ORIGINAL ARTICLE

Intestinal endometriosis: A rare cause of acute care surgery

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ABSTRACT

BACKGROUND: Intestinal endometriosis is a rare condition that can cause gastrointestinal symptoms such as abdominal pain, constipation, and diarrhea. It occurs in approximately 5%–15% of women with endometriosis. Although it rarely leads to obstruction or perforation, there is no clear consensus on its optimal management. Hormonal therapy is considered the first-line treatment for endometriosis; however, the best approach for intestinal involvement remains controversial. This study aims to contribute to the literature by evaluating patients with intestinal endometriosis who underwent surgery for acute abdomen.

METHODS: Sixteen patients who underwent emergency surgery for acute abdomen at the Emergency General Surgery Clinic of İstanbul University-Cerrahpaşa, Cerrahpaşa Medical Faculty of Medicine, between February 2016 and April 2023 were identified. Four patients voluntarily withdrew from the study, and 12 were included in the analysis. Demographic data, laboratory findings, surgical records, length of hospital stay, pathology reports, postoperative complications within the first 30 days, and their management were reviewed. Patients' current health status was assessed through telephone interviews.

RESULTS: The mean age of the patients was 39.3±9.2 years. Nine patients underwent surgery with a preoperative diagnosis of intestinal obstruction, while three were operated on for suspected acute appendicitis. Among the patients with intestinal obstruction, three underwent laparoscopic ileocecal resection, and three had segmental small bowel resection. One patient underwent anterior resection with appendectomy, and another underwent both anterior resection and ileocecal resection with ileocolostomy. One patient underwent a left hemicolectomy. The mean hospital stay was 7.9±5.9 days. Postoperative complications occurred in three patients (25%). The mean age of patients who experienced complications was significantly higher than that of those who did not ($p<0.007$). Histopathological examination revealed benign full-thickness endometriosis in all cases. The mean follow-up period was 50.6 months, with no recurrences observed.

CONCLUSION: Acute abdomen due to intestinal endometriosis-related obstruction is extremely rare. In reproductive-aged women presenting with acute abdomen, intestinal endometriosis should be considered in the differential diagnosis. In cases of clinical suspicion, intraoperative consultation with a gynecologist is recommended, and a multidisciplinary approach should be adopted to optimize treatment planning.

Keywords: Intestinal endometriosis; acute abdomen; diagnosis; treatment approach; emergency surgery.

INTRODUCTION

Endometriosis is a chronic disease of unknown etiology, characterized by the presence of endometrial stroma and glandular tissue outside the uterine cavity. Although several theories have been proposed to explain its pathophysiology, Sampson's theory of retrograde menstruation is the most widely accepted. During menstruation, endometrial tissue flows backward through the fallopian tubes into the peritoneal cavity. There, it implants on the serosal surfaces of organs and proliferates, forming endometrial nodules (endometriomas).[1] Although the prevalence of endometriosis varies between 2% and 10%

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in the general population, it can reach up to 35% in women of reproductive age with infertility.[2]

While endometriosis most commonly affects the pelvic organs, it can also involve other sites such as the gastrointestinal tract, lungs, liver, bladder, kidneys, umbilicus, and abdominal wall. In cases of gastrointestinal involvement, the disease can infiltrate the lumen and cause obstruction or perforation, leading to an acute abdomen that requires emergency surgical intervention. Intestinal endometriosis occurs in approximately 5%–15% of women with endometriosis and is typically asymptomatic or presents with nonspecific gastrointestinal symptoms such as bloating, constipation, or diarrhea. In some cases, the diagnosis is made incidentally during surgery performed for unrelated conditions. The rectosigmoid region is the most commonly affected site in intestinal endometriosis.

