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Ileo-colic endometriosis: a rare localization of a frequent disease

Case report

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Ileo-colic endometriosis: a rare localization of afrequent disease. Case report

Endometriosis is a common entity affecting females of reproductive age. Clinical manifestations are not specific, making the preoperative diagnosis difficult to establish. Intestinal endometriosis is common, but ethiology is unknown. The complications of intestinal endometriosis include intestinal obstruction, perforation, hemorrhagic ascites, protein-losing enteropathy, anasarca, and intussusception. We report a case of a young woman, 26 years old, that for 3 years had a conditioned life by monthly sub-occlusion due to a small-bowel obstruction for an ileocaecal endometriosis. A high index of suspicion is required to have a diagnosis of this rare localization of endometriosis.

KEY WORDS: Endometriosis, Ileocolic obstruction

Introduction

Endometriosis is a common disease, affecting around 15% of childbearing women and was first described by von Rokitansky in 1860 [1]. It has a peak incidence in the third and fourth decade. Its aetiology is unknown, although there is a high incidence in sterile females as well as in those who have a family history [2]. This disorder is characterized by the presence of normal endometrial tissue outside the uterus. In 5% of cases there is the involvement of gastrointestinal tract because intestinal endometriosis is quite common [3] and usually affect the rectum and the sigmoid colon in 50-90%, small bowel in 2-16%, appendix 3-18%, caecum 2-5% of cases. Small-bowel localization causing obstruction is extremely rare with an incidence of 0.15% [4]. Clinically, the symptoms of bowel endometriosis are numerous and include abdominal pain, rectal pain, tenesmus, rectal bleeding and constipation and considering the lack of specificity, diagnosis can be difficult [5]. Classically, the symptoms are worse during menses as in our patient.

Case report

A 26-year-old nulliparous woman presented to our operative unit reporting abdominal colicky pain and distension in the last 24 hours, with nausea and vomiting. She had constipation and had been unable to defecate for the last 2 days. She is in her menstrual period. She reported a long-standing history of constipation and several episodes of abdominal pain during the last 3 years for some of which she was admitted to hospital. She had no diagnosis because disappearance of symptoms stopped diagnosis's procedure. The patient's past medical history included a spontaneous abortion. At the time of admission, she was taking the oral contraceptive pill. Laboratory data revealed no elevation in the white blood cell count. The β-HCG test was negative. Blood tests revealed a 2-fold increase in CA-125 tumor marker val-

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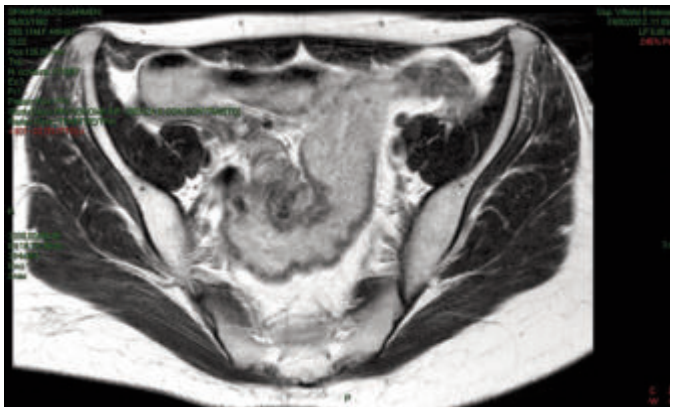

