



Acute Bowel Occlusion Complicating Ileocecal Endometriosis: About Two Cases

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Received Date: November 24, 2021

Published date: December 01, 2021

Introduction

Digestive endometriosis represents 5 to 12% of the forms of deep endometriosis, largely dominated by far by the involvement of the rectosigmoid hinge (65%), the ileocecal junction is confronted with this entity only in less than 15%. The occlusive complication generated by this location remains exceptional.

Goals

The objectives of our work are to clarify the epidemiological rarity of ileocecal endometriosis, to shed light on the anatomico-clinico-radiological and evolutionary aspects of this form of digestive endometriosis. Also to underline the diagnostic and therapeutic difficulties, as well as the prognostic factors linked to this pathology.

Patients and Methods

Two observations of acute intestinal obstruction on ileocecal endometriosis collected at the Obstetrics Gynecology Department of the Mohammed VI University Hospital of Oujda.

Observations

1st observation

A 48-year-old patient consults the emergency room for spasmodic abdominal pain located in the right iliac fossa, which has progressed crescendo for five days during her period. It is associated with an occlusive and infectious syndrome. She is the mother of three living children, the last of which was born by an emergency Caesarean. For about ten years, she has had dysmenorrhea, deep dyspareunia, and sometimes abdominal pain, sometimes fueled by episodic colic which reaches their paroxysms during menstrual periods with frequent recourse to traditional medicine leading to a temporary regression of functional signs. Admission to the emergency room is marked by stability and preservation of general condition. Nonetheless, a fever, a very tender painful distended abdomen in the right iliac fossa and an empty rectal bulb are highlighted after the physical examination. There is hyperleukocytosis at 19,720 GB / mm³ and an increase in C Reactive Protein (127mg / L). An ASP objectified wider than high central hydro-aeric levels in favor of high occlusion (Fig. 1A).

In the wake of a pelvic-abdominal MRI preceding the exploratory median laparotomy is performed, evoking bilateral endometriomas, uterine endometriosis, superficial and deep peritoneal, with marked infiltration of the last ileal loops by numerous adhesions and peritoneal implants responsible for an occlusion. intestinal. Intraoperative exploration revealed a blocked perforation of the last ileal loop, with false membranes covering the cecum, bladder, uterus and right appendix. An ileocecal resection involving the small perforation (Fig. 1B) and the right appendix, protected from a transient ileostomy, followed after three months by an end-to-end anastomosis are the therapeutic sanctions. The pathologic study concluded in ileocecal subserosa endometriosis, with right ovarian endometrioma. Continuous progestin-only pills without marked improvement in gynecological symptoms, therefore treatment with a GnRH antagonist is successfully initiated. No recurrence is to be noted with four years of follow-up. And The patient reports a considerable improvement in digestive symptoms and gynecological pain

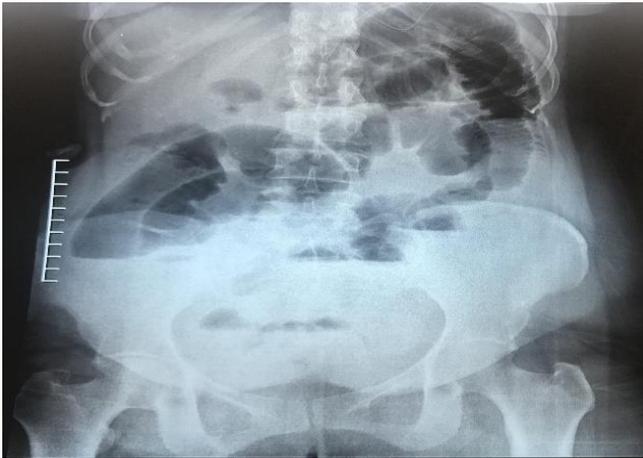


Figure 1: A: ASP objectifying central hydro-aeric levels with very marked haustral dilation in pre-colic. B: ileo-cecal resection piece with the small perforation

