



A Rare Case of Small Bowel Endometriosis

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Abstract

Background: This case report emphasizes the recent studies in small bowel Endometriosis i.e. Endometriosis is an often painful disorder in which tissue similar to the tissue that normally lines the inside of the uterus- the endometrium- grows outside the uterus.

Case presentation: A 41-year-old woman went to the emergency room with abdominal pain as her main complaint. The patient had been suffering from persistent stomach pain for almost two months, with the pain in her right lower abdomen getting worse. The ED physician determined a clinical diagnosis of small bowel obstruction based on a physical examination, relevant laboratory results, and radiographic studies. The most important radiological examinations, an abdominal X-ray and a CT scan of her belly and pelvis, revealed brief segments of thickened small intestine wall and dilated bowel loops, which were compatible with a clinical diagnosis of small bowel obstruction.

Keywords: Endometriosis • Uterine ligaments • Molecular histology • Medical physiology

INTRODUCTION

Small bowel endometriosis is an uncommon clinical occurrence. Unless doctors have a strong index of suspicion, the clinical disease manifests with nonspecific abdominal symptoms and is typically not identified initially. After several clinical encounters, the majority of patients are diagnosed. We describe a case of endometriosis-related small bowel blockage that was discovered after surgery. The presence of normal endometrial tissue outside of the endometrial cavity and myometrium is classified as endometriosis. It is a frequent ailment that affects approximately 6%-10% of reproductive-age women. Endometriosis can affect the ovaries, uterine ligaments, rectovaginal septum, cul-de-sac, pelvic peritoneum, colon, and appendix, in that order. Intestinal endometriosis accounts for 3%-37% of all intestinal instances, according to Wolthuis et al., while the small bowel is only involved in roughly 10% of all intestinal endometriosis cases. Small intestinal obstruction related to endometriosis, on the other hand, occurs in less than 7% of cases. Only about 1% of these cases require surgical resection. According to Saleem et al., the incidence of endometriosis in the appendix ranges from 0.2% to 1.3% in different studies. Endometriosis producing small intestinal obstruction with associated appendiceal endometriosis is an exceptionally unusual clinical occurrence, according to these findings. As a result, we present a case of small bowel blockage caused by endometriosis. It's worth noting that the majority of cases are discovered after surgery.

Pathology

In A 23-centimeter length of small bowel with an exterior diameter ranging from 4 to 6 centimetres was used as the specimen.

The intestinal mucosa was erythematous, with edoema in localised

regions. Multiple loops of adherent serosa and multifocal regions of thickened muscularis externa were visible on the intestinal wall, which had a maximum thickness of 2.2 cm. Our laboratory also received the appendix as a separate specimen. The appendix was unimpressive in the extreme. Histologic Multiple regions of endometrial tissue within the muscularis externa were visible in hematoxylin and eosin (H&E) sections of the small intestine. The microscopic findings revealed benign endometrial glands and endometrial stroma, as well as active bleeding and hemosiderin-laden macrophages in some locations. Endometrial glands and stroma were also seen in appendix sections. The mesoappendix and appendiceal wall were found to have endometriotic lesions.

Discussion

Endometriosis' aetiology and pathology has been the subject of numerous ideas offered by various authors. The regurgitation theory of retrograde menstrual blood flow; (2) the metastatic theory of endometrial tissues spreading via blood or lymphatic channels; (3) the metaplastic development theory of coelomic epithelium transforming into endometrial tissue; and (4) the most recent stem cell theory of bone marrow stem cells differentiating into endometrial tissue Patients nevertheless endure the clinical effects of this sickness, regardless of which hypothesis specialists subscribe to. The difficulty in obtaining a noninvasive clinical diagnosis is largely to blame for this. However, intriguing new research is shining new light on developing noninvasive diagnostic laboratory procedures for endometriosis confirmation.

Conclusion

In premenopausal women, endometriosis should be evaluated as a differential diagnosis with a high index of suspicion, especially in individuals with no prior surgical history. In these individuals, there should be a low threshold for early laparoscopy and resection of the afflicted intestine.

References

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