Rectosigmoid endometriosis

Rektosigmoid endometriozis

To the Editor

Extra-pelvic endometriosis is most commonly seen in the bowels, with a reported incidence of 5-20%. Rectosigmoid endometriosis (RE) accounts for 71% of cases of intestinal endometriosis (1, 2). Bowel endometriosis might show non-specific symptoms, such as abdominal colic-like pain, nausea, vomiting, constipation, diarrhea, and rectal bleeding (1, 3).

We retrospectively reviewed the charts of six patients with histopathologically proven RE between December 2001 and January 2006 (Table 1). Two patients were treated for infertility, and pelvic endometriosis was found on diagnostic laparoscopy previously. The most common findings in ultrasonography (USG) and computerized tomography (CT) were solitary, necrotic mass adhering to the bowel wall and bowel wall thickening. In one patient, a submucosal lesion was found. The results of abdominal USG and CT did not help in diagnosing intestinal endometriosis. Colonoscopy was performed in five of the six patients. Edema, luminal narrowing and increasing thickness of the bowel wall near the rectosigmoid junction were found in four patients. Submucosal tumoral mass was seen with overlying normal mucosa in one patient. Because biopsies almost always include only the lamina propria, histopathologic findings of biopsy materials were in normal range.

The patients were operated electively. In one patient, in the gynecologic operation due to myoma uteri, an incidental mass was detected at the rectosigmoid junction narrowing the lumen and in order to exclude a bowel tumor, anterior resection-Hartmann colostomy was made, in addition to total abdominal hysterectomy + bilateral salpingo-oophorectomy (TAH+BSO). In two patients, only anterior resection was performed. TAH+BSO and anterior or low anterior resection were performed in the other three patients. In one patient, a whitish plaque over the appendix was found incidentally and appendectomy was added. Histopathological examination revealed appendiceal endometriosis in addition to RE. There was no recurrence over a mean follow-up period of 32 months (11 months-5 years).

Due to the presence of risk of malignant transformation and fibrosis development after medical treatment, optimum therapeutic-diagnostic choice in RE is surgery. Surgery is also indicated in case of intestinal obstruction and severe abdominal pain. Limited surgery or cauterization of lesions following frozen-section pathologic examination could be performed (1, 4, 5).

Rectosigmoid endometriosis may mimic various gastrointestinal diseases, including primary bowel carcinoma, diverticulosis, chronic inflammatory bowel disease and gastrointestinal stromal tumors. It is remarkably difficult to diagnose intestinal endometriosis by endoscopic and radiological imaging methods (2, 5). Since there are no pathognomonic radiological or endoscopic findings, definitive diagnosis could only be done by histopathological examination.

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Table 1. The characteristics, radiological/endoscopic findings and surgical treatment in patients with rectosigmoid endometriosis

Patient number	Age	Symptoms	Infertility	Previous surgery	Colonoscopy / rectosigmoidoscopy	Abdominal USG	Abdominal CT	Surgery
1	39	Abdominal pain, constipation	+	Diagnostic laparoscopy for pelvic endometriosis 12 years ago	Mucosal edema, luminal narrowing and increasing thickness of the bowel wall (distance 15- 20 cm from anus)	Left adnexal mass (4 cm diameter) compressing rectum wall	Left adnexal mass causing external compression in rectosigmoid junction	Anterior resection
2	48	Cyclic, colic abdominal pain	-	-	External mass effect and increasing thickness of the bowel wall (distance 15 cm from anus)	Left adnexal necrotic mass (2.6 cm diameter) strictly adhered to bowel wall	Bowel wall thickening at sigmoid colon	TAH+BSO, anterior resection
3	49	Vaginal bleeding	-	-	-	Myoma uteri	-	TAH+BSO, Hartmann procedure
4	42	Pelvic pain, cyclic rectal bleeding	+	Diagnostic laparoscopy for infertility 5 years ago	External mass effect and mucosal hyperemia (distance 13 cm from anus)	Thickening of colonic wall	-	TAH+BSO, anterior resection,
5	51	Pelvic pain, cyclic rectal bleeding	-	-	Luminal obstruction due to mass, mucosal hemorrhage (distance 13 cm from anus)	-	Bowel wall thickening at rectum	TAH+BSO, low anterior resection
6	40	Constipation, pelvic pain	-	-	Submucosal tumoral mass (distance 22 cm from anus) with overlying normal mucosa	-	Submucosal mass lesion in rectosigmoid junction and luminal narrowing	Anterior resection