2nd Observation

The 34-year-old nulliparous patient was admitted to the emergency room for abdominal pain, stoppage of materials and gas followed by early postprandial vomiting. In her history, the patient was appendectomized. The questioning indicates, for a decade, gynecological manifestations reminiscent of those of endometriosis with a recent onset - less than six months - of intermittent abdominal pain without transit disorders, with cyclic recrudescence secondarily complicated by an occlusive syndrome for which it is admitted to the emergency room in a stable hemodynamic state and a temperature of 36.8 °. On examination, the abdomen is distended, painful, and the eardrum on percussion. On the rectal examination, the rectal bulb is empty. An emergency x-ray of the abdomen without preparation showed significant small dilation, very marked in pre-colic. Laparoscopic exploration revealed an adherent abdomen with pelvic lesions involving en masse the last 2 ileal loops, the appendages and the uterus. Open conversion revealed a stenosing lesion of the last ileal loop 5 cm from the ileocecal valve, segmental resection with a dual therapeutic and diagnostic vocation, resulting in the lesional process (Fig. 2A) and an end-to-end anastomosis. terminal in pre-valvular are then carried out. Pathologic study of the piece concluded that there was intestinal endometriosis (Fig. 2B). Therefore the patient is lost to follow-up.

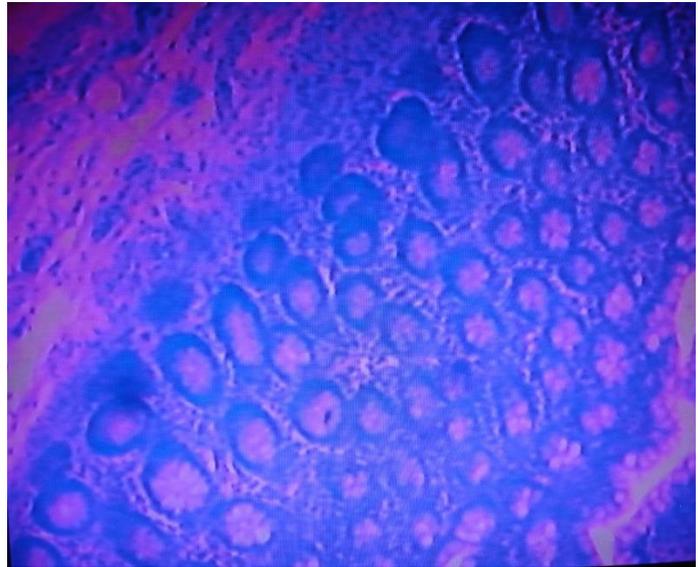


Figure 2: A. Operative part of a segmental ileal resection: Stenosing lesion involving the last two ileal loops 5 cm from the ileocecal valve.

B. Ectopic foci of regular endometrial glands surrounded by a cytotrophoblastic chorion under a normal ileal mucosa

Discussion

The ectopic presence of functional endometrial tissue outside the uterine cavity histologically defines endometriosis. When associated with pain and / or infertility, the term "endometriosis disease" takes on its full legitimacy [1]. Benign and very heterogeneous disease affecting one in ten women, although its actual prevalence and incidence would not be precisely estimated in the general population [1]. Deep endometriosis is slow onset, usually discovered between the third and fourth decade. It corresponds histologically to lesions which infiltrate in depth more than 5 mm below the peritoneal surface [2], it affects various anatomical structures, typically the uterosacral ligaments (50% of cases), the torus uterinum and the cul-de-sac - posterior vaginal sac (15%), and much less frequently the intestine (20-25%) - mainly represented by the rectosigmoid hinge (65%), the anterior surface of the rectum (10-15%), ileocecal junction is subject only in less than 15% -. The incidence of bladder and ureteral involvement is estimated at 10% and 3%, respectively [3-7]. Deep endometriosis lesions are multifocal and are associated in 80% of cases with adnexal involvement often in the form of endometriomas [5], and with another deep pelvic location in 70% of cases [8]. Melody et al. have shown that 97% of lesions of the small intestine are localized in the last ten centimeters of it [9]. Most often limited to an attack of the serosa or the muscularis rarely reaching the mucosa. Yantiss et al. in a series presenting 57 lesions of intestinal endometriosis, 40 were found affecting at least the muscularis (70%), 29 the submucosa (51%)

and 13 the mucosa (23%) [10-11]. Usually, most of these lesions appear to be asymptomatic [12]. Abdominal symptoms, when present, are subject to great diversity and variability, sometimes suggestive due to the cyclical nature of menstrual recrudescence (15 to 40% of cases) [13].

