts of interest concerning this article.

References

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Received 7 March 2012
Accepted 3 April 2012
Available online 28 May 2012

© 2012 Published by Elsevier Masson SAS.
http://dx.doi.org/10.1016/j.lpm.2012.04.006

Contribution of diffuse-weighted whole body imaging with background body signal suppression (DWIBS) in multisystemic Castleman’s disease

Contribution du Diffuse-Weighted Whole Body Imaging With Background Body Signal Suppression (DWIBS) dans la maladie de Castleman multicentrique

Castleman’s disease (CD) is a rare lymphoproliferative disorder divided into unicentric Castleman’s disease (UCD) which represents 90% of the cases, and Multicentric Castleman’s Disease (MCD), which represents the remaining 10%. Compared to UCD, MCD presents at a later age, is always symptomatic, shows an important association with HIV, is more difficult to treat and has a bleaker prognosis [1]. Almost all cases of MCD are symptomatic, albeit with symptoms of unspecific nature (fever, night sweats, weight loss, fatigue...). Possible complications of MCD include fulminant infection and malignancies, notably lymphoma and Kaposi sarcoma [2]. Enlarged lymph nodes have been shown to exist in multiple locations with multiple imaging methods. However, definitive diagnosis requires histological confirmation. The different imaging diagnostic modalities used are chest X-Ray, CT Scan or MRI [3–5]. 18F-Fluorodeoxyglucose positron emission tomography/computed tomography (FDG PET-CT) was also used in some instances [6]. The use of diffuse-weighted whole body imaging with background body signal suppression (DWIBS) for MCD has not been reported so far. DWIBS is a whole body MRI using diffusion sequences with a b factor of 1100 with reconstruction of the whole body in 3D using Mobi view software and Maximum Intensity Projection (MIP) after color inversion and fat signal suppression [7]. There is no consensus for the treatment of MCD. Multiple modalities have been attempted, including steroids [8], chemotherapy, antiviral agents [9], anti-CD20 antibody [10] and splenectomy [11] with variable efficacy.

Case

We relate the case of a 72-year-old woman who was admitted for fever, lethargy, paleness, decreased appetite and diffuse arthralgias. The physical exam showed a splenomegaly and adenopathies of elastic consistence. Initial workup showed normocytic anemia (Hb: 7.8 g/dL, MCV: 83 fL) and thrombocytopenia (PLT 90.10⁹/L). An extensive infectious workup, including HIV serology was negative. A research of autoimmune disease markers was also negative. Bone marrow aspirate