Although several studies have investigated intestinal endometriosis, large-scale analyses focusing on surgical outcomes are still lacking. Previous reviews and meta-analyses have primarily concentrated on hormonal therapy, leaving a gap in the understanding of the efficacy and long-term outcomes of surgical management in patients presenting with acute abdomen. This study aims to contribute to the literature by analyzing the clinical characteristics and surgical treatment outcomes of patients with intestinal endometriosis requiring emergency intervention. Hormonal therapy is the preferred treatment for endometriosis; however, it does not resolve cases involving intestinal obstruction. In such cases, resection of the affected bowel segment followed by anastomosis is considered the most effective approach.[3] In this study, we present the clinical profiles and treatment methods of 12 patients who were admitted to our clinic with acute abdomen due to gastrointestinal involvement of endometriosis.

Recently, several studies have focused on the surgical treatment of colorectal endometriosis. For instance, a systematic review by Schneyer et al.[4] analyzed surgical outcomes following colorectal surgery for endometriosis, highlighting the benefits and risks associated with various surgical approaches. Additionally, a study by Kondo et al.[5] reported a case series of patients treated with laparoscopic surgery for intestinal endometriosis, emphasizing the technical challenges and outcomes of such procedures. These studies underscore the complexity of surgical management for intestinal endometriosis and the ongoing need for further research to optimize treatment strategies.

MATERIALS AND METHODS

This retrospective study was conducted between 2016 and 2023 in the General Surgery Emergency Department of İstanbul University-Cerrahpaşa, Cerrahpaşa Medical Faculty Hospital. Quantitative data are expressed as mean ± standard deviation (SD) for normally distributed variables, and as median (min–max) for non-normally distributed variables. Qualitative variables are presented as frequencies and percentages (%). The study was approved by the Ethics Committee of İstanbul University, Cerrahpaşa- Cerrahpaşa Medical Faculty, on 04/12/2024. Patients over 18 years of age who had not been previously diagnosed with gastrointestinal endometriosis and who underwent surgery with a prediagnosis of acute abdomen were included in the study. Patients who declined to sing the informed consent form or requested to withdraw from the study were excluded. Patient selection was based on meeting the inclusion criteria. For patients with a known history of endometriosis, both preoperative and postoperative management were coordinated through consultation with the Obstetrics and Gynecology Department, ensuring that medical treatment was adjusted using a multidisciplinary approach. In patients without a prior diagnosis of endometriosis, the postoperative medical treatment plan was determined in consultation with the Obstetrics and Gynecology Department based on pathology findings.

Each patient underwent emergency surgery under general anesthesia and received preoperative antibiotic prophylaxis consisting of ceftriaxone and metronidazole. All patients were evaluated preoperatively and informed about their current health status.

Statistical Analysis

The Kolmogorov-Smirnov and Shapiro-Wilk tests were used to assess the normality of data distribution. For normally distributed data, the independent samples t-test was applied, while the Mann-Whitney U test was used for non-normally distributed data. The chi-square test was used to analyze qualitative independent variables; Fisher's exact test was employed when the assumptions of the chi-square test were not met. Statistical analysis was performed using SPSS software (version 28.0; IBM, Armonk, NY, USA).

RESULTS

The study included 12 patients who presented with abdominal pain at the General Surgery Emergency Surgery Clinic of İstanbul University, Cerrahpaşa-Cerrahpaşa Medical Faculty Hospital, between 2016 and 2023, and who underwent surgery with a prediagnosis of acute abdomen. Postoperative pathological examination confirmed gastrointestinal endometriosis in all cases. The mean age of the patients was 39.3±9.2 years. All patients had a history of live births, and 16.6% had a prior diagnosis of endometriosis.

All patients underwent preoperative radiological imaging. Nine were diagnosed with intestinal obstruction, and three with acute appendicitis. Laparoscopic appendectomy was performed in the three patients diagnosed with appendicitis. Among those who underwent surgery for intestinal obstruction, three with ileocecal involvement underwent laparoscopic ileocecal resection, while two with mid-ileal involvement underwent segmental small bowel resection followed by anastomosis. One patient with an obstructive mass in the

left colon underwent left colon resection. In another patient with ileus secondary to an endometrioma localized in the rectum, intraoperative exploration revealed adhesion of the ileal segment to the rectal mass; a wedge resection of the ileal segment followed by primary small bowel repair was performed (Table 1).