TAH+BSO: Total abdominal hysterectomy + bilateral salpingo-oophorectomy.

REFERENCES

1. Singh K, Lessells A, Adam DJ, et al. Presentation of endometriosis to general surgeon: a 10-year experience. Br J Surg 1995;82:1349-51.
2. Houtmeyers P, Ceelen W, Gillardian J, et al. Surgery for gastrointestinal endometriosis: indications and results. Acta Chir Belg 2006;106:413-41.
3. Olive DL, Schwartz LB. Endometriosis. N Engl J Med 1993;328:1759-69.
4. Mussa FF, Younes Z, Tihan T, Lacy BE. Anasarca and small bowel obstruction secondary to endometriosis. Clin Gastroenterol 2001;32:167-71.
5. Tran K, Kuijpers H, Willemsen W, Bulten H. Surgical treatment of symptomatic rectosigmoid endometriosis. Eur J Surg 1996;162:139-41.

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Ansa pancreatica: A rare pancreas ductal variation

Ansa pankreatika: Nadir bir pankreas kanal varyasyonu

To the Editor

The accessory dorsal pancreatic duct fuses with the main ventral duct at the pancreas head region in about 90% of the population, and drains through the major papilla, but it may also remain patent, emptying via the minor papilla. When the dorsal pancreatic duct enters the minor papilla by forming an arch like a reverse 'S' character, this type of ductal anatomy is referred to as 'ansa pancreatica'. It has been proposed in the literature that this type of anatomic variation may predispose to acute or chronic pancreatitis (1-3).

Among the patients who had undergone magnetic resonance cholangiopancreatography (MRCP) at our institution between November 2003 and June 2006, 4 patients (2 M, 2 F, age range: 49-71 years) had ansa pancreatica anatomic variation. MRCP was performed with a 1-T system (Signa Horizon; GE Medical Systems, Milwaukee, WI).

One patient had focal pancreatitis in the pancreatic tail; 1 had recently suffered from acute cholecystitis; 1 complained of nonspecific upper right quadrant pain; and 1 was being evaluated for elevated serum alkaline phosphatase (ALP) and gamma glutamyl transferase (GGT) levels. On the MRCP images of these patients, the dorsal pan-

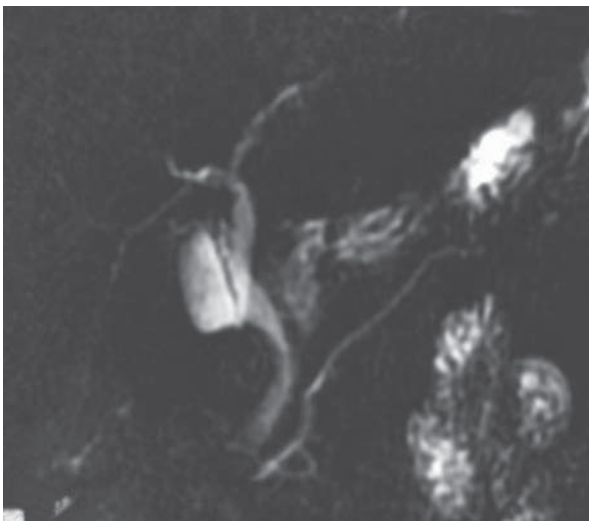

Figure 1. MRCP image in a 57-year-old man with remote acute cholecystitis demonstrating an incidental ansa pancreatica anatomic variation.

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