Case Report of IleoCaecal And Appendicular Endometriosis with Mucosal Involvement in a 49 year old

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Citation

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Abstract

Background:

Endometriosis with Intestinal involvement is not uncommon in women of childbearing age. Mucosal involvement however is rare. Differential diagnosis from colon cancer may be difficult due to the lack of symptoms. It is rare to find this as the primary manifestation of the disease in a perimenopausal woman.

Case presentation:
A fit 49-year-old woman presented with acute small bowel obstruction. She underwent a laparotomy and right hemicolectomy for a palpable mass in the ileo caecal region. Histology confirmed ileo-caecal endometriosis with full thickness involvement.
Conclusion:
Ileo colic endometriosis is a rare differential diagnosis in pre menopausal women. It can mimic malignancy; the diagnosis is seldom made pre operatively in the absence of previous endometriosis.

BACKGROUND

Extra pelvic endometriosis is defined as the presence of endometrial glands and stroma in ectopic areas in the gastrointestinal tract , urinary system , pulmonary system , CNS, skin and striated muscle . The exact prevalence is unknown. The median age at diagnosis is 34 to 40 years. Periodic hematochezia and abdominal pain during the menses is a sign associated with intestinal endometriosis . Accompanying symptoms may be absent, making it difficult to exclude other serious pathology including malignancy. In this report we present the case of a 49 year old woman with ileo-caecal endometriosis. Initial diagnosis favoured a carcinoma of the caecum causing acute small intestinal obstruction.

CASE PRESENTATION

A 49 yr old lady presented to the Surgical emergency unit with symptoms of acute intestinal obstruction since last 3 days and worsening over the last 24 hours . She had no history of recent weight loss, cyclical hematochezia, concurrent medical problems or any abdominal surgical procedures. She denied the presence of any relevant familial diseases.

She had her menarche at the age of 16 yrs. Thereafter she had 28 day menstrual cycles which lasted for 3 days. She had diffuse lower abdominal pain associated with her periods since a long time back. She underwent a single ventouse delivery, at the age of 31 yrs and gave birth to a healthy male infant.

She was seen on the surgical ward with profuse vomiting and grossly distended abdomen and intermittent severe abdominal colicky pains mostly localise over the periumbilical region. On examination she had diffuse abdominal tenderness, hurried peristaltic sounds and rectal examination showed slight stool and the absence of any mass or blood. The gynaecological examination showed that her vulva, vagina and cervix were normal. Her uterus had normal size and was anteverted.

Blood tests revealed normal haemoglobin and raised white blood cells of 18.1 (neut: 80.6%, lymph: 12.3%, mono: 4.6%). Coagulation profile, serum urea, creatinine, electrolytes, and liver function tests and amylase levels were all within normal range.

Abdominal x-rays showed grossly distended loops of small bowel and minimal gas in the large bowel with no gas in the

rectum.

Exploratory laparotomy was performed in view of her symptoms. The findings at laparotomy were, distended terminal ileum and a firm mass at the ileocaecal junction. The mass was relatively free and related solely to the intestine. Rest of the gut was normal. Right Hemicolectomy, extending from terminal ileum to the mid transverse colon, along with ileotransverse anastomosis was performed .The recovery was uneventful. Histopathology reports of the resected specimen showed a firm constricting mass at the ileo caecal region very close to the base of the appendix. The ileocaecal valve was swollen. The microscopy suggested gross endometriosis involving the Terminal Ileum, Proximal Caecum and the Appendix with disease extending in all layers from serosa to the mucosa. There were no signs of any malignancy or any inflammatory bowel disease.

