Cecal Endometriosis: An Unusual Cause of Adult Ileocolic Intussusception

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Endometriosis is defined as the presence of endometrial tissue outside the endometrium and the myometrium. The gastrointestinal tract is the most common site for extrapelvic endometriosis, affecting 5-15% of women in the childbearing age group; the rectum and the sigmoid colon are the most common sites involved. Terminal ileal and cecal involvement is rare and may mimic malignancy of the colon. It is even rarer for endometriosis of the cecum to cause intussusception. The diagnosis of endometriosis in the ileocecal region is seldom made preoperatively in the absence of the previous endometriosis. Ileocolic endometriosis presenting predominantly as a mural mass and causing intussusception is very rare with few reports in world literature. We report a case of ileocolic endometriosis causing intussusception in an adult.

Keywords: Cecal involvement, Endometriosis, Intussusception

INTRODUCTION

Endometriosis is defined as the presence of endometrial tissue outside the endometrium and the myometrium. Although the most common sites include the pelvic organs such as ovary, uterine ligaments, rectovaginal septum, cul-de-sac, and the overlying peritoneum, rarer extrapelvic sites including scars, large and small bowel, appendix, lungs, soft-tissue, and brain have been described.¹ Endometriosis of the bowel is a distinct entity with several clinical differential diagnoses including diverticulitis, appendicitis, Crohn’s disease, tubo-ovarian abscess, irritable bowel, carcinoma, and lymphoma.² Presentation of cecal endometriosis can be deceptive mimicking a carcinoma and warrants surgical intervention especially when there is no definite pre-operative diagnosis.³ Ileocolic endometriosis presenting predominantly as a mural mass and causing intussusception is very rare with few reports in the world literature. We report a case of ileocolic endometriosis causing intussusception.

CASE REPORT

A 37-year-old female patient presented with intermittent cyclical central abdominal pain since 4 years. The pain coincided with the first day of her menstrual cycles, lasting for 3-4 days. Moreover, it was occasionally associated with bilious vomiting. She had no history of abdominal distension, constipation, obstipation, malena, or loss of weight or appetite. The patient had a lower segment cesarean section 11 years earlier with the last normal childbirth being 4 years earlier.

On examination, the abdomen was soft, non-tender, and there was no palpable mass. There was no evidence of intestinal obstruction. Digital rectal and per vaginal examination did not reveal any abnormality. Her hematological parameters were within normal limits, and carcinoembryonic antigen level was 3.54. Ultrasonography (USG) showed findings suggestive of ileocolic intussusception with a hypoechoic area in the cecum. The other organs including the uterus and adnexae were normal. Computed tomography (CT) scan showed an ill-defined mucosal lesion at the ileocecal junction involving the mesentery. Colonoscopy showed an ileocecal growth with intussusception of the terminal ileal mucosa. Endoscopic differential diagnosis included a gastrointestinal stromal tumor. The endoscopic biopsy showed scanty submucosal benign spindle cells.

At laparotomy an ileocecal mass (6 cm × 8 cm) with ileocolic intussusception was noted with omental adhesions. Right hemicolecotomy with ileotransverse anastomosis was done. Resected specimen as shown in Figure 1. She had an uneventful post-operative period.

Histopathology report showed on gross examination of the specimen revealed intussusception of the ileocecal...
region into the colon as shown in Figure 2. On sectioning, a firm gray-white mass was seen in the ileocecal region with puckering of the underlying mesocolon mimicking a neoplastic growth. Histopathology showed an endometriotic mass in the colonic wall with islands of endometrial glands surrounded by endometrial stroma seen in the muscularis propria extending into the mucosa with endometrial glands opening through the surface epithelium. The pericolic fat, in addition, showed evidence of endometriosis Figure 3.

The patient was put on gonadotropin-releasing hormone agonists. On follow-up after 2 months, the patient was asymptomatic.

**DISCUSSION**

Bowel endometriosis is defined as the presence of endometrial glands and stroma infiltrating the bowel wall reaching at least the subserous fat or adjacent to the neurovascular bundle (subserous plexus). More than 80% of affected patients are in the reproductive age group. Patients can present with a wide range of symptoms including constipation, diarrhea, abdominal bloating, painful bowel movements, and passage of mucus in the stools and can closely mimic other diseases such as malignancy of the colon, inflammatory bowel disease, or irritable bowel syndrome.

Intussusception is uncommon in adults compared with the pediatric population. It is estimated that only 5% of all intussusceptions occur in adults and approximately 5% of bowel obstructions in adults are the result of intussusceptions. Leon showed that in adults a pathologic cause was identified in 85% of patients with 8 of 22 (36%) small bowel and 4 of 5 (80%) of large bowel lesions being malignant.

Very few isolated case reports of cecal endometriosis presenting with intussusception have been described in literature. The gold standard for the diagnosis of pelvic endometriosis is laparotomy. Cecal endometriosis does not have definite diagnostic features though magnetic resonance imaging, multislice CT, and transvaginal USG can point be suggestive. Hence, malignancy is always considered in the differential diagnosis when adult cecal intussusception occurs. Endoscopic diagnosis of endometriosis is rare since the lesion usually does not reach the mucosa and the secondary mucosal changes due to endometriosis can mimic other diseases. Hence, a differential diagnosis of myogenic tumor is considered. Theories supporting endometriosis include metaplasia of peritoneum of Müllerian origin and retrograde menstruation which highlights a serosal and mural involvement over a mucosal involvement. The colonoscopic biopsy, in this case, showed only spindle cells and was not conclusive. An unusual and interesting finding, in this case, was mucosal involvement on microscopy.
without a definite history of colonic/rectal bleed. Only a few cases of endometriosis in the intestinal wall causing intussusception has been reported in the literature so far.\textsuperscript{8-12}

Bowel endometriosis can be small and asymptomatic. However, nodules causing intractable abdominal cyclical/noncyclical pain warrant hormonal therapy with surgery reserved for obstruction.

Long-term follow-up after hormonal therapy is a must.

CONCLUSION

Cecal endometriosis presenting as ileocolic intussusception is very rare and can be challenging.

Endometriosis should be considered as a differential diagnosis of adult intussusceptions in female patients within the reproductive age. A history of cyclical pain and rectal bleed may not be obtained in all cases.

REFERENCES


\textbf{How to cite this article:} Sunny A, Mohan LN. Cecal Endometriosis: An Unusual Cause of Adult Ileocolic Intussusception. IJSS Case Reports \\& Reviews 2016;3(3):6-8.

\textbf{Source of Support:} Nil, \textbf{Conflict of Interest:} None declared.