



E-ISSN: 2708-0064
P-ISSN: 2708-0056
IJCRS 2020; 2(1): 04-06
www.allcasereports.com
Received: 05-04-2020
Accepted: 16-05-2020

Akogu Simon PO
Department of Obstetrics and
Gynecology, Kogi State
University/Kogi State
University Teaching Hospital
Anyigba, Kogi State Nigeria/
Neighbour Multicare Hospital
and Women Welfare Centre,
Anyigba, Nigeria

Anthony I Emeka
Department of Obstetrics and
Gynecology, Kogi State
University Teaching Hospital,
Anyigba

Corresponding Author:
Akogu Simon PO
Department of Obstetrics and
Gynecology, Kogi State
University/Kogi State
University Teaching Hospital
Anyigba, Kogi State Nigeria/
Neighbour Multicare Hospital
and Women Welfare Centre,
Anyigba, Nigeria

Endometriosis: A diagnostic merry-go-round: A case report

Akogu Simon PO and Anthony I Emeka

DOI: <https://doi.org/10.22271/27080056.2020.v2.i1a.12>

Abstract

Endometriosis affects mainly menstruating women. We present a case of endometriosis complicated by a tortuous diagnostic course and intestinal obstruction in a 28 year old nulliparous woman who had three laparotomies on account of two wrong diagnosis in a resource limited setting.

Keywords: Endometriosis. Misdiagnosis. Intestinal obstruction. Anyigba. Kogi

Introduction

Endometriosis is the growth of endometrial tissue in other places outside the endometrium. It is a well-known and discussed cause of sub fertility. It is the cause of 15% of pelvic pain and seen in 21% of women being investigated for infertility. It occurs in 5- 15 % of menstruating women while 20% of women with endometriosis are asymptomatic [1, 3, 5, 13, 14, 15].

Gastrointestinal involment in endometriosis has been reported in 3-37% of menstruating women and the involvement of the ileaum causing intestinal obstruction has been found in 7-23% of cases of endometiosis [13].

Case Report

Miss K.A presented at Neighbor Multicare Hospital and Women Welfare Centre Anyigba at 28 years of age, she was a nulliparous secondary school graduate. She presented in October 2018 with on and off pain for two years.

Pain was colicky, sometimes severe in the night. It was located at the right lower quadrant of her abdomen and became generalized. She could not count the number of episodes but later became constant prior to presentation.

There was non-projectile vomiting of any recently eaten solid meal. She could take only liquid diet. She had lost significant weight. She had gradual swelling of her lower abdomen. There was change in her bowel habit from daily to once in five days with semi-solid stool.

The pain increased during her menses on some occasions. She also experienced pains before, during and after her monthly menstruation in the last 3 years. Her menstrual cycle length was 26-28 days with flow duration of 3-5 days. There was no menorhagia.

She was sexually active but had not used contraception before.

She had two previous surgeries on account of the recurrent pain: in October 2016, she had open abdominal surgery for the pain said to be due to appendicitis and fibroid following an abdominal ultrasonography.

At surgery no fibroid was found, the Appendix was removed. The pains returned less than 2 weeks post operation. She was in and out of the hospital and did not get relief.

In April 2017, she was admitted in another hospital for surgery. The diagnosis was ovarian cyst and fibroid. At surgery, there was no fibroid but an ovarian cyst was removed. In less than 3 weeks after discharge, the pain continued and became severe during menstruation.

She went back to the hospital where she had the last surgery and was counseled for another exploratory laparotomy which she declined and changed hospital to our facility.

At presentation, she was restless, not febrile to touch, not pale and anicteric. She was poorly nourished.

The thyroid and Breasts were normal.

The respiratory rate was 22 cycles per minutes, the lungs fields clear.

The pulse rate was 94 beats per minutes, small volume and regular. The blood pressure was 110/60mmHg. Only first and second heart sounds were heard, no murmurs or added sounds.

Abdomen moved with respiration, was distend at the suprapubicarea. There was vague tenderness and a mass in the suprapubic region.

The vulva was normal, there was fullness in the vaginal fornices more on the right side; the cervix looked healthy but mildly tender.

Rectal examination revealed good anal hygiene and normal sphincteric tone, no mass was palpable.

A provisional diagnosis of Pelvic mass (Tubo–Ovarian) causing partial intestinal obstruction was made.

The patient was admitted into the ward and received immediate supportive care. She was worked up for surgery.

