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Rare manifestation of endometriosis causing complete recto-sigmoid obstruction: A case report

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ABSTRACT

INTODUCTION: Endometriosis is a disease in which endometrial epithelium implanted outside the uterus. Although the endometrial tissue can implant anywhere, the most common places are the ovary and pelvic peritoneum. We present a rare case of recto-sigmoid endometriosis that causes a complete large bowel obstruction in a non-reproductive age woman who came with no specific symptoms of endometriosis and the diagnosis was made after surgical resection.

CASE PRESENTATION: A 50 years old female who never been married and admitted to have no sexual experience in her life, presented with symptoms of acute bowel obstruction. She underwent sigmoid colectomy as the primary diagnosis was colonic tumor, but the histopathological reports showed the diagnosis with recto-sigmoidal Endometriosis. At the second laparotomy for closure of colostomy, the uterus was abnormal and she had a hysterectomy with salpingio-oopherectomy to prevent recurrence. The histopathological report revealed cervical, ovarian, and fallopian tube endometriosis.

DISCUSSION: Unlike our patient, most patients complain of the common symptoms of endometriosis such as dysmenorrhea, dyspareunia, and dyschezia and many of them came with infertility as a main complaint which make them undergo further investigations like laparoscopy, and lead to pre-surgical diagnosis of endometriosis. But in case of complete bowel obstruction, urgent laparotomy is the treatment of choice.

CONCLUSION: Although Intestinal endometriosis is rare to cause bowel obstruction physicians and surgeons should always consider it as a differential diagnosis of bowel obstruction even without specific symptoms, to prevent surgery in incomplete obstruction.

1. Introduction

Endometriosis is a disease in which endometrial epithelium implanted outside the uterus [1]. It can be found anywhere but its involvement in the gastrointestinal tract is limited to 3%–37% [2]. Of all reproductive age women 40–80% present with symptoms such as pelvic pain, infertility or both [3]. Endometriosis can be a cause of colonic obstruction that occurs in the sigmoid colon in only 1–10% of all cases [4]. The incidence of complete large bowel obstruction due to endometriosis is rare because of its large intraluminal diameter. Bowel endometriosis is often asymptomatic but it can cause non-specific symptoms such as colic pain, constipation, nausea, and vomiting [5]. A PubMed search reveals only few cases of large bowel obstruction caused by endometriosis in the past years. We present a case report of recto-sigmoid endometriosis that cause a complete bowel obstruction diagnosed after surgical exploration in a female patient of non-reproductive age.

2. Case

A 50 years old, not sexually active ever women, came to our hospital with a one-month history of constipation and abdominal cramps, in the past two days she failed to pass stool or faeces completely with generalized abdominal pain, she complained also of vomiting and mild fever. She mentioned a history of weight loss and anorexia in the past two months in addition to irregular menses in the past year with last menstrual period two months ago with no history of dysmenorrhea or rectal bleeding. On examination she was in pain and ill looking, her vital signs were normal except of tachycardia of 120/min. The abdomen was distended, tympanic with accelerated bowel sounds and no palpable masses were found. Digital rectal examination was empty. Complete blood count showed signs of inflammation with leucocyte 24600\mm3 86% neutrophils and 10% lymphocytes. Other labora-

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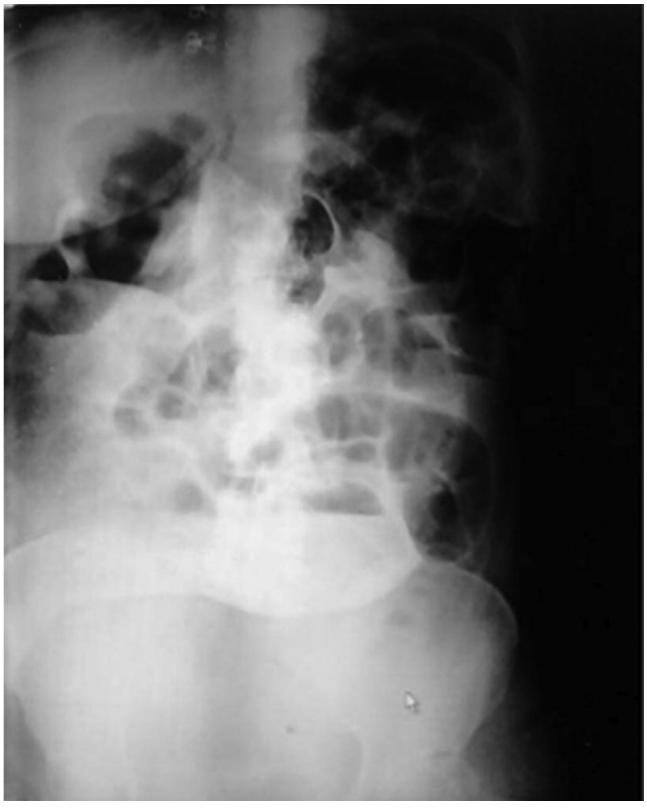

Fig. 1. Erect abdomen x ray showing. Distended Sigmoid and large bowel.