Although the abdominal symptoms are then largely dominated and set back by genital symptoms (disabling dysmenorrhea, deep dyspareunia, chronic pelvic pain), Daraï et al. in a series of 40 patients with symptomatic digestive endometriosis lesions found associated dysmenorrhea in 90% of cases, dyspareunia in 85% of cases and infertility in 32.5% of cases [14]. Digestive symptoms are not specific and may, wrongly, orient the diagnosis towards other more frequent digestive pathologies, thus inducing diagnostic delay. They are hypogastric cramps, alternating constipation / diarrhea, bloating, tenesmus, dyschezia, melenas, and exceptionally, immediately an acute abdomen - acute bowel obstruction (7-23%) [15], intussusception intestinal (12 cases in the literature) [16], intestinal perforation (5 cases of ileal perforation) [17]. The interest of radiological examinations is obvious, and the first examination of choice is the endovaginal ultrasound. This tool offers sensitivity and specificity ranging from 83 to 97% in the diagnosis of deep endometriosis [8,18,19]. Once the diagnosis is made, MRI is necessary to establish an exact map of the lesions [8,18,19].

The therapeutic approach of digestive endometriosis and more specifically ileocecal endometriosis is medico-surgical, it must be comprehensive, taking into account the symptoms, the desire for pregnancy, the side effects of therapies, the impact on quality of life and the priority of the patients or the couple (pain and / or infertility?). Medical treatments are reported to be relatively effective on symptoms [20-22]. Currently the medical arsenal enjoys a wide range, based on the use of estrogen-progestins and progestins, both of which can be taken discontinuously or continuously, or progestins delivered through intrauterine devices, and GnRH analogues with "add back therapy" [23]. However, their limited or incompletely effective suspensive effect is an argument to legitimize surgical stealing [23]. Although being a functional pathology, surgery for this condition must meet specifications of the "carcinological" type allowing maximum reduction of lesions to be obtained with few per- and postoperative complications, the laparoscopic approach is in progress. full development aspiring to reduce pain and improve quality of life, risks to be taken into account: complications and recurrences, with three imperatives: identification of good candidates for surgery, conservative surgery (Shaving and discoid resection), and the interest of expert centers with multidisciplinary consultation meeting decisions [23].

What about fertility? Today, there is no clearly demonstrated argument that allows IVF or surgery to be favored to treat first-line infertility associated with deep endometriosis, and the subject still remains problematic [24].

Conclusion

The occlusive complication of small endometriosis is rare, however, the deep localizations of endometriosis with digestive involvement represent one of the major challenges of our specialty.

Although it is a benign pathology, it severely impacts the quality of life of patients. In addition to the positive diagnosis, management can only be conceived in referral services and by practitioners with indisputable competence.

