CASE REPORT

A Rare Presentation of Endometriosis

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Introduction

Endometriosis is defined as the presence of functional endometrial tissue outside the uterine cavity. The common sites of involvement in decreasing order of frequency are the ovaries, pelvic peritoneum, deep pelvic subperitoneal spaces, intestinal system, urinary system, scar endometriosis, and thoracic endometriosis. But, in the literature, till today, it has not been found in the ischio-rectal fossa. We report a rare case of endometriosis in the ischio-rectal fossa.

Case Report

A 45-year-old lady presented with abdominal distension for the past 2 years. Her symptoms were pain in the abdomen, constipation for the past 2 days, and retention of urine for the past 1 day. The patient gave a history of having undergone surgery for prolapse 2 years ago, performed by a general surgeon, first by the vaginal route and later by the abdominal route in the same sitting.

Her vitals were stable. Abdominal examination revealed a 24-week-sized cystic, horizontally mobile mass, the

lower border of which was not made out. A diffuse swelling over the right gluteal region was noticed. It was tender to touch and there was a local rise in the temperature. The labia majora was swollen. There was a bulge over the posterior vaginal wall occluding the visualization of the vault. On bi-manual examination, the cervix was not felt, the vault was intact, and the same mass could be felt. On per-rectal examination, the bulge was seen on the right side and rectal mucosa was free.

The following investigations were done. On ultrasonography, there was a collection in the uterine cavity with a thinned out uterine wall. The collection was also seen in the pouch of Douglas and ischio-rectal fossa. Hematometra with ischio-rectal abscess was seen.

Incision and drainage of the abscess were decided upon followed by laparotomy.

Incision and Drainage

Altered blood, non-foul smelling, drained from the ischio-rectal fossa.

The explorative laparotomy findings were as follows:

Hemoperitoneum.

Uterus 20 weeks' size with altered blood in it.

Minimal collection in the tubes.

Multiple pseudocysts adherent to the left ovary and intestine with altered blood in it.

Hysterectomy with bilateral salphingo-oophorectomy with removal of pseudocyst was done.

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Fig. 1 Diffuse swelling over the right gluteal region, bulge over the posterior vaginal wall

Fig. 2 Abdominal mass

Fig. 3 Enlarged uterus

The postoperative period was uneventful. Histopathology confirmed the diagnosis of endometriosis (Figs. 1, 2, 3, 4, 5, 6, 7, 8, 9).

Discussion

Endometriosis can occur commonly at sites like the ovary, pouch of Douglas, uterosacral ligament, and extra pelvic

Fig. 4 Altered blood being aspirated from a pseudocyst

Fig. 5 Pseudocyst cut open

Fig. 6 Pseudocyst cut open

sites like the gastrointestinal system, thorax, central nervous system, and umbilicus [1]. The presence of endometrial tissue in other sites is a rare event. It can present as recurrent hemorrhagic ascites or even as cervical endometriosis [2, 3].

Fig. 7 Pseudocyst

Fig. 8 Pseudocyst

The patient was scheduled for hysterectomy for prolapse 2 years ago. Due to the presence of adhesions, it would not have been possible to proceed further to apply the second clamp, and vault closure was done. The surgeon failed to perform the hysterectomy even by the abdominal route. Following this, when the woman had her regular periods, due to blockage of the outflow tract, it got collected in the

Fig. 9 Specimen of the Uterus with enlarged tubes

uterine cavity. Due to increased intrauterine pressure, the collected menstrual blood might have seeped through the pelvic floor into the ischiorectal fossa. A rare variety of colocutaneous fistula may arise when a paracolic abscess spreads downward and ruptures through the levator ani into the ischiorectal fossa, necessitating drainage [4].

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