Colonic obstruction secondary to endometriosis

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A 35-year-old white nulliparous woman was admitted with intermittent nausea, post-meal vomiting, abdominal distension, and diffuse abdominal pain initiated in the last 3 weeks. She lost 18 kg in the last 2 months. Patient referred constipation and laxative abuse for 15 years. She had regular menstrual cycles and sporadic dysmenorrhea. Abdominal inspection revealed distension, increased bowel sounds, discomfort during abdominal examination without peritonitis signs. Abdominal X-ray evidenced small bowel and colonic distension. Colonoscopy showed stenosis lesion in sigmoid, suggestive of neoplastic lesion. Colonoscopic biopsy showed inflammatory characteristics, without malignant cells. Barium enema was also performed, showing the same lesion.

Laparotomy was performed, evidencing stenotic tumor in the sigmoid colon (Fig. 1), with great intestinal distention. Enterostomy was done to intestinal content aspiration. Enterorrhaphy, rectosigmoidectomy with lymphadenectomy, and colostomy were performed (Hartmann procedure). Pathological examination was compatible with endometriosis with pericolic adipose tissue, serosal and muscle layer involvement (Fig. 2).

After surgery, the patient developed enterocutaneous fistula. Good response was achieved with conservative treatment. Six months later, the colostomy was closed. Appendectomy and left oophorectomy were also performed, the last due to a hemorrhagic corpus luteum cyst. One year after, patient has no complain.

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Fig. 1 Colonic lesion

Fig. 2 Pericolic endometriosis, presence of endometrial glands and stroma in muscle tissue. HE stain $\times 100$

Discussion

Endometriosis is a rare cause of intestinal obstruction, and seldom suspected by surgeon. The most frequent sites of implantation are pelvic organs. Less frequent is the involvement of the gastrointestinal tract with 3–37% of the cases [1, 2]. Intestinal strictures and adhesions to neighboring pelvic structures or bowel loops can be explained by localized fibrotic reaction in the bowel wall caused by cyclical hemorrhage from endometriomas. This may result in intestinal obstruction with recurrent abdominal pain and bowel habits modifications. Radiological studies can be useful to establish the anatomical tumor place. Biopsy through colonoscopy may not be useful because it can only collect the internal layers of the intestinal tissue and the endometriosis implantation happens in the outer layers.

Ablation of all recognizable intestinal endometriosis points along with bowel resection is indicated especially in intestinal occlusion situations. Bowel resection associated with bilateral oophorectomy and hysterectomy is more likely to achieve complete symptom relief [3]. Women with endometriosis have a higher risk to develop various types

of cancer including ovarian cancer and non-Hodgkin's lymphoma [4]. Postoperative follow-up is required due to recurrent symptoms and neoplastic development.

In summary, endometriosis can be misinterpreted with a colonic malignant tumor. The diagnosis is a challenge to the surgeon and should always be included in the differential diagnosis of women with gynecological and intestinal symptoms in the childbearing age.

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