

An Unusual Presentation of Endometriosis as an Ileocolic Intussusception with Cecal Mass: A Case Report

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Abstract

Background: Bowel endometriosis affects about 3.8-37% of women with endometriosis diagnosis. Most of the time endometriosis involves the recto-sigmoid. Right colon involvement is not common in endometriosis and also a few studies have reported obstructive endometriosis of bowel. Here, a case of endometriosis was reported with the ileocolic intussusception and cecal mass.

Case Presentation: A 32y old woman was referred to Yas hospital due to severe low abdominal pain and vomiting. Ultrasonographic examination of her pelvis revealed bilateral ovarian cysts. Abdominal erect X-ray showed dilatation of small bowel segments. Diagnostic colonoscopy showed one small ulcer with the pressure effect of mass like lesion at cecum. The patient was taken to the operating room for excision of the mass; as a result the ileocolic intussusception was seen. After reduction, a firm mass was recognized at cecum so the ileocecal resection was performed. In pathologic examination of mass, endometriosis was reported. The postoperative period was uneventful.

Conclusion: The diagnosis of bowel endometriosis is sometimes difficult. The case of bowel obstructive endometriosis is rare. Surgical excision of bowel endometriosis is necessary for symptomatic patients with bowel obstruction. Bowel endometriotic nodules are excised by nodulectomy or segmental resection.

Keywords: Bowel, Endometrioma, Endometriosis, Intestinal obstruction.

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Introduction

It has been estimated that 8-15% of young ladies have endometriosis (1-3). Bowel endometriosis affects about 3.8-37% of women with endometriosis diagnosis (1, 4, 5). Most of the time, endometriosis involves the recto-sigmoid (80% of cases) and very rarely the small intestine (5, 6). Bowel endometriosis can mimic other bowel diseases including inflammatory bowel disease, ischemic colitis, or even malignant tumors. Bowel endometriosis sometimes leads to surgical resections (1, 5, 6). The gastrointestinal symptoms are non-specific such as abdominal pain, nausea and vomiting (5-7). Right colon involvement is not common in endometriosis and also few studies

have reported obstructive endometriosis of bowel. Here, a case of endometriosis was reported with the ileocolic intussusception and cecal mass.

Case Presentation

A 32y old woman was referred to Yas hospital due to severe low abdominal pain and vomiting on May 2017. Ultrasonographic examination of her pelvis revealed bilateral ovarian cysts. During the 5 days before the admission, she had experienced severe right lower abdominal pain and vomiting especially after a meal. She had a long history of dysmenorrhea and, one cesarean delivery 3 years before. She was taking no medication. Her

physical examination report included the temperature of 37°C, systolic blood pressure of 100 mmHg and heart rate of 120 beats per minute. The right lower quadrant of her abdomen was tender along with hypoactive bowel sounds. Laboratory data reported leukocytosis ($16 \times 10^9/L$) with neutrophilia, C-reactive protein of 20 mg/dl and erythrocyte sedimentation rate of 60 mm/hr. Abdominal erect X-ray showed dilatation of small bowel segments. Colonoscopy was requested by gastroenterologist for finding the cause and excluding colon neoplasm. Diagnostic colonoscopy showed one small ulcer (8 mm) with the pressure effect of mass like lesion at cecum and scope couldn't find the ileocecal valve. It was thought that a mass like lesion had caused the ileum obstruction. Colonoscopic biopsies were taken and histopathological examination revealed endometriosis. Afterwards, the patient was taken to the operating room for excision of the mass. At the exploration of the abdominal cavity, adequate exposure was attained by a vertical incision across the midline of the abdomen with a transverse extension to the right. The ileocecal part was covered by the omentum and was adherent to the abdominal wall. The ileocolic intussusception was seen without ischemic changes. Reduction of the intussusception was performed at first. After reduction, a firm mass was recognized at cecum, located close to the ileocecal valve. Then, the ileocecal resection was performed (Figure 1). Pathological examination confirmed endometriosis.

The postoperative period was uneventful and she was discharged on the third postoperative day. She was doing well at the 6 months follow up.

Consent: Written informed consent was obtained from the patient for publication of this case report and accompanying images.

Discussion

Some studies have indicated misdiagnosis of endometriosis as irritable bowel syndrome in young ladies due to nonspecific symptoms of both (6, 8). The types of endometriosis include superficial peritoneal lesions, ovarian endometriosis, and deep infiltrating endometriosis (DIE) (9, 10). Most of the patients with ovarian endometriosis expect to find disease elsewhere and should be evaluated especially for bowel endometriosis (7, 11). Transvaginal ultrasound, magnetic resonance imaging or transrectal ultrasound can find lesions of endometriosis (4, 9). The standard diagnostic test for bowel endometriosis is the laparoscopic visualiza-

