Title:
Bowel obstruction secondary to deep infiltrating endometriosis of the ileum

Authors:
Marco Antonio Ávila Vergara, Violeta Sánchez Carrillo, Felipe Peraza Garay

DOI: 10.17235/reed.2018.5364/2017
Link: PubMed (Epub ahead of print)

Please cite this article as:

This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.
Dear Editor,

Deep infiltrating endometriosis (DIE) of the ileum is an uncommon lesion that may have a severe clinical presentation. Diagnosis is challenging in the absence of a gynecological history of endometriosis and due to the anatomical location (1). We read the article by Sánchez, Candel, and Albarracín (2) and would like to report an additional case that was managed urgently.

Case report

The case was a 41-year-old female who presented to the Emergency Room (ER) due to acute abdominal pain. She had a history of irritable bowel syndrome. On admission, the patient was conscious, well oriented, with mild mucosal dehydration. The vital signs were
normal and there were no respiratory complications. She had abdominal tenderness on deep palpation and the abdomen was distended with tympanites and increased peristalsis. The pelvic ultrasound was normal. Small-bowel loops and the stomach were dilated, with a reduced caliber area at the terminal ileum. An emergency exploratory laparotomy (ELAP) was performed, which revealed lax interloop adhesions and an ileal growth of 2.5 cm in diameter that occluded 90% of the intestinal lumen at 6 cm from the ileocecal valve. A segmental resection of the terminal ileum, cecal appendix and ascending colon, with a partial omentectomy and side-to-side ileotransversal anastomosis, was performed. The outcome was uneventful. The histopathology analysis identified deep infiltrating endometriosis of the ileum (Fig. 1). The tumor markers were as follows: CA125 of 212 and CAE of 3 ng/ml. A single subcutaneous dose of goserelin acetate at 10.8 mg was prescribed. After two months, the CA125 levels were 22.

Discussion
The diagnostic difficulty associated with ileal DIE has been extensively reported (3,4). Most patients experience mild symptoms in the long-term, although intestinal complications may occur. Furthermore, endoscopic findings may mimic other inflammatory bowel conditions. In cases with no mucosal involvement, the differential diagnosis should include carcinoma and inflammatory bowel disease (5). In contrast with the series reported by Sánchez et al., no endometriosis lesions were found in the peritoneum.

Acknowledgements
We are grateful to Dr. Jaime Moya Núñez for his contribution to the histopathological diagnosis and to Dr. Jaime Alberto Sánchez Cuen and Dr. Gerardo Arturo Reyes Moctezuma for their review of the paper. Medicine Faculty, Universidad Autónoma de Sinaloa, Culiacán, Sinaloa, Mexico.

References


Fig. 1. Microscopic image. A. The intestinal mucosa is shown. The muscular layer includes tissue clusters comprised of linear glands, some tortuous and some overtly dilated. Some hemosiderophages are seen (old bleeding). Since the glands are imbedded in a loose stroma, this is identified as endometrial tissue. B. Endometrial cell cluster within the muscular layer. Glands (straight, tortuous, dilated) are imbedded in a loosely cellular stroma.