EXTENDED ABSTRACT

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Small Bowel Endometriosis Case Report and Review of Literature

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Introduction

Endometriosis usually occurs in menstruating women up to 15%. Most common gastrointestinal involvement of endometriosis is found in the sigmoid colon, rectum and terminal ileum in 3%–37% of women. Proliferation and infiltration of the intestinal wall with endometrial implants may cause fibrotic reaction with formation of strictures and adhesions, probably from the effect of cyclical hormonal influences of menstruation. Eventually, this may lead to bowel obstruction and recurrent abdominal pain. We are presenting an interesting case of terminal ileum endometriosis required surgical resection.

Abstract

Endometriosis usually occurs in menstruating women up to 15 % (PMCID: PMC4954939). It is characterized by the presence of functional endometrial tissue consisting of glands and stroma outside the uterus. Intestinal obstruction could be the presentation of ilia involvement, but this is very rare, up to 23% of all cases with ileum involvement (PMCID: PMC4954939). Endometriosis prevalence is 1-20% in asymptomatic women, 10%-25% in infertile patients and 60%-70% in women with chronic pelvic pain [PMID: 9436699, PMID: 14560892]. We are reporting a case of small bowel endometriosis causing recurrent small bowel partial obstruction.

Features

• Small entrail impediment has a wide rundown of conclusion.

• Thorough history and physical assessment alongside legitimate imaging is the key in deciding the reason.

• Endometriosis whenever analysed preoperatively may react to hormonal treatment.

• Laparoscopic investigation might be both symptomatic and remedial.

Case presentation

This patient has been suffering from a long standing undiagnosed abdominal pain that started eight years earlier. The pain was colicky, localized in the right iliac fossa and seldom associated with nausea and vomiting. The laboratories evaluations were normal. Few years back, patient underwent ultrasound of the abdomen for work up, showed a right ovarian complex cyst. Despite removing the ovarian cyst laparoscopically, patient still had persistent pain. Patient was referred to gastroenterology and underwent upper and lower gastrointestinal endoscopies for suspicion of Crohn's disease. These endoscopic evaluations and biopsies were normal. Patient presented to our emergency room with abdominal pain, nausea, vomiting and constipation, but passing flatus for 2 days. She was vitally stable. Her abdomen was distended with tenderness over the right lower quadrant but no peritoneal signs. Her abdominal series showed multiple air-fluids levels, dilated segments of small bowel and absence of gas in the rectum. Patient was resuscitated and an enhanced CT scan with contrast was done to determine the nature of the obstruction. There was a suspicion for terminal ileum intussusceptions that was planned for surgical intervention but clinically, patient improved. Patient responded well to conservative management and discharged home three days later on oral diet. She came for follow up but had similar complaints. Due to her recurrent semi-obstructive symptoms, she was scheduled for elective laparoscopic exploration. An irregular mass of 3×2cm was attached to the serosa of the terminal ileum. Intra-operative frozen section of the mass was sent. Giving its close proximity to the ileocecal valve, decision was made to proceed with right hemicolectomy as discussed previously with patient.

Discussion

Endometriosis is described by the nearness of practical endometrial tissue comprising of organs and stroma outside the uterus. Intestinal impediment could be the introduction of ilial association. Be that as it may, this is exceptionally uncommon up to 23% of all cases with ileum inclusion. Sampson's retrograde monthly cycle hypothesis is the most broadly acknowledged hypothesis. Endometrial tissue refluxes through the fallopian tubes, embedding on the serosal surface of stomach and pelvic organs which regularly happens during monthly cycle. Be that as it may, different speculations and components, immunological, hereditary and familial, could be associated with the pathogenesis of this infection. Endometriosis presents as a rule with pelvic agony, fruitlessness and dyspareunia; however, it might regularly be vague. In view of terminal ileum inclusion, our patient had intermittent pelvic agony with related queasiness and retching as an image of fractional little inside check.

Our patient isn't hitched and her side effects were not related with menses and backslid sporadically. Many GI ailments including little entrail obstacle, fiery inside infection and neoplasm make preoperative finding increasingly tricky because of clinical similitudes. Backsliding manifestations are the sign of this sickness. Endometriosis of the distal ileum is a

rare reason for intestinal impediment, running from 7% to 23% of all cases with intestinal inclusion. The rate of intestinal resection for entrail impediment is 0.7% among patients experienced careful treatment for abdomino-pelvic endometriosis. In any case, endometriosis of the little entrail ought to be suspected in youthful, nulliparous patients with stomach torment, related to indications of obstacle as this is the situation in our patient.

Imaging work up might be uncertain. Endoscopy and barium bowel purge are not useful on the grounds that the sickness doesn't include the mucosa. In our patient, endoscopies and biopsies neglected to show any provocative or neoplastic malady. Nonetheless, Magnetic Resonance Imaging appears to have a higher affectability and laparoscopy is viewed as best quality level. The determination can be affirmed uniquely on histology. Gastrointestinal endometriosis is typically found as a coincidental finding on stomach investigation. Asymptomatic and somewhat suggestive cases might be dealt with utilizing hormonal treatment.

Doubt of threat just as intense obstructive cases may warrant an extreme resection. The administration ought to incorporate hormonal treatment and medical procedure. The previous treatment with danazol or gonadotrophin-discharging hormone analogs might be utilized in patients without impediment. Be that as it may, resection of the included gut remains the decision of treatment for muddled or uncertain cases. For our situation, our patient had a delayed history of backsliding side effects for a considerable length of time with image of repetitive halfway little entrail obstacle notwithstanding a picture demonstrating conceivable mass causing little gut stenosis and block. Because of those reasons, we chose to perform analytic laparoscopy and discovered this endometrioma and performed right hemicolectomy in the wake of affirming solidified segment with histopathology.

Conclusion

Small bowel endometriosis is a rare entity. Clinical picture is similar to other GI diseases and careful assessment is warranted. Surgical resection is sometimes indicated for diagnosis or failing medical management. High suspicious of index is warranted in these cases.