Colo-colic intussusception secondary to endometriosis

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Introduction:

Endometriosis is a frequent gynaecological pathology. The digestive tract is involved in 5 to 10% of case, mostly at the recto-sigmoid junction[1]. Usually asymptomatic, these lesions are discovered during laparoscopic staging for endometriosis. However, endometrial implants on the digestive tract can lead to chronic inflammation, making the thickened wall at risk for intussusception.

Method:

We report the case of a 58-year-old woman known for endometriosis with a previous MRI staging showing a stable disease with only tubary and uterine involvement. She was addressed to the emergency department complaining of colicky abdominal pain associated with bloody mucous diarrhoea. The initial diagnosis was a gastro-enteritis and the patient was hospitalized. Two days later, the patient presented a worsening left flank tenderness associated with a white cell count and C reactive protein elevation. The stool cultures were negative. A colonoscopy showed a circumferential turgid mucosa at the level of left colic flexure impeding further progression of the endoscope. The CT-scan revealed a thickened transverse colon with a target-shaped lesion. (fig1 & 2).

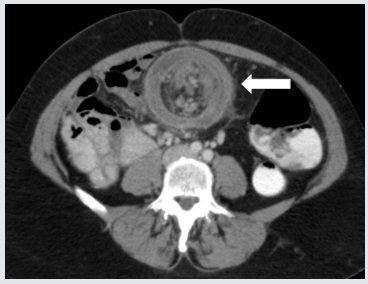

Fig1: Abdominal CT-scann

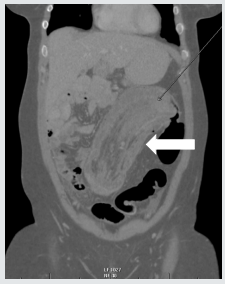

Fig2: Abdominal CT-scann reconstruction

Results:

Exploratory laparotomy confirmed a complete colo-colic intussusception of the right into the distal transverse colon. A right and transverse colectomy extended to the left colonic flexure was performed with an ileo-transverse anastomosis. Histopathological analysis revealed a totally invaginated right into the transverse colon due to a full thickness wall endometriosis associated with fibro-hyalinic inflammation (fig 3). The patient had an uneventful recovery

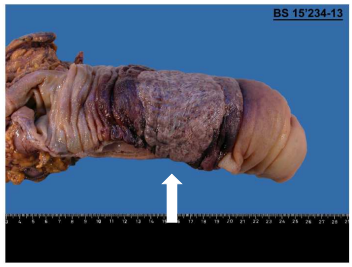

Fig3: Colectomy specimen after fixation
White arrow: transmural endometriosis associated with high inflammatory response

Conclusion:

Although very rare, colonic intussusception in adults is mostly secondary to an underlying pathology (up to 90%)[2] and cancer should always be considered in the differential diagnosis. Resection is thus mandatory for diagnosis and treatment purpose. Transmural endometriosis associated with locally marked inflammation is the corner stone that leads to intussusception or stenosis. For symptomatic patients resection is the gold standard but control of the endometriosis disease remains the key to prevent recurrence.

1.Denève E, et al. Ileocecal intussusception due to a cecal endometriosis *J. Jgyn* 2008; 37: 796-798
2. Azar T, Berger DL. Adult intussusception. *Ann Surg* 1997;226:134-8

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