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Case Report

A rare presentation of rectal endometriosis

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ABSTRACT

Endometriosis is the ectopic growth of viable endometrium outside the uterus, affecting approximately 7% women. It can occur in the absence of visible pelvic disease. Most common sites are gastrointestinal and urinary tract. Common sites of involvement are rectosigmoid (51%), appendix (15%), small bowel (14%), rectum (14%), cecum and colon (5%). Cyclical hematochezia is a definitive, but rare association of intestinal endometriosis. The diagnosis of colonic endometriosis is also difficult owing to the poor diagnostic yield of colonoscopy.

Keywords: Rectal endometriosis, Perforation peritonitis, Perimenopausal

INTRODUCTION

Recto-sigmoid endometriosis is not uncommon, though perforation of the involved bowel has been very rarely reported1, and more than 90% of those are known to occur in pregnancy (2nd or 3rd trimester) or early puerperium. We have not encountered any report of endometriosis related rectal perforation in a peri-menopausal lady.[4] We report the case of a perimenopausal lady with rectal endometriosis who presented with perforation peritonitis. Imaging was corroborative and intra-operative findings revealed a large mass in the proximal rectum with a perforation proximal to it, leading to a strong suspicion of a loco-regionally complicated rectal carcinoma but the histopathologic examination of the resected specimen revealed transmural endometriosis.

CASE REPORT

A 45-year-old lady presented with clinical features of peritonitis. She had a normal menstrual history, no comorbidities and had never been diagnosed with endometriosis. Rectal examination revealed ballooning and tenderness. After adequate resuscitation and investigations, a laparotomy was proceeded with.

The peritioneal cavity had faecal contamination, with a perforation in the sigmoid colon and a large indurated mass in the upper third of the rectum. An anterior resection and Hartmann's procedure was performed. Postoperatively, she recovered well and was discharged on the 7th POD. Laparoscopic reversal of Hartmann's colostomy was performed after 3 months. During the reversal, a left ovarian cyst was identified, but the biopsy did not reveal endometriosis. There was no evidence of the disease elsewhere in the abdomen or pelvis at that time.

Pathology

Transmural involvement of the rectum with endometrial tissue was noted.

DISCUSSION

The gastrointestinal tract is the most common site of extra-pelvic endometriosis, affecting 5-15% of women with pelvic endometriosis, the most common site being the recto-sigmoid.[1] Only the serosa and the muscularis propria are usually involved, while the mucosa is very rarely affected.[5,6] Intestinal endometriosis may present with rectal bleeding, bowel obstruction and rarely with

perforation or malignant transformation. Symptoms are cyclical in 40% of patients, and include abdominal pain, distention, diarrhea, tenesmus and hematochezia.[7,8] The classic but uncommon triad comprises dysmenorrhea, dyspareunia and infertility.

Figure 1: Transmural rectal involvement on histopathology

Although endoscopic diagnosis of colorectal endometriosis has been reported, often the findings are not diagnostic. MRI seems to be the most sensitive imaging technique; yet, the gold standard for diagnosis is laparoscopy.

This case is unique in the fact that recto-sigmoid endometriosis is an uncommon disease of younger women and it rarely perforates, that too either during pregnancy or in puerperium. This peri-menopausal patient, with no history suggestive of the disease, presented with transmural endometriosis and perforation, having no association with pregnancy. The histopathology revealed transmural, full-thickness rectal involvement, which is rather rare. In most cases, the serosa or muscularis propria is the extent of involvement.

Treatment options generally include surgery with or without hormonal manipulation, depending on the patient's age, desire to preserve fertility and also on the severity and complications of the disease.

CONCLUSION

Intestinal endometriosis is often a diagnostic challenge and should be considered in any menstruating woman with or without cyclical symptoms from the lower gastrointestinal tract. Surgical treatment outcomes are good with recurrence rates of 7-11%, depending on the stage of disease. A high index of suspicion is key to clinching the diagnosis, even in the peri-menopausal woman, as in our case.

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