Extragenital Pelvic Endometriosis with Acute Intestinal Obstruction Presentation in a Postmenopausal Woman. Case Report.

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ABSTRACT

Endometriosis is the presence of endometrial cells outside the uterine cavity. It is a benign disease that affects women both during the reproductive and postmenopausal period. Endometriotic lesions involving pelvic organs such as the rectum, sigmoid, and bladder are called extragenital pelvic endometriosis. We present a 71-year-old patient with a 3-month history of abdominal pain and changes in bowel habits who was admitted with 5-day duration of bowel obstruction. In the exploratory laparotomy, an inflammatory lesion was found in the rectosigmoid colon involving the small intestine, and a Hartmann procedure was performed. The pathological study reports colonic wall with foci of endometriosis and adherence to the ovarian and tubal parenchyma. In extragenital endometriosis, the sigmoid colon is the most frequently affected. Preoperative diagnosis in the emergency setting is difficult and depends on the histological confirmation of the resected specimen to differentiate it from other colonic causes of intestinal obstruction such as Crohn's disease or neoplasms.

Keywords: *Colonic Endometriosis, Extragenital Pelvic Endometriosis, Deep Endometriosis*

INTRODUCTION

Endometriosis is defined as the presence of implanted endometrial mucosa in locations other than the uterine cavity.[1,2] Its gastrointestinal manifestations are common and occur in 5-12% of patients. The most frequent locations in the gastrointestinal tract are the rectum (13-50%), the sigmoid colon (18-47%), the small intestine (2-5%) and the cecal appendix (3-18%).[3,4] The term extragenital pelvic endometriosis describes more precisely those endometriotic lesions that affect the pelvic organs such as the rectum, sigmoid colon and bladder.[1] Endometriosis can be the cause of sigmoid obstruction in only 1-10% of cases. Although there are some rare cases of large bowel obstruction due to endometriosis in premenopausal women, this is even more rare in the postmenopausal period.[5]

CASE REPORT

A 71-year-old patient was admitted to the emergency department due to diffuse crampy abdominal pain of five days duration associated with abdominal distension, nausea and inability to pass gas. She has a 3-month history of abdominal pain and changes in bowel habits with taped stools, hystero-salpingo-oophorectomy (unknown cause), bariatric surgery and cholecystectomy. A videocolonoscopy had never been done. The vital signs are normal.

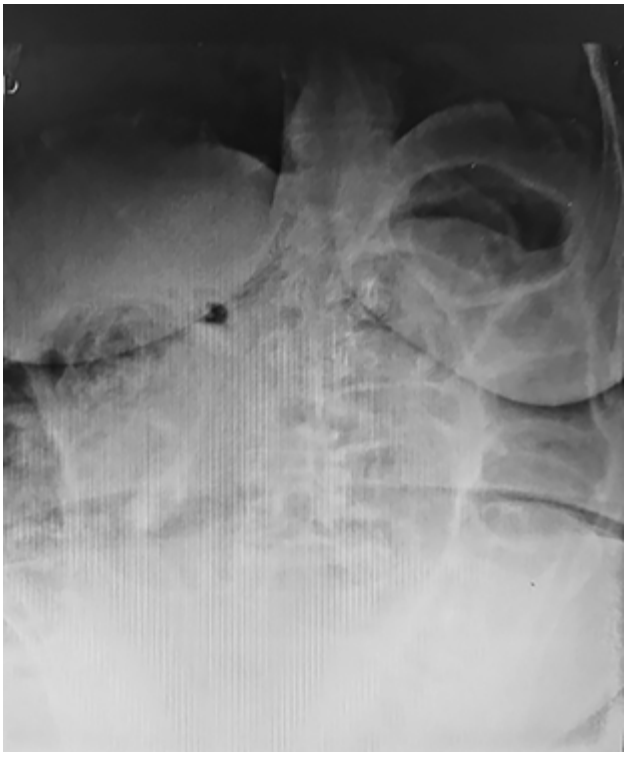

Figure 1: Colonic air-fluid levels without distal air, compatible with intestinal obstruction.