Reference

- [1] Borghese B, et al. "Définition, description, formes anatomo-cliniques, pathogenèse et histoire naturelle de l'endométriose, RPC Endométriose CNGOF-HAS". *Gynécologie Obstétrique Fertilité & Sénologie* (2018), <https://doi.org/10.1016/j.gofs.2018.02.017>
- [2] Koninckx PR, Meuleman C, Demeyere S, Lesaffre E, Cornillie FJ. "Suggestive evidence that pelvic endometriosis is a progressive disease, whereas deeply infiltrating endometriosis is associated with pelvic pain". *Fertil Steril* 1991;55(4):759–65.
- [3] Chapron C, Bourret A, Chopin N, Dousset B, Leconte M, Amsellem-Ouazana D, et al. "Surgery for bladder endometriosis: long-term results and concomitant management of associated posterior deep lesions". *Hum Reprod Oxf Engl* 2010;25(4):884–9.
- [4] Chapron C, Chopin N, Borghese B, Foulot H, Dousset B, Vacher-Lavenu MC, et al. "Deeply infiltrating endometriosis: pathogenetic implications of the anatomical distribution". *Hum Reprod Oxf Engl* 2006;21(7):1839–45.
- [5] Chapron C, Fauconnier A, Vieira M, Barakat H, Dousset B, Pansini V, et al. "Anatomical distribution of deeply infiltrating endometriosis: surgical implications and proposition for a classification". *Hum Reprod Oxf Engl* 2003;18(1):157–61.
- [6] Dousset B, Leconte M, Borghese B, Millischer A-E, Roseau G, Arkwright S, et al. "Complete surgery for low rectal endometriosis: long-term results of a 100- case prospective study". *Ann Surg* 2010;251(5):887–95.
- [7] Chapron C, Chiodo I, Leconte M, Amsellem-Ouazana D, Chopin N, Borghese B, et al. "Severe ureteral endometriosis: the intrinsic type is not so rare after complete surgical exeresis of deep endometriotic lesions". *Fertil Steril* 2010;93(7):2115–20.
- [8] Leconte M, Borghese B, Chapron C, et al. "Localisation digestive de l'endométriose". *Presse Med* 2012;41:358—66.
- [9] Melody GF. "Endometriosis causing obstruction of the ileum". *ObstetGynecol* 1956;8:468–72.
- [10] Scully RE, Eugene JM. "Case records of the Massachusetts General Hospital. Weekly clinicopathological exercises. Case 13-2000. A 26-year-old woman with bouts of abdominal pain, vomiting, and diarrhea". *N Engl J Med* 2000;342:1272–8.

- [11] Yantiss RK, Clement PB, Young RH et coll. "Endometriosis of the intestinal tract: a study of 44 cases of a disease that may cause diverse challenges in clinical and pathologic evaluation". *Am J Surg Pathol* 2001;25:445–454.
- [12] Boulton R, Chawla MH, Poole S, Hodgson HJ, Barrison IG. Ileal "endometriosis masquerading as Crohn's ileitis". *J Clin Gastroenterol* 25: 338–342, 1997.
- [13] Pillay SP, Hardie IR. "Intestinal complications of endometriosis". *Br J Surg* 1980;67:677–9.
- [14] Darai E, Thomassin I, Barranger E, Detchev R, Cortez A, Houry S, et al. "Feasibility and clinical outcome of laparoscopic colorectal resection for endometriosis". *Am J Obstet Gynecol* 2005;192:394–400.
- [15] De Ceglie A, Bilardi C, Bianchi S, et al. "Acute small bowel obstruction caused by endometriosis: a case report and review of the literature". *World J Gastroenterol* 14: 3430–3434, 2008.
- [16] E. Denève et al. "Invagination iléocœcale secondaire à une endométriase du cœcum. *Journal de Gynécologie Obstétrique et Biologie*" de la Reproduction (2008) 37, 796–798.
- [17] Decker D, König J, Wardelmann E, et al. "Terminal ileitis with sealed perforation—a rare complication of intestinal endometriosis: case report and short review of the literature". *Arch Gynecol Obstet* 269: 294–298, 2004.
- [18] Verspyck E, Lefranc JP, Blondon J. "Diagnostic et traitement de l'endométriose rectale et sigmoïdienne". *Ann Chir* 1997;51:1106–10.
- [19] Roman H, Bourdel N, Rigaud J, et al. "Endométriose et douleurs pelvipérinéales chroniques". *Prog Urol* 2010;20:1010–8.
- [20] Brown J, Farquhar C. "Endometriosis: an overview of Cochrane Reviews". *Cochrane Data base Syst Rev* 2014;(3):CD009590.
- [21] Dunselman GAJ, Vermeulen N, Becker C, Calhaz-Jorge C, D'Hooghe T, De Bie B, et al. "ESHRE guideline: management of women with endometriosis". *Hum Reprod Oxf Engl* 2014;29(3):400–12.
- [22] Schweppe KW. "Current place of progestins in the treatment of endometriosis-related complaints". *Gynecol Endocrinol* 2001;15(Suppl 6):22–8.
- [23] Bendifallah S, et al. "Prise en charge chirurgicale des lésions d'endométriose profondes avec atteinte digestive et urinaire". *Presse Med.* (2017).
- [24] Cohen J, et al. Endométriose profonde et fertilité. *Presse Med.* (2017), <https://doi.org/10.1016/j.lpm.2017.10.002>