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DOI: 10.17235/reed.2021.8140/2021
Link: PubMed (Epub ahead of print)

Please cite this article as:

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Endometriosis associated intestinal tumour: a new challenge

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Marta Merayo-Álvarez participated in the acquisition, data collection and article redaction. Daniel Fernández-Martínez participated in the acquisition, data collection, article redaction and critical review. Jose Antonio Alvarez Perez participated in the acquisition, data collection and the critical review. Luis Joaquin Garcia Flórez participated in the critical review and final approval of the article

Conflict of interest: The authors declare that they have no competing interests.

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Keywords:
Endometriosis. Endometriosis associated intestinal tumours. EAIT. Bowel obstruction.

Dear Editor,
A 66-year-old woman consulted for headache associated with diaphoresis, constipation and melena.
Urinalysis revealed elevated metanephrines. Colonoscopy identified an extrinsic sigmoid stricture. CT and MRI showed a presacral mass infiltrating the sigma. Scintigraphy and SPECT ruled out the diagnosis of paraganglioma. Based on these findings the patient was proposed to undergo surgery (Fig. 1. A-B). The
immunohistochemical examination confirmed an endometriosis associated clear cell carcinoma (Fig. 1. C-F). During follow-up no complications were registered and adjuvant radio-chemotherapy was administered. A localised recurrence in the pelvis presented after 12 months of follow up. Complete remission was achieved after chemotherapy.

Endometriosis-associated intestinal tumours (EAIT) are a rare finding (1-3). Symptoms are non-specific or reveal such as different complications: bowel obstruction, intussusception or perforation (1,2). The differential diagnosis includes any neoformation which invades the intestinal wall and especially, in the presence of mucosal disruption, colorectal carcinoma. Immunohistochemical analysis establishes the definitive diagnosis, distinguishing between endometrial adenocarcinoma (CK7+/CK20-) and intestinal adenocarcinoma (CK20+/CK7-) (3,4).

The standard treatment is excision preserving oncological criteria (5). Although the effectiveness of adjuvant chemotherapy is unknown, the use of platinum-taxanes is well established. On the other hand, adjuvant radiotherapy is only indicated in EAIT confined to the pelvis (2,4). The 5-year overall survival reaches up to 82-100% (5). Nevertheless, adenocarcinoma represent most malignant lesions in the colon, different diagnosis must be suspected to optimize the therapeutic course and surgical approach.

REFERENCES


Figure 1. A. Detail of the surgical specimen showing the endometrioma (circle) which determines the colonic lumen stenosis. B. Detail of the open surgical specimen showing integrity of the mucosa at the site of injury (circle). C. Colonic wall in which endometrial glands (arrows) are identified in the thickness of the muscularis propria (H&E at 40x). D. Detail at higher magnification of the glandular units (H&E at 200x). E. Histological section (H&E at 200x) in which the clear cell tumour component (to the left of the broken line) and the glandular component with papillary pattern (to the right of the broken line) are identified. F. Histological section (H&E at 200x) showing the clear cell tumour component and a band of endometrial glandular epithelium (arrows).