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Case Report

Intestinal Deep Infiltrating Endometriosis at Young Age: A Case Report

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Abstract

Chronic pelvic pain is a common clinical presentation for general physicians and gynaecologists. Endometriosis must be included in the differential diagnosis in female patients. Physical examination combined with transvaginal ultrasound and or magnetic resonance imaging are the tools of accurate diagnosis. Deep infiltrating endometriosis involving the bowel can be found at young childbearing age women. A 21-year-old woman with a 2-years history of chronic pelvic pain with deep dyspareunia, dysmenorrhea and dyschesia presented to gynecological consultation. The physical examination followed by an ultrasound and a magnetic resonance imaging reported a rectovaginal endometriosis nodule of 3 cm. A laparoscopic disc rectal excision was performed and subsequent histology confirmed the lesion to be an endometrial fibrotic nodule.

Keywords: *Intestinal Deep Infiltrating Endometriosis; Chronic Pelvic Pain*

Background

Chronic pelvic pain in adolescents accounts for 10% of outpatient gynecology visits, and 70% of adolescent patients whose pelvic pain is unresponsive to initial therapy have endometriosis [1].

Endometriosis is defined as the presence of normal endometrial mucosa outside of the uterine cavity. Endometriosis is found almost exclusively in women of reproductive age. It is estimated to affect 10 - 12% of women, with diagnosis usually occurring in the third decade of life [2]. The diagnosis of deep infiltrating endometriosis is often missed in young women with a delay in its management. Laparoscopic surgical treatment is often needed to treat early diagnosed endometriosis.

Case Presentation

We report a case of a 21-year-old Caucasian woman presented to the gynecologic consultation on July 31, 2018, with a 2-years history of chronic pelvic pain, dychesia 10/10, deep dyspareunia 10/10 and dysmenorrhea 10/10. The physical examination using a speculum to analyze the Vagina and the posterior fornix showed the absence of dark nodule, and the vaginal digital exam revealed a normal vesicle vaginal pouch, and a fibrous rectovaginal nodule of around 3 cm with invasion of the torus uterinum, without involvement of the parametrium. The transvaginal ultrasound done on August 13, 2018 and the magnetic resonance imaging done on September 5, 2018 reported a fibrous deep infiltrating endometriosis nodule of around 3 cm involving the middle rectum and the torus uterinum (Figure 1 and 2). The patient was treated by combined oral contraceptive pills (0.03 mg Ethinylestradiol - 0.15 mg Levonorgestrel) and nonsteroidal anti-inflammatory drugs for 6 months without improvement of her symptoms.

We decided to perform a surgical laparoscopic treatment with extensive adhesiolysis freeing the fallopian tubes and the adnexa, dissection of the pararectal fossa on both sides with lateralization of the ureters and the inferior hypogastric nerves up to the inferior limit of the rectovaginal nodule, and then separation of the rectum from the vagina with resection of the nodule by shaving followed by manual disc resection of the shaved rectum. The rectum was then sutured by two layers of Vicryl 4.0 stitches and the integrity of the rectal wall was checked after suturing by filling the peritoneal cavity with Ranger lactate and insufflating 120 ml of gas through the anus (Figure 3-5).