She presented a distended abdomen, diffuse pain predominantly in the left iliac fossa, parietal guarding and decreased bowel sounds. On digital rectal examination no lesions or evidence of bleeding were found. Plain x-ray of the abdomen reveals air-fluid levels with absence of distal colonic gas (Fig. 1). An intravenous line, a nasogastric tube and a bladder catheter are placed. Given the clinical

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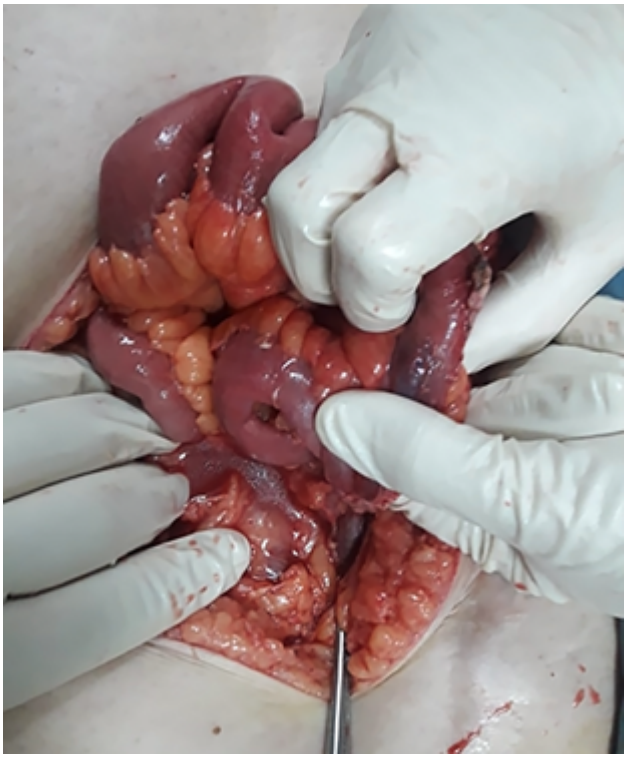

Figure 2. Inflammatory-like lesion in the rectosigmoid colon involving the small intestine.

evolution and the non-response to medical treatment together with the imaging findings, it was decided to perform an emergency laparotomy. During the surgical procedure, an inflammatory-like lesion in the rectosigmoid colon that involves the small intestine is evidenced (Fig. 2). A Hartmann´s procedure is performed. Twenty-four hours later the patient presented colostomy retraction and a new colostomy is performed. The histopathology study reports colonic wall with foci of endometriosis, adherence to the tubal and ovarian parenchyma (with the presence of the body albicans) and diverticulosis, without evidence of neoplasia. The patient suffered from in-hospital pneumonia and died during hospitalization.

DISCUSSION

The reported gastrointestinal tract involvement occurs in 3.8-37% of women diagnosed with endometriosis. Both adolescents of reproductive age and menopausal women can be affected. The involvement of different sites of the gastrointestinal tract close to the uterus supports the theory of implantation of endometriotic foci due to retrograde menstruation. Implants limited to the serous layer of the colon are usually asymptomatic. Conversely, deeply infiltrating lesions can cause severe gastrointestinal symptoms. Rectosigmoid involvement often causes changes in bowel habits, such as constipation, diarrhea, decreased caliber of the stool, tenesmus, or rarely, rectal bleeding. Such symptoms appear more frequently around the time of menstruation. Since the intestinal mucosa is rarely affected, rectal bleeding is an unusual symptom, although it can occur due to severe intestinal obstruction and ischemia.

Our patient had a history of hystero-salpingo-ooforectomy and it would have been important to know its indication. Nonetheless, it is interesting the abdominal pain and the change in bowel habits in the last three months, beginning at 71 years of age that would suggest neoplastic pathology in the first instance. Colonic endometriosis obstruction can be difficult to differentiate from other causes of large bowel obstruction, such as Crohn's disease or neoplasms.

Magnetic resonance imaging can be useful for the diagnosis of multifocal endometriosis, as well as for defining the anatomical location of the condition with a sensitivity and specificity of approximately 90 %. Rectosigmoidoscopy or colonoscopy is of little diagnostic value since endometriosis is an extrinsic, typically non-transmural disease. The diagnosis is usually made or confirmed by laparoscopy or during laparotomy.

We can conclude that endometriosis is a disease characterized by the presence of endometrial glands and stroma outside the uterine cavity and that its presentation is rare in postmenopausal women. Pelvic endometriosis is a rare cause of large bowel obstruction and its treatment can be challenging. Preoperative diagnosis in the emergency setting is often difficult and depends on postoperative histological confirmation, especially in women without a history of endometriosis, due to the low sensitivity of imaging studies in this setting.

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COMMENT

This is an interesting case of colonic obstruction due to a cause as rare as deep endometriosis, especially in a postmenopausal patient. Endometriosis obstruction is mostly reported in isolated case reports and has an approximate incidence of 1 % among patients with deep endometriosis.[1,2]

A common point among the case reports is the finding on surgical exploration of a large inflammatory component. This is usual in this condition, so the great challenge is to perform a good dissection by planes, on one hand to comply with the oncological principles of colectomy (given the lack of prior diagnosis of certainty in emergency cases) and on the other to avoid damaging other structures that may be intimately involved in the inflammatory process, such as the ureters, iliac vessels, or gynecological organs.

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