Ileocaecal Endometriosis with Intestinal Obstruction

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Introduction

Presence of endometrial tissue seen at various sites other than uterus is known as endometriosis. It is a relatively frequent disease in women of childbearing age. Various extra uterine sites of endometriosis are pleura, diaphragm, urinary bladder, ovaries, vulva, vagina, skin of inguinal region, umbilicus and lower abdomen. Intestinal involvement is seen in 12-37% of cases and most of them show serosal implantation without causing any stricture and obstruction. Only 1% can have intestinal obstruction [1]. However, intestinal endometriosis involving full thickness of the wall of intestine and mucosa causing stricture and complete intestinal obstruction is very rare. In the ileo-caecal region it can mimic tuberculosis and create confusion in the diagnosis. We report one such case of ileo-caecal endometriosis.

Case report

A 33-year old lady with previous history of primary infertility underwent a right-sided salpingo-oophorectomy in 1993, which on histopathology confirmed to be endometriosis. 2 years later she developed right lower abdominal pain with a palpable mass in right iliac fossa. Investigations were inconclusive. She was therefore put on a course of ATT empirically, to which she showed hepatotoxicity, ATT had to be stopped. She however continued to have pain for which she received anti amoebic therapy and was in and out of hospital on many occasions. In 1999 laparoscopy revealed dense adhesions in right iliac fossa. A biopsy taken proved inconclusive. She was then again put on ATT. She tolerated ATT well but there was no improvement in her symptoms or finding. She completed full course of ATT (06 months). On 4th of Feb 2001 she reported with features of acute intestinal obstruction. Investigation (Barium meal) showed a strictured segment of terminal ileum (Fig 1). She was therefore subjected to an exploratory laparotomy same day. At operation a large mass measuring 06 cms X 07 cms X 06 cms was found involving the terminal ileum, caecum and omentum. Rest of the part of abdomen was normal. There were no ascitis or

tubercles. In pelvic cavity dense adhesions on right side were noted. A limited right hemicolectomy was done (Fig 2). Postoperative recovery was uneventful. Histopathology of the resected specimen has revealed endometriosis involving terminal ileum (transmural type). Patient has been reviewed and doing well, although her infertility status remains same.

Discussion

Endometriosis is defined as the presence of endometrial tissue outside the uterine cavity. Although it is a benign disease, it may be aggressive producing local invasion and even metastases [2]. Endometrial tissue presence has been explained by various theories viz-direct myometrial extension, coelomic metaplasia, lymphatic and haematogenous metastasis. Implantation during salpingography, due to operative spillage and reverse menstruation is also blamed. Presence in the small and large intestines leads to acute and chronic symptomatology. It may mimic a large number of diseases. Clinical differential diagnosis includes diverticulitis, appendicitis, Crohn's disease, tubo ovarian abscess, ileo-caecal Koch's, irritable bowel syndrome, carcinoma and lymphoma. Histopathology of resected specimen shows predominantly mural masses. In addition others may have luminal stenosis or strictures, mucosal polyps, submucosal masses that ulcerated the mucosa and serosa causing adhesions. Mural changes include marked concentric smooth muscle hyperplasia and hypertrophy, neuronal hypertrophy, hyperplasia and fibrosis of muscularis propria [3]. These changes were classically present in our case. Small bowel involvement is seen in 5-18% of patients of intestinal endometriosis but nodular endometriosis involving the entire wall of the terminal ileum and resulting in complete obstruction is extremely rare [4,5]. If obstruction is partial, preoperative diagnosis is difficult and seldom suspected. No reliable diagnostic test is available. Endometrial foci may be inaccessible to endoscopic biopsy or may not be sampled because of their focality [3].

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Fig. 1 : Barium meal follow through showing dilated ileum

Laparoscopy when performed as diagnostic modality for infertility or else for pelvic endometriosis, bowel lesions may easily be overlooked, especially in women with abdominal adhesions from earlier surgery [4]. An increased awareness of intestinal endometriosis in reproductive age women, infertility with acute bowel obstruction, associated with an accurate anamnesis regarding the chronology of pain onset (typically only during the menstruation at first) and intraoperative histopathologic examination may allow pre or intra operative diagnosis, which is a clue to less aggressive operation. Hormonal therapy is mandatory, which may add to the misery of an infertile woman.

Our patient was investigated for infertility, found to have a chocolate cyst of ovary and confirmed

Fig. 2 : Specimen of (R) Hemicolectomy. Arrow showing stricture at ileo-caecal junction

histopathologically as endometriosis, however because of her persistent symptoms in right iliac fossa and laparoscopic findings in subsequent surgery a clinical diagnosis of Koch's was entertained and put on ATT contributing to the delay in diagnosis. Lower abdominal pain in an infertile women must invite the attention of the surgeon or gynecologist to entertain the possibility of endometriosis a mimicker of many diseases like Koch's.

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