The abdominal ultrasonography revealed “a mixed echo mass measuring 20 x 40cm extending from the right adnexum towards the midline with the right ovary showing multiple non septated cysts. The left ovary was enlarged too”.

She had a third Exploratory Laparotomy. The findings at surgery were:

1. Previous midline laparotomy scar that healed by secondary intention.
2. Pelvic adhesions majorly on the right side of the pelvis matting together the caecum, an enlarged right ovary, part of the terminal ileum (about 10cm), swollen part of right fallopian tube, uterus and an endometrioma on the ovary and fallopian tube that formed part of the complex..
3. An enlarged left ovary that was 10cmx 25cm.
4. Pusy thick exudates from both Ovaries.

The uterus, the caecum and ileum were carefully separated from the ovary by blunt dissection and the loops of ileum bound in adhesion were separated by blunt dissection. The pockets of pus and the endometrioma were cleared.

Further adhesiolysis was performed and parts of both ovaries were resected for histology. The peritoneum was lavaged, mopped clean and closed with a drain left for abdominal drainage.

The abdomen was closed in layers. She was transfused one unit of blood intra operatively. Her immediate post operative condition was satisfactory.

The ovarian tissue and endometrioma–like tissues was sent for histology.

The patient's post operative condition remained progressively stable. The management included close monitoring, Supportive care, analgesia, antibiotherapy and fluid therapy.

She was discharge home on the 9th day post operation.

She was seen 4 weeks later, saw her menses once and was doing well. Clinical examination yielded no abnormality.

The histology report: ***“specimens consist of 2 pieces of dark brown tissue together measuring 3x3x2cm. Cut section shows grayish white surface.***

Histologic sections of the tissue shows ovarian stroma containing islands of endometrial glands and stroma, with areas of surrounding haemorrhage consistent with Endometriosis”

The patient was placed on intramuscular Depoprovera 150mg every 3 months for one year. This provided effective relief of her pains. Eleven months later, she expressed fertility desires and was referred to the out patients gynecology clinic of the Kogi state University Teaching hospital, Anyigba to further fertility care.

Discussion

Endometriosis is a condition with diverse presentations that

present a diagnostic challenge to many practitioners. It shows a non-definite course in its pathogenesis.

The clinical features of endometriosis include lower abdominal or pelvic pain, periumbilical pain, pelvic pain, pain in the vagina and/or pain in the rectal area [1, 4].

The pain is usually cyclic. In severe cases the urinary bladder and bowels are affected. Endometriosis may also present with dyspareunia, and dysmenorrhea.

It is believed that retrograde menstruation is cause of endometriosis . The backward flow of the menstrum carry endometrial tissue into the peritoneal cavity as a form of transplantation. This argument is supported by the fact that suppressors of menstruation like oral contraceptive pills and pregnancy tend to reduce the prevalence of endometriosis [1, 2, 3].

Coelomic metaplasia, surgical transplantation, genetic origin and auto immune pathogenesis have also been implicated in the aetiology of endometriosis [9, 10, 11, 12].

Endometriosis is a complex syndrome largely due to an inflammatory event that is estrogen dependent. Among the Several factors associated with endometriosis include early menarche which appear to increase the risk of endometriosis while current use of use of contraceptive and parity are associated with decreased risk of endometriosis [3, 4].

The management of endometriosis can be expectant, medical and/or surgical. Expectant management is for patients that are asymptomatic (mild endometriosis). Since they have no symptoms, there is no need for any medical or surgical interventions. Endometriosis is a progressive disease; treating an asymptomatic patient has not been found to prevent further progression [12].

Medical management include analgesia for pains, drugs like danazol, a testosterone derivative and aromatase inhibitors like anastrozole and letrozole [12]. Oral contraceptives, progestogens and GnRH agonists are also useful and effective in the medical management of endometriosis [10, 11, 12].

In severe disease and with desires for fertility, the surgical approach is aimed at restoring the pelvic anatomy to as normal as possible. The procedure involves excision or destruction of the endometriotic tissues and adhesiolysis [12].

The impact of advanced or severe (stage III and IV) endometriosis on fertility and the advances in diagnostic techniques like ultrasonography and laparoscopy has heightened knowledge and depth management of endometriosis.

Our patient was a 28 year old nulliparous woman, a little outside the peak age of incidence of endometriosis which is 30 – 45 year. Her case presented a diagnostic challenge leading to her case of endometriosis been diagnosed wrongly on two occasions; first as Appendicitis and uterine fibroid and secondly as ovarian cyst and uterine fibroid. It was on the third occasion that a diagnosis of pelvic mass causing intestinal obstruction was made which turned out to be an endometriotic mass that trapped the terminal ileum in an adhesion complex causing intestinal obstruction. This diagnostic failure and merry-go-round deserved to be reported to raise practitioners alertness in dealing with such presentations.

