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Laparoscopic management of a small bowel obstruction caused by an endometriotic focus

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Key words: Endometriosis. Intestinal obstruction. Laparoscopy.

Dear Editor,

We have carefully read several articles published in recent years in your journal in relation to digestive endometriosis (Marqués Ruiz et al. [1], Ávila et al. [2], Guerra et al. [3], Sánchez Cifuentes et al. [4] and Sánchez Justicia et al. [5]) and would like to provide information about a new case.

Case report

The case was a 36-year-old female who came to the Emergency Room due to abdominal pain, nausea, vomiting and the absence of depositions of a four-day duration. During the physical examination, the abdomen was distended and painful, without peritoneal irritation. Hernias were not palpated. The analysis showed slight leucocytosis with neutrophilia and a slight elevation of the C reactive protein. Simple x-ray of the abdomen showed a generalized dilation of small bowel loops, confirming a change of caliber in the distal ileum on computed tomography (CT). Urgent surgery was performed via a laparoscopic approach, which was aimed at a thickening of the wall that conditioned proximal dilatation 15 cm from the ileocecal valve. Finally, 20 cm of terminal ileum were resected and the pathological analysis identified endometriotic

foci that affected the serosa and muscle.

Discussion

The incidence of intestinal endometriosis is between 3-37% of cases; the most frequent location is the rectosigma (75-90%). Ileocecal involvement occurs in 4-25% of cases and the symptomatology is not specific. The most common presentation is cyclic abdominal pain (76.5%), constipation or diarrhea (25-40%) and a palpable mass (41.2%). The presentation of acute abdomen is less common (intestinal obstruction, as described by Ávila et al. and ourselves; intussusception, as described by Guerra et al.; and perforation, as reported Sánchez Justicia et al.). In these cases, the treatment of choice was surgery, preferably laparoscopic, as in our case.

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