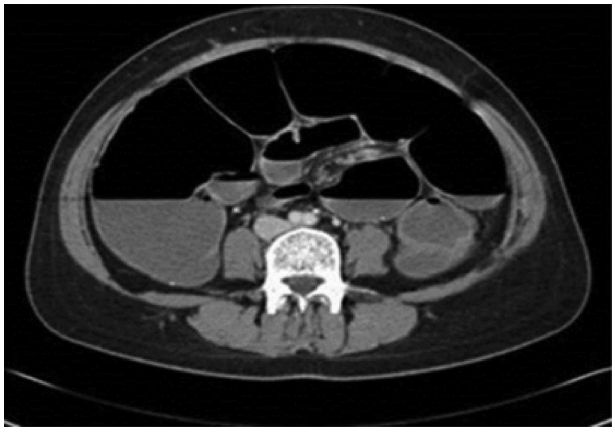

Fig. 2. CT abdomen showing distended sigmoid colon.

tory tests were normal. Abdominal x-ray and CT showed a colonic distension (Figs. 1 and 2). A sigmoidoscopy was performed and showed constriction 11 cm distal to anus that could not bypass with mucosal infiltrations, biopsies were taken that later reported mild non-specific inflammation with congestion and no malignancy.

The patients underwent an urgent laparotomy. In surgery the colon was distended with solid tumor on recto-sigmoidal junction measured 5 × 6 cm in diameter and adhesions to the posterior surface of the uterus with no other abnormalities. There was no gross appearance of endometriosis. The adhesions were released and sigmoid colectomy with end colostomy were performed. Postoperatively, she had a total hospital stay of 5 days. Postoperative CEA was within normal limits. Microscopically, the specimen reveals an obstructing tumor within the wall of the sigmoid without mucosal involvement composed of benign looking endometrial glands lined by columnar cells without atypia surrounded by specialized stroma with sever acute inflammation (Figs. 3 and 4). Histological report revealed the diagnosis of colonic Endometriosis (4 cm) with inflammatory changes. Surgical resection lines were free of endometriosis, in addition to free 8 reactional lymph nodes (Figs. 5 and 6).

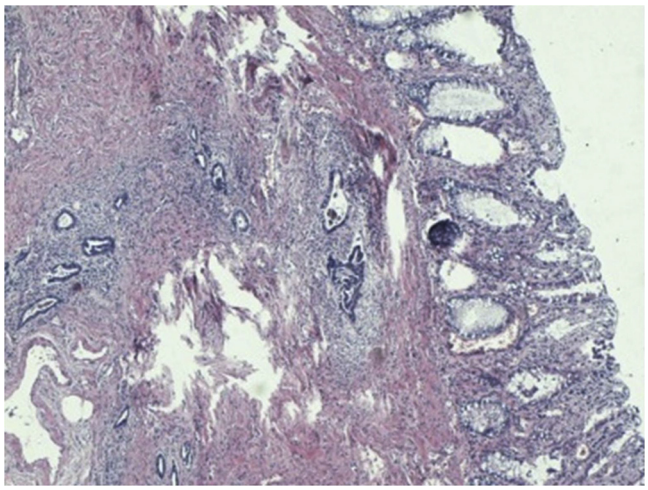

Fig. 3. Colonic endometriosis, with inflammatory changes. by specialized stroma with sever acute inflammation.

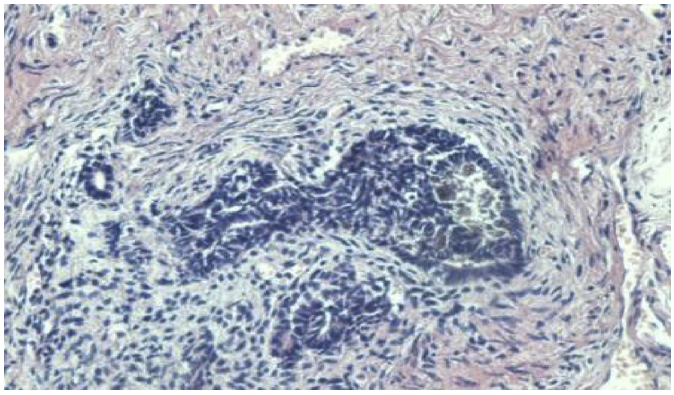

Fig. 4. Hemorrhagic Endometrial glands + stroma within colonic wall.

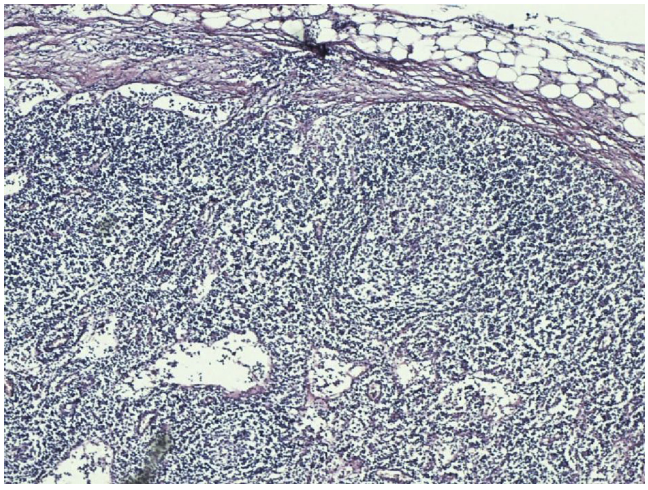

Fig. 5. Lymph node free of malignancy.

The patient referred to gynecologist and put on a treatment with only progesterone pills for one year. After two months the