

EDITORIAL

LARGE BOWEL OBSTRUCTION AND ENDOMETRIOSIS

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A young lady 31 years old, single presented to the surgical emergency with abdominal pain & vomiting for 4 days. Pain was of sudden onset poorly localized, but severe & continuous. It was associated with vomiting and absolute constipation. There was burning micturition, but no changes of colour or increased frequency. No pain or bleeding per rectum. Her menarche was at 14, cycle 6/30, regular with dysmenorrhoea, otherwise normal. The patient looked ill, not pale and was febrile. Pulse was 120/min, respiratory rate 30/min. Chest, cardiovascular and central nervous systems were normal. Abdominal examination showed distended, tender abdomen all over with guarding and was resonant on percussion. Bowel sounds were heard. Per rectal examination revealed a high upper rectal mass just touched by the tip of the finger. The mucosa over it was smooth and intact. The rectum was empty. No mucus or blood in the examining finger. The provisional diagnosis of large bowel obstruction due to tumor(?Malignant) was suggested and intussusception was put as a differential diagnosis. The investigations done were: Hemoglobin was 84%, urine showed a trace of protein no red blood cells, serum potassium was 2.5 mmol/L, sodium was 126 mmol/L. X ray abdomen showed distended bowel. The patient was resuscitated and prepared for laparotomy. Under general anesthesia, a lower- mid line incision was made extended above the umbilicus and the abdomen opened. There was distended transverse, and ascending colon and caecum. Small bowel not distended. A very hard mass felt in the upper rectum firmly fixed and inseparable from the uterus. The suspected diagnosis was rectosigmoid carcinoma, otherwise the abdomen was normal. Loop transverse colostomy was made and a biopsy was taken. The patient smoothly from anesthesia. The postoperative course was uneventful.

The histopathology report came as endometriosis.

The patient was started on danazol one tab 3 times daily and contraceptive pill, mainly progesterone tablet/day.

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She returned after one follow up. She said she passed some motions per anus. We did barium study to ascertain the patency of the alimentary tract. Barium was introduced from above through the colostomy, but was arrested at the site of obstruction.

Sigmoidoscopy was tried and showed evidence of pressure from outside. The scope could not pass through.

Barium (from below) was also tried, but no evidence of patency. The tumor is inoperable routine surgery. We haven't got facilities to do laser surgery, which was claimed to be effective in removing the disease without resection.

We discharged her with the colostomy and doubled her dose of danazol in the hope that it may help. But we told her that probably she may live with her colostomy forever.

Discussion :

90% of colonic obstruction are due to Cancer, diverticulitis or volvulus ⁽¹⁾

Although statistics vary, approximately 8-15 % of young women have some degree of endometriosis ^(2,3). Entopic endometrial tissue has been found everywhere in the body including the skin. ^(4,5) The incidence of bowel involvement with endometriosis is 3-34% ^(6,7). The most frequent location is rectosigmoid (72%), followed by small bowel (7%), coecum (3.6%). Appendix (3%). (Macafee and Greer ⁽⁶⁾ in a review of 7177 cases in 1960). Because many patients with intestinal endometriosis are either asymptomatic or have non-specific symptoms these figures may be underestimation of the true incidence of the condition. Reports of bowel obstruction secondary to endometriosis are rare, especially in the colon, because of the larger intraluminal diameter.

The symptoms depend on the degree of invasion of the bowel wall. Because of the proximity of rectosigmoid to the vagina and cervix, there is painful intercourse (Dysparuenia) ^(8,10)

It may give signs & symptoms of acute appendicitis. ⁽⁹⁾

Adhesion may from causing abdominal pain and sometimes obstruction of the bowel, infertility and entopic pregnancy. If the mucosa was invaded there may be rectal bleeding. Bloating, nausea and loose stools during menses are known to occur. Diagnosis is difficult preoperatively as endometriosis goes more outside than inside the bowel. Therefore barium and colonoscopy are no help in diagnosis. At this time there is no cure for endometriosis ^(8,11) but surgical methods may alleviate signs and symptoms. Bowel resection in limited areas may be possible. But the best form of treatment now available is laparoscopic laser surgery. Medical treatment is not satisfactory. Lupron injection, birth control pills and danazol were all tried, but without any avail. In conclusion teamwork is recommended ^(8,9,10,11) as the disease does not respect the boundaries of the various medical specialities

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