CASE REPORT

Chronic Intestinal Obstruction Due to Rectosigmoid Endometriosis: A Case Report.

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ABSTRACT

Background: *Intestinal endometriosis is not commonly reported in Nigeria and Africa. This paper presents a case of chronic intestinal endometriosis in a young Nigerian woman presenting with features of chronic intestinal obstruction.*

Method: *The case records of a 29-year old Nigerian female, who presented with chronic intestinal obstruction secondary to endometriosis at the Olabisi Onabanjo University Teaching Hospital (OOUTH) Sagamu, Nigeria and literature review on the subject using medline and manual library search is presented.*

Result: *A young woman presented with a three- month history of progressive abdominal distension and worsening constipation. Examination revealed a grossly distended abdomen, slightly tense but no area of tenderness. Bowel sounds were slightly exaggerated. A plain radiograph of the abdomen showed features of small and large bowel obstruction. A diagnosis of chronic large bowel obstruction was made. She was found to have a stricture in the rectosigmoid at laparotomy. Hartmann's resection was done. Histologically, the stricture was due to endometriosis. Subsequent closure of colostomy and re-establishment of intestinal continuity gave excellent results.*

Conclusion: *A young Nigerian female diagnosed with chronic intestinal obstruction due to rectosigmoid endometriosis was successfully treated. Though this condition is believed to be relatively uncommon in Nigeria, there is a need for a high index of suspicion, to ensure early diagnosis.*

KEYWORDS: *Endometriosis; Rectosigmoid; Chronic large bowel obstruction.*

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INTRODUCTION

Endometriosis is the presence of ectopic endometrial tissue in extra uterine sites and affects 8-15%[1] of women. The incidence of intestinal involvement varies between 3 and 37%[1]. Common sites include the sigmoid colon and rectum (85%), small bowel (7%), caecum (3.6%) and appendix (3%) [1]. Commonly, involvement occurs in the sub-serosal part of the bowel, and extension may occur towards the luminal surface. Clinical presentation may be acute or chronic. A case of recto sigmoid obstruction due to endometriosis is presented.

CASE REPORT

A 29-year old woman presented in the Surgical Outpatient clinic of the Olabisi Onabanjo University Teaching Hospital (OOUTH) Sagamu with a three month history of progressive abdominal distension and worsening constipation. She also complained of intermittent lower abdominal colic. She weighed 41kg. One month prior to presentation, she had a laparotomy at another hospital where she was told she had an inoperable neoplasm and the abdomen was closed. She was then placed on daily enema. Her menstrual cycle had been regular. On examination, she was mildly pale, apyrexial and not in any respiratory distress. Abdominal examination revealed a grossly distended abdomen (abdominal girth at umbilicus was 102cm), slightly tense but no area of tenderness. Bowel sounds were slightly exaggerated. Rectal examination was normal. A radiograph of the abdomen showed features of small and large bowel obstruction. Double-contrast barium enema was ordered but the quality of the film was poor. She was prepared for laparotomy with the aim of assessing the obstructive lesion and planning treatment. At laparotomy, a fibrotic lesion at the recto sigmoid junction, binding the gut firmly to the posterior abdominal wall, was found. A Hartmann's resection was done. The mobilized descending colon was brought out as end-colostomy; while the rectal stump was closed. Post-operative recovery was uneventful and the patient left hospital on the 12th post operative day, with a functioning colostomy. Histology of the resected specimen revealed focal infiltration of the wall of the intestine by nests of endometrial glands and stroma. There were areas of haemorrhage and fibrosis. She was thereafter booked for closure of colostomy and re-establishment of intestinal continuity when her weight reached 55kg. This was achieved three months after initial surgery. Follow-up at 3,6 and 9 months revealed no clinical abnormality and the patient was symptom-free. She was later referred to the gynecologists for further management.

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DISCUSSION

A few cases of intestinal endometriosis have been reported in the Nigerian or African literature[2]. The presentation may be acute or chronic. Repeated episodes of acute or chronic intestinal obstruction may occur either very close to or during menstruation. The cause of bowel obstruction could be either endometrial tissue causing an intussusception or volvulus, or as seen in this case, a fibrotic stricture in the bowel wall [3,4]. The latter is due to release of fibrogenic ferrous material from degraded blood[4], occurring at each menstruation from ectopic endometrial tissue. Presenting symptoms of the chronic variety may mimic colorectal carcinoma [4, 5]. Understandably, the pre-operative diagnosis of bowel endometriosis is extremely difficult and diagnosis is only made at histological examination. A search should be made for other extra uterine involvement, in the absence of which, no further treatment is needed.

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