Sigmoid Colon Endometriosis Presenting as Acute Large Bowel Obstruction in 42 years' female patient: A Case Report and literature review

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Introduction

Endometriosis is a common gynecological condition defined by the presence of functional endometrial glands and stroma outside the uterine cavity, affecting approximately 10–15% of women of reproductive age [1]. Gastrointestinal involvement occurs in a minority of cases, most commonly affecting the recto sigmoid colon [2]. Although relatively frequent in location, intestinal endometriosis rarely presents as acute bowel obstruction. When it does, the clinical and radiological features often mimic colorectal malignancy, making preoperative diagnosis challenging [3,4].

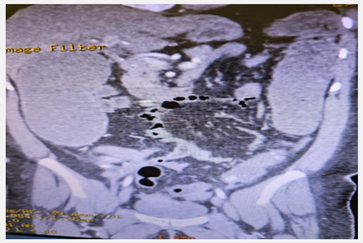

Figure 1: Contrast-enhanced coronal CT image of the abdomen demonstrating marked proximal colonic dilatation with a short-segment circumferential stricture at the sigmoid colon (arrow).

Case Presentation

A 40-year-old woman presented to the emergency department with a one-week history of progressively worsening colicky abdominal pain associated with nausea and vomiting. She reported passing only scanty stool on the day of admission. There was no significant weight loss or prior change in bowel habits. Her past medical history was unremarkable. Surgical history included three previous cesarean sections, the last performed in 2015.
On examination, the abdomen was distended with generalized tenderness and hyper-resonance on percussion. Bowel sounds were absent. Digital rectal examination revealed empty rectum without a palpable mass.
Plain abdominal radiography demonstrated multiple air–fluid levels consistent with intestinal obstruction. Contrast-enhanced computed tomography of the abdomen and pelvis revealed a short collapsed segment of the sigmoid colon with marked proximal colonic dilatation, including cecal dilatation up to 10 cm, raising strong suspicion of malignant large bowel obstruction.
Surgical Management .
Given the clinical presentation and radiological findings, emergency laparoscopic exploration was undertaken. Intraoperatively, an obstructing lesion was identified in the sigmoid colon. Due to significant proximal colonic dilatation and an unprepared bowel, laparoscopic resection of the affected colonic segment was performed with formation of a proximal colostomy. The postoperative course was uneventful.
Figure 1: Contrast-enhanced coronal CT image of the abdomen demonstrating marked proximal colonic dilatation with a short-segment circumferential stricture at the sigmoid colon (arrow), associated with mesenteric fat stranding. These findings resulted in mechanical large bowel obstruction and radiologically mimicked colorectal malignancy. Histopathology confirmed colonic endometriosis.
No evidence of malignancy was identified

Discussion

Colonic endometriosis remains a diagnostic challenge, particularly in emergency presentations. The recto sigmoid colon accounts for the majority of intestinal endometriosis cases [5,6]. Radiological findings are often nonspecific and commonly interpreted as malignant obstruction [7]. Endoscopic assessment may be inconclusive because mucosal involvement is uncommon [8].
In cases presenting with acute large bowel obstruction, surgical intervention is mandatory. A staged approach with temporary diversion is often safer, particularly in the presence of colonic distension or unprepared bowel [9]. Laparoscopic surgery has been shown to be safe and effective in experienced hands, with reduced postoperative morbidity and faster recovery .Postoperative hormonal therapy plays a key role in disease control and recurrence prevention[9]

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Conclusion

Colonic endometriosis should be considered in the differential diagnosis of large bowel obstruction in women of reproductive age, even when imaging suggests malignancy. Emergency laparoscopic resection with temporary diversion followed by medical therapy and delayed stoma closure represents a safe and effective management strategy.

References

1. Giudice LC, Kao LC. Endometriosis. Lancet. 2004;364:1789–1799.
2. de Ceglie A, Bilardi C, Blanchi S, et al. Acute intestinal obstruction caused by endometriosis. World J Gastroenterol. 2008;14:3430–3434.
3. Remorgida V, Ferrero S, Fulcheri E, et al. Bowel endometriosis: presentation and diagnosis. Obstet Gynecol Surv. 2007;62:461–470.
4. Fauconnier A, Chapron C. Endometriosis and pelvic pain. Hum Reprod Update. 2005;11:595–606.
5. Abrão MS, Petraglia F, Falcone T, et al. Rectosigmoid endometriosis. Hum Reprod Update. 2015;21:329–339.
6. Bazot M, Darai E. Diagnosis of deep endometriosis. Fertil Steril. 2017;108:886–894.
7. Ruffo G, Scopelliti F, Scioscia M, et al. Laparoscopic colorectal resection for endometriosis. Surg Endosc. 2010;24:63–67.
8. Nezhat C, Li A, Falik R, et al. Bowel endometriosis: diagnosis and management. Am J Obstet Gynecol. 2018;218:549–562.
9. Darai E, Dubernard G, Coutant C, et al. Laparoscopic versus open colorectal resection. Br J Surg. 2010;97:98–103.