Figure 1

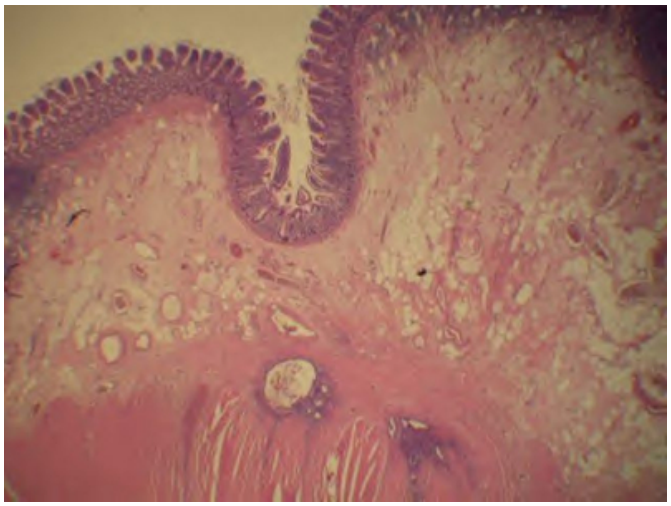
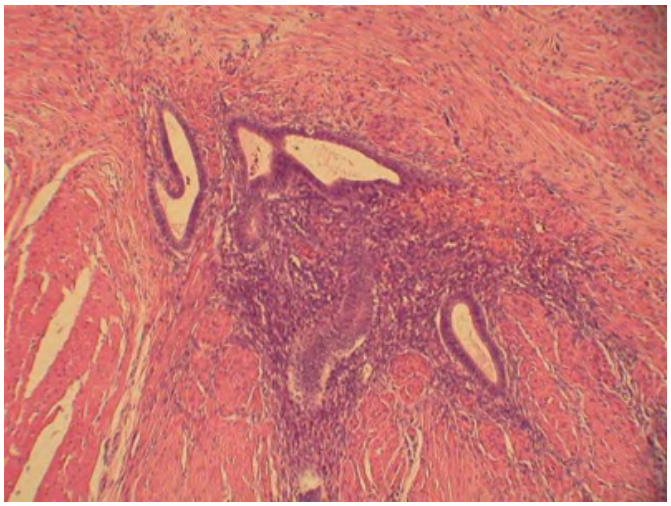


Figure 2



DISCUSSION / CONCLUSION

Endometriosis can occur commonly at sites like ovary, pouch of Douglas, uterosacral ligament and extrapelvic sites. Of the extrapelvic sites the commonest is the gastrointestinal tract affecting roughly 5 – 15 % of women with rectum and sigmoid colon being the most commonly involved areas (75–90%) with the distal ileum (2–16%), and appendix (3–18%) being less common . Only the serosa and the muscularis propria are usually involved, while the mucosal involvement is very rarely encountered.

The symptoms in intestinal endometriosis are often very vague and can simulate other disorders like inflammatory bowel disease, cancer of colon, pelvic inflammatory disease, diverticular disease, irritable bowel disease and infection. Presentations are with gastrointestinal bleeding, abdominal pain, distension, diarrhoea, signs of intestinal obstruction and most of it being associated with the periods. The classic triad of dysmenorrhea, dyspareunia and infertility, as a result of concomitant pelvic disease, may also exist. But it is also significant to note that the clinical manifestations in inflammatory bowel disease and irritable bowel syndrome may aggravate during the periods as well.

Radiological or endoscopic picture can be misleading and can simulate other diseases like cancer or inflammatory bowel disease. The pathological confirmation comes from the histological diagnosis of the endoscopic or operative specimen though biopsies obtained endoscopically often yield insufficient tissue for a definite pathologic diagnosis. Moreover the secondary mucosal changes from endometriosis can be very similar to inflammatory bowel disease or neoplastic changes.

Medications used for endometriosis are GnRH analogues, danazol and high dose progestin. GnRH agonists are usually better tolerated. The indication of surgery in the treatment is failed medical treatment. But very often a surgical route is preferred to deal with the severity of symptoms and of course in acute emergencies.

Our patient presented as an acute emergency for which she underwent emergency laparotomy. The rarity of this case rests upon a few facts. First, the mucosal involvement of the disease which is a rare entity was found in the operative specimen in this case. Second, the patient was 49 yrs old which is very near to menopause and consideration of the first severe manifestation of this disease in this age group is quite unusual. Thirdly, though she had cyclical lower abdominal colicky pains she had never presented with

gastrointestinal bleeding or dyspareunia . She had one child of her own.

As a conclusion, gastrointestinal endometriosis is often a challenging diagnosis to be made and should always be kept in mind while dealing with female patients of childbearing and premenopausal age groups.

ACKNOWLEDGEMENTS

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