



**ORIGINAL RESEARCH PAPER**

**Gynaecology**

**A CASE REPORT OF COLONIC ENDOMETRIOSIS WITH COLONIC STRICTURE**

**KEY WORDS:** Colonic endometriosis, Colonic stricture, Infertility

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**ABSTRACT**

**Introduction:** Endometriosis is a gynaecological condition where functional endometrial tissue is found outside of the uterus<sup>1</sup>. Intestinal endometriosis is the most common extra-pelvic site and it is found in 12% of women with endometriosis<sup>3</sup>. Endometriosis causing intestinal obstruction is extremely rare with reported incidence between 0.1-0.7%<sup>5</sup>.

**Case Report:** 28year old female with secondary infertility having normal menstrual cycles presented with MRI showing 31 x 21mm lesion in the sigmoid colon. Colonoscopy showed extrinsic mass lesion with stricture in the sigmoid colon. Resection of the part of sigmoid colon with stricture and end to end anastomosis was done. Biopsy showed nests of non-secretory endometrium intersecting muscle bundles of muscularis propria.

**Conclusion:** Extrapelvic endometriosis is often confused with other pathological conditions which can lead to difficulty and challenging for diagnosis and management.

**Introduction:**

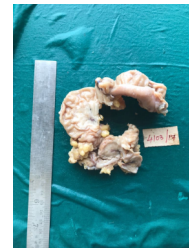
Endometriosis is a gynaecological condition where functional endometrial tissue is found outside of the uterus<sup>1</sup>. Endometriosis is found in 6-10% of women in reproductive age and about 50% women have pelvic pain, abnormal menstruation and infertility<sup>2</sup>. Common sites include pelvic peritoneum, ovaries and rectovaginal septum. Rarely does it involve the pleura, pericardium, small and large intestines, diaphragm and other tissues<sup>2</sup>. Intestinal endometriosis is the most common extra-pelvic site and it is found in 12% of women with endometriosis<sup>3</sup>. Rectosigmoid being the most common site contributes to 72% of intestinal endometriosis<sup>4</sup>. Despite this, endometriosis causing intestinal obstruction is extremely rare with reported incidence between 0.1-0.7%<sup>5</sup>.

**Case Report:**

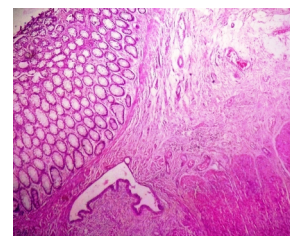
A 28year old female with secondary infertility and secondary dysmenorrhea of seven years duration with normal menstrual cycles came to NRI Medical College with reports of Ultrasound showing 33 x 28mm hypoechoic lesion in left adnexa likely endometriosis and MRI showing 31 x 21mm lesion in the sigmoid colon. Colonoscopy showed extrinsic mass lesion with stricture in the sigmoid colon and colonoscopy could not be negotiated beyond the stricture.

General and abdomen examination was normal. Patient was posted for laparoscopic surgery. Intra operative findings were normal uterus, fallopian tubes, right ovary normal, left ovarian cyst of 4x4cms, omental adhesions, and strictured band of sigmoid colon. In view of uncontrolled excessive bleeding procedure was converted to laparotomy. Resection of strictured region of sigmoid colon with end to end anastomosis with staplers and left ovarian cystectomy was done.

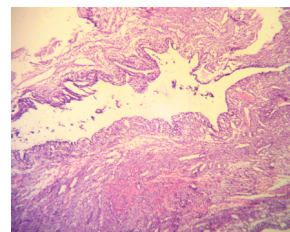
Post-operative period was uneventful and patient was discharged on 8<sup>th</sup> post-operative day (POD). She was readmitted on 16<sup>th</sup> POD in view of persistent vomiting and constipation. CT scan done showed grossly dilated bowel loops with narrowing of sigmoid colon proximal to anastomosis. Patient was posted for laparoscopy followed by laparotomy which showed dense adhesions at anastomosis site. Adhesiolysis with loop ileostomy was done. Biopsy report showed nests of non-secretory endometrium composed of both glands and stroma intersecting muscle bundles of muscularis propria. Ovarian tissue showed multiple follicles and follicular hematoma. Post-operative recovery was good following re-laparotomy. 3 months later closing ileostomy was done. Patient has been on regular follow up without any complications.



**Figure 1: Specimen of resected sigmoid colon with stricture**



**Figure 2: Histology of stricture of sigmoid colon**



**Figure 3: Histology of ovarian cyst**

**Discussion:**

The pathogenesis of endometriosis is not entirely known. There are various theories for pathogenesis of endometriosis which include retrograde menstruation, vascular dissemination, coelomic metaplasia and autoimmune disease<sup>5</sup>. Ectopic endometriosis behaves very much like uterine endometrial tissue and responds to ovarian hormones. It can implant, proliferate and form cysts or nodules<sup>6</sup>. At distant sites, endometriosis can cause bleeding, pain, scarring and fibrosis<sup>5</sup>. Intestinal endometriosis often presents in the submucosal layer and involves the muscularis propria and subserosa or mesentery<sup>7</sup>. It rarely implants at the

mucosal layer of the bowel and if it involves the sigmoid colon or rectum, patients can have catamenial rectal bleeding or dyschezia. Penetration of endometriosis into the intestinal lumen is found in 4.8% of patients with intestinal endometriosis according to one study<sup>7</sup>. Diagnosis of intestinal endometriosis can be challenging as gastrointestinal symptoms can be non-specific and large lesions can lead to acute obstruction mimicking adenocarcinoma of the colon<sup>8</sup>. Pelvic or abdominal CT scan may reveal thickened bowel wall with narrowed lumen. Transvaginal ultrasonography (USG) and pelvic magnetic resonance imaging (MRI) are better used in evaluating endometriomas, however they do not give confirmative diagnosis in characterising deposits and adhesions<sup>2</sup>. Intestinal endometriosis is typically found in the serosa and muscularis layer, sparing the mucosa<sup>5,6</sup>. Endoscopic evaluation generally does not show any pathology unless lesions are nearly obstructing such as in our patient. Biopsies of the mucosa will often be normal. The gold standard diagnosis is laparoscopy and biopsy, which allows a full assessment of the pelvis as well as surgical resection if required<sup>8</sup>. In presence of any recurrent/cyclical and catamenial symptoms, any clinician should suspect extra pelvic endometriosis and investigate accordingly. Extrapelvic endometriosis is associated with pelvic endometriosis and presents with gastrointestinal symptoms (GI). In our case, there is neither associated pelvic endometriosis nor any GI symptoms.

#### CONCLUSION:

As Extrapelvic endometriosis is located in unusual sites, it is often confused with other pathological conditions. This can lead to difficulty and challenging for diagnosis and management.

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