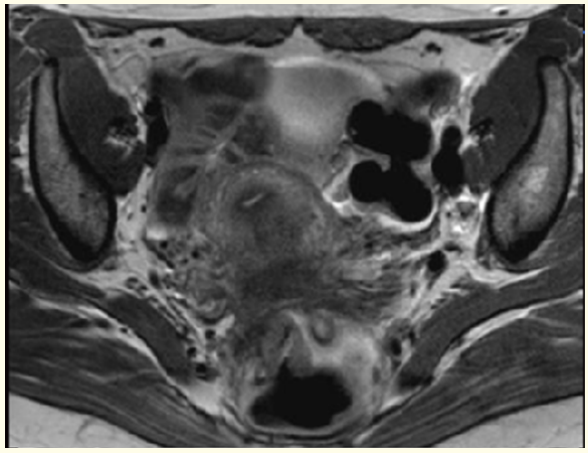

Figure 1

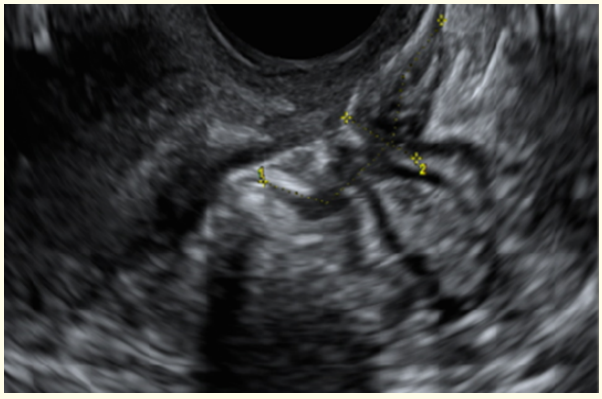

Figure 2

Figure 3

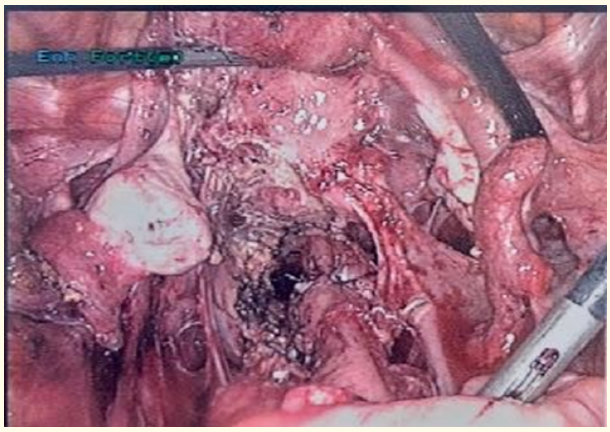

Figure 4

Figure 5

The patient made an uneventful postoperative recovery with normal bladder voiding after removal of the Foley catheter on day 1 after surgery, gas emission on day 2, and left the hospital on day 3 after surgery with a continuous combined oral contraceptive pills (0.03 mg Ethinylestradiol - 0.15 mg Levonorgestrel) treatment considering that she had no fertility goals. Histology confirmed the excised tissue to be an endometriosis nodule.

The 2 months postoperative follow-up revealed a complete improvement of the symptoms, with complete decrease of the pelvic pain, absence of dyschesia and dyspareunia.

Discussion

This case shows that intestinal deep infiltrating endometriosis can start very early in the second decade of life. The misdiagnosis and the delay in accurate management can worsen the severity of the disease [3-5,7,8].

In our case, the disease was mainly located in the rectovaginal septum with involvement of the torus uterinum. All the peritoneal cavity can be concerned by endometriosis and three types of lesions are described: peritoneal lesion, ovarian lesion or endometrioma, and deep infiltrating endometriosis [9]. Going deeper than 5 mm into the peritoneum defines the deep infiltrating endometriosis [3,4,8,9]. The rectosigmoid is affected in 5% to 12% of the cases having endometriosis [4,5,9,10]. The endometriosis can also be located in the bladder, the ureters, the torus uterinum, the uterosacral ligaments and the vaginal wall [9].

Deep dyspareunia, dysmenorrhea, dyschesia were the main symptoms of our patient, which are the most frequent symptoms of the intestinal deep infiltrating endometriosis [3,4,9,11,12]. The combined oral contraceptive pills used continuously by the patient failed to control the symptoms. This is explained by the fact that chronic inflammation leads to extensive fibrosis that accounts for the severe symptoms of the deep infiltrating endometriosis at advanced stage. The medical treatment can helps in symptoms improvement without eradication of the deep infiltrating endometriosis with bowel involvement. In addition, the uncertain control of the disease progression, the high risk of recurrence after treatment discontinuation and the considerable side effects are another arguments that medical management is not the primary treatment for symptomatic deep infiltrating endometriosis involving the bowel, and surgical resection should be considered [13-16].

Deciding between conservative radical lesion resection by rectal shaving or discoid resection and segmental bowel resection depends on the preoperative workup using transvaginal ultrasound or/and magnetic resonance imaging that should define the lesion size, the lesions cartography, the depth of muscular involvement, the circumference involved and the distance from anal verge [17,18].

In general, the size of 3 cm, 50% of bowel circumference involvement and 7 mm of depth of intestinal wall infiltration, are considered the limit for conservative radical resection and above these limits, bowel resection should be considered in women with intestinal deep infiltrating endometriosis lesions [10,19,20]. In our case, the eventuality of the discoid resection was discussed with the patient preoperatively, explaining the low probability of segmental resection, considering the high sensitivity of the preoperative imaging detecting a rectovaginal nodule of 3 cm.

Conclusion

This case shows that intestinal deep infiltrating endometriosis can affect very young women. General physicians and gynecologists should think about it when dealing with patient complaining of chronic pelvic pain. The main tools of the diagnosis are the physical examination combined with ultrasonography and/or magnetic resonance imaging. The surgical treatment is the primary treatment of deep infiltrating endometriosis involving the bowel, and the less invasive radical option should be chosen.

Competing Interests

The author declare that he has no competing interests.

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