Where specific diagnostic tools and/or expertise for diagnosis are not available as in this case, wrong diagnosis is very common. The patient received two different wrong diagnosis on two separate occasions within one and half year.

The first and second surgeries compounded and masked some peculiar symptoms like cyclic abdominal pain concurrent with menstrual flow.

Endometriosis can involve the bladder, intestine and other pelvic structures. In our patient the endometrioma and adhesion therein involved the right ovary, right fallopian tube, the terminal ileum, the caecum and the uterus causing partial intestinal obstruction. It was a stage III disease.

The management include adhesiolysis, excision of endometrioma, analgesia and hormonal therapy. Where complicated as in this case, specific steps are taken.

The patient had adhesiolysis, excision of endometrioma and a one year treatment with medroxy progesterone acetate (Depoprevera). She did well on this until she expressed fertility desire and was referred for further management.

Conclusion

The diagnostic merry-go-round gone through by the patient could be averted if there adequate diagnostic capacity and clinical acumen of clinicians. Efforts should be made to improve on this for practitioners providing surgical services in resource limited settings.

References

1. David M. Luesley, Phillip N. Baker et al Obstetrics and Gynecology. Evidenced based text for MRCOG, 544-8.
2. Waddle PG, Hull MRG. Is endometriosis a disease? *Bailliere's Clin. Obstec. Gynecol.* 1993; 7(4):673-85
3. Mahmood TA, Templeton A. Prevalence and Genesis of Endometriosis. *Human Reprod.* 1991; 6:544-9.
4. Guidice LL, Kao LC. Endometriosis. *Lancet.* 2004; 364(9447):1789-99 (PubMed) [GoogleScholar]
5. Farland LV, Shah DK, Kvaskeff M. Zondervan K, Missmer SA. Epidemiological and Clinical Risk for Endometriosis. In: D'hooghe T, editor. *Biomarkers for endometriosis.* Springer Science; New York, 2015. (Google Scholar)
6. Bulun SE. Endometriosis. *N.Engl J med.* 2009; 360(3):268-79. doi 10.10561NEJMra0804690 (PubMed) [Cross Ref] (Google Scholar)
7. Dun EC, KhoKa, Morozov VV, Kearney S, Zurawin JL, Nezhat CH. Endometriosis in adolescent JSLS. 2015; 19(2). doi 10.4293 IJLS. 2015.00019: Pii: e2015.00019. (Pmc free article) [Pub Med] (Cross Ref) Google scholar)
8. Vercelini P, Easkanazi B, Consonni D, Somighana E, Parazzin F, Abloitia A, et al. Oral Contraceptives and Risk of Endometriosis: *Reprod update.* 2011; 17(2):159-70 [PubMed] (Google Scholar)
9. Parveen Parasar, Pinar Ozcan, Kathryn L Terry, Endometriosis, Diagnosis and Clinical Management. *Curr Obstet Gynecol Rep.* 2017; 6(1):34-41.
10. Aruikumaran S, Symond IM, FowlieIn A. Oxford hand book of Obstetrics and Gynecology. Endometriosis, 577-81.
11. Joan Pitkin, Alison B Peattie, Brain A Magowan. Endometriosis. In *Obstetrics and Gynecology. An illustrated colour text,* 128-9.
12. Alan H. Dedierny, Lauren Nathan, Murphy Godwin, Nerilauffer, Endometriosis in Current diagnosis and treatment; *Obstetrics and Gynecology, 10th Edition,* 712-9.
13. Atonella De Ceglie, Claudio Bilardi, Sabrina Bianchi, Massimo Picasso, Marcelo D Musio Alberto Trimachi,

Massimo Conio; Acute small bowel obstruction caused by Endometriosis: A case report and review of literature. *World J Gastrzoenterol.* 2008; 14(21):3430-3434, Doi10.3748/wjg.14.3430.

14. Olive DL, Schartz LB. Endometriosis: *NEng J Med.* 1993; 328:1759-1769 [PubMed][Google scholar]
15. Pritts EA, Taylor RN: An evidenced based evaluation of endometriosis-associated Infertility. *Endocrinolmetab Clin North Am* 2003;653-667 [PubMed][Google Scholar]