Fig. 1

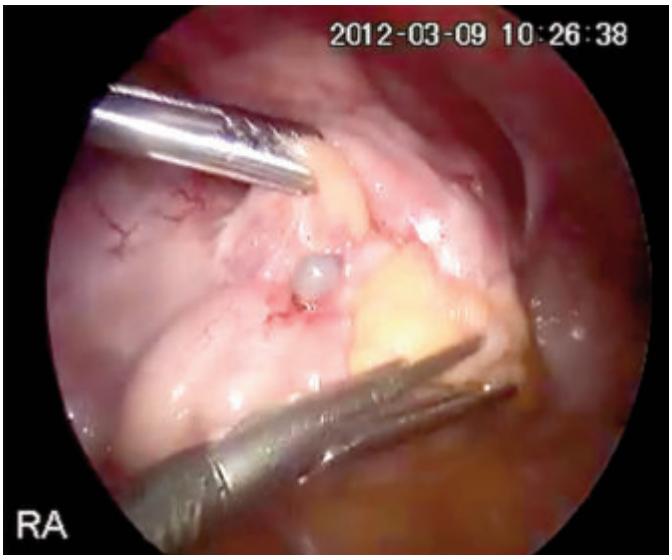

Fig. 2

ues. A CT scan of abdomen emphasized a remarkable swelling of small bowel with an obstruction at 5 cm from ileo-cecal valve due to a small solid node with irregular margin, diameter 2,5 cm. MRI confirmed the suspect of endometriosis with the evidence of a fibrotic nodule 2 cm obstructing small bowel. An explorative laparoscopy was performed. The loops of small bowel were dilated. A cyst of dark brown (chocolate) color could be seen on top of the mass that obstruct the terminal ileum near ileocecal valve. We decided to excise the cecum, appendix, and terminal ileum en block. An end-to-end anastomosis was performed in 2 layers of absorbable stitches. The pathologic examination of the resected sample revealed three endometriotic nodule comprising endometriotic tissue blendend with adipose and fibromuscular tissue localized in the muscularis propria and submucosa.

Discussion

Endometriosis is a benign condition, affecting 4 to 17% of menstruating women. It has a peak incidence in the third and fourth decade. Its aetiology is unknown, although there is a high incidence in sterile females as well as in those who have a family history [2,6]. Various theories have been proposed to explain its development, and the most widely accepted is that of retrograde migration of endometrial tissue from the uterus to fallopian tubes and then to the peritoneal cavity [7]. Two reviews comprising almost 7200 cases of endometriosis each showed that small-bowel involvement has a frequency of less than 1% [2]. The three clinically distinct forms of endometriosis are: 1) endometriotic implants on the surface of the pelvic peritoneum and ovaries (peritoneal endometriosis); 2) ovarian cysts lined by endometrioid mucosa (endometriomas); 3) a complex solid mass comprised of endometriosis tissue blended with the adipose and fibromuscular tissue residing, more frequently, between the rectum and the vagina, rarely small bowel or ileocecal tract (endometriotic nodule). Ileal endometriosis is usually located within the last 10cm before the ileocaecal valve [7]. Last data in literature reports complications of small bowel endometriosis including intestinal obstruction and intussusception, which is mainly related to the vermiform appendix [9,10]. Clinical manifestations are not specific, making the preoperative diagnosis difficult to establish. The case presented is rarely seen as small bowel obstruction only accounts for only 0.7% of all surgical interventions for endometriosis [2]. Small bowel endometriosis can manifest with acute and chronic symptoms that can mimic many different pathologies such as malignancy, inflammatory bowel disease, ischaemic colitis, infectious diseases and IBS. Colicky abdominal pain is the most common presenting symptom of enteric endometriosis and is common to many other conditions such as Crohn's and is non-specific in cases of bowel obstruction [11]. Similarly, other common symptoms such as loose motions, constipation, nausea, emesis, pyrexia, anorexia and weight loss in isolation will not be diagnostic. Haematochesia, such as was seen in our case is an uncommon symptom due to the low incidence of mucosal involvement. The patient's symptoms following her menses aided our diagnosis. Laboratory tests such as CA-125 are not sensitive enough for diagnostic use. Enteric endometriosis should be considered as a differential diagnosis when assessing females of reproductive age with acute small bowel obstruction. A CT scan can be useful in diagnosis as it may demonstrate focal or constricting bowel lesions. MRI is currently the best imaging modality for enteric endometriosis with a sensitivity of between 77-93%. A high index of suspicion is required to obtain a diagnosis of this rare localization of endometriosis that can be unknown for long time.

Riassunto

L'endometriosi è una comune patologia che colpisce le donne in età fertile. Le manifestazioni cliniche sono aspecifiche e ciò rende difficile una diagnosi pre-operatoria. L'endometriosi intestinale è frequente ma l'eziologia é sconosciuta. Le complicanze dell'endometriosi intestinale includono l'ostruzione, la perforazione, l'ascite emorragica, la proteino-dispersione intestinale, l'anasarca e l'intussuscezione. Noi riportiamo un caso di una giovane donna, 26 anni, che per 3 anni ha avuto subocclusioni mensili dovute all'ostruzione ileocecale da endometriosi che le hanno condizionato la vita di relazione è necesario un alto senso di sospetto per giungere una diagnosi di queste rare localizzazioni dell'endometriosi.

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