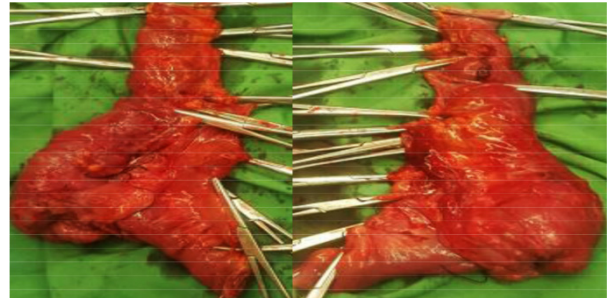


Figure 1. Postoperative specimen of the bowel. The mass is visible at cecum segment

tion of bowel lesions (5, 9, 10). The endometriotic nodules are common in rectosigmoid (80%) then ileum, appendix (0.8%) and cecum (3-5). Although some studies have indicated diagnosis of bowel endometriosis by colonoscopy, but colonoscopy (7% sensitivity and 98% specificity) is not a useful diagnostic procedure in evaluating patients with bowel endometriosis in most gynecology centers (1, 10). Because the incidence of colonoscopic finding is low even in DIE (4%) (10). Distortion, narrowing or inward bulging of the colon lumen, polyp or mass, and mucosal invasion such as erythema and nodularity are bowel endometriosis findings by colonoscopy (5, 10). Eccentric wall thickening is the most common picture (82%) of bowel endometriosis in colonoscopy (1, 10). Colonoscopic biopsies are small tissue for pathologist to report definite diagnosis. The diagnostic accuracy of colonoscopic biopsy is high when the mucosal invasion of endometriosis is seen macroscopically (1). The treatment options for bowel endometriosis depend on size and location of the lesion, stenosis of bowel lumen, severity of the symptoms, desire of patient to conceive and tolerability of hormonal therapies (4, 7). Hormonal therapies (Progestin, gonadotropin releasing hormone analogues and aromatase inhibitors) improve gastrointestinal symptoms in patients with bowel stenosis less than 60% if they do not wish to conceive (4, 5). But hormonal therapies are not effective for bowel endometriosis and do not prevent disease progression. Careful monitoring should be considered for patients receiving long-term treatment (4). Surgical excision of bowel endometriosis is necessary for symptomatic patients with bowel stenosis more than 60% (4, 5). Bowel endometriotic nodules are excised by nodulectomy or segmental resection (4, 12). Surgery is crucial for bowel obstructive endometriosis. Some studies have reported that the pregnancy rate is 49% after the surgery (5). Endometriosis has been reported

in 15-44% of all laparotomies or laparoscopies in young ladies (2). Unfortunately, some studies have indicated unnecessary aggressive surgical resections in some patients with bowel endometriosis due to misdiagnosis as a neoplastic lesion (1, 6).

Conclusion

The clinician should be aware that endometriosis can be multifocal and with an unusual presentation. The diagnosis of bowel endometriosis is sometimes difficult. Bowel obstructive endometriosis is rare and surgery is the main treatment. Bowel endometriotic lesions may be excised by segmental resection or nodulectomy.

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Conflict of Interest

No conflicts of interests to disclose.

References

1. Kim KJ, Jung SS, Yang SK, Yoon SM, Yang DH, Ye BD, et al. Colonoscopic findings and histologic diagnostic yield of colorectal endometriosis. *J Clin Gastroenterol*. 2011;45(6):536-41.
2. Eljuga D, Klarić P, Grbavac I, Kuna K. Abdominal wall endometriosis: case report. *Acta Clin Croat*. 2012;51(2):261-3.
3. Paramythiotis D, Stavrou G, Panidis S, Panagiotou D, Chatzopoulos K, Papadopoulos VN, et al. Concurrent appendiceal and umbilical endometriosis: a case report and review of the literature. *J Med Case Rep*. 2014;8:258.
4. Ferrero S, Camerini G, Maggiore UL, Venturini PL, Biscaldi E, Remorgida V. Bowel endometriosis: recent insights and unsolved problems. *World J Gastrointest Surg*. 2011;3(3):31-8.
5. Ono H, Honda S, Danjo Y, Nakamura K, Okabe M, Kimura T, et al. Rectal obstruction due to endometriosis: A case report and review of the Japanese literature. *Int J Surg Case Rep*. 2014;5(11):845-8.
6. Soumekh A, Nagler J. Gastrointestinal endometriosis causing subacute intestinal obstruction with gradual development of weight loss and misdiagnosed as irritable bowel syndrome. *Case Rep Gastroenterol*. 2014;8(1):51-5.
7. Ling CM, Lefebvre G. Extrapelvic endometriosis: a case report and review of the literature. *J Soc Obstet Gynaecol Can*. 2000;22(2):97-100.
8. Seaman H, Ballard K, Wright J, de Vries C. Endometriosis and its coexistence with irritable bowel syndrome and pelvic inflammatory disease: findings from a national case control study Part 2. *BJOG*. 2008;115(11):1392-6.
9. Hsu AL, Khachikyan I, Stratton P. Invasive and non-invasive methods for the diagnosis of endometriosis. *Clin Obstet Gynecol*. 2010;53(2):413-9.
10. Milone M, Mollo A, Musella M, Maietta P, Sosa Fernandez LM, Shatalova O, et al. Role of colonoscopy in the diagnostic work-up of bowel endometriosis. *World J Gastroenterol*. 2015;21(16):4997-5001.
11. Redwine DB. Ovarian endometriosis: a marker for more extensive pelvic and intestinal disease. *Fertil Steril*. 2015;72(2):310-5.
12. Remorgida V, Ferrero S, Fulcheri E, Ragni N, Martin DC. Bowel endometriosis: presentation, diagnosis, and treatment. *Obstet Gynecol Surv*. 2007;62(7):461-70.