The mean hospital stay was 7.9±5.9 days. Postoperative complications occurred in three patients (25%): two (16.6%) developed intra-abdominal abscesses, and one had a wound site infection. Histopathological examination confirmed benign full-thickness endometriosis in all cases. The mean follow-up period was 50.6 months, and no recurrences were observed.

Table 1. Clinical and surgical characteristics of patients

Variable	Statistical Representation
Age (years)	Median: 39.5 (Min: 26.0 – Max: 58.0); Mean±SD: 39.3±9.2
Presenting Symptoms	- Abdominal pain: n=10 (83.3%)
	- Abdominal pain, nausea, vomiting: n=2 (16.7%)
Duration of Symptoms (hours)	Median: 48.0 (Min: 29.0 – Max: 96.0); Mean±SD: 51.2±19.4
Comorbidity	- Absent (-): n=10 (83.3%)
	- Present (+): n=2 (16.7%)
Surgical Procedures	- Laparoscopic appendectomy: n=3 (25.0%)
	- Laparoscopic ileocecal resection: n=3 (25.0%)
	- Segmental small bowel resection: n=2 (16.7%)
	- Anterior resection + Appendectomy: n=1 (8.3%)
	- Ileocecal resection + Double barrel ileocolostomy + Low anterior resection: n=1 (8.3%)
	- Resection of rectal anterior wall endometrioma: n=1 (8.3%)
	- Left hemicolectomy: n=1 (8.3%)
Parity	- Multiparous: n=9 (75.0%) → Cesarean section (C-section): n=4; → Vaginal delivery: n=5
	- Nulliparous: n=3 (25.0%)
Complications	- Absent (-): n=9 (75.0%)
	- Present (+): n=3 (25.0%)
WBC (×10³/µL)	Median: 11.5 (Min: 6.9 – Max: 15.4); Mean±SD: 10.6±2.9
HGB (g/dL)	Median: 11.4 (Min: 10.0 – Max: 14.0); Mean±SD: 11.4±1.1
PLT (×10³/µL)	Median: 212.0 (Min: 196.0 – Max: 417.0); Mean±SD: 235.2±62.8
PDW	Median: 16.0 (Min: 16.0 – Max: 17.7); Mean±SD: 16.3±0.5
Neutrophil (%)	Median: 75.4 (Min: 65.0 – Max: 91.8); Mean±SD: 76.9±7.3
Neutrophil-to-Lymphocyte Ratio (NLR)	Median: 5.9 (Min: 2.5 – Max: 27.5); Mean±SD: 8.8±8.0
C-Reactive Protein (mg/L)	Median: 13.5 (Min: 4.2 – Max: 112.0); Mean±SD: 31.7±34.9
Reactive Hyperplasia	Median: 11.0 (Min: 3.0 – Max: 38.0); Mean±SD: 15.9±14.0
Postoperative Pathology Findings	- Appendix, full-thickness endometriosis: n=3 (33.3%)
	- Sigmoid colon, full-thickness endometriosis: n=3 (33.3%)
	- Ileal endometriosis: n=2 (16.7%)
	- Terminal ileum endometriosis: n=2 (16.7%)
	- Rectal endometrioma: n=1 (8.3%)
	- Combined terminal ileum and sigmoid colon endometriosis: n=1 (8.3%)
Endometriosis Size (cm)	Median: 6.5 (Min: 5.0 – Max: 10.0); Mean±SD: 6.9±1.7
Length of Hospital Stay (days)	Median: 7.5 (Min: 3.0 – Max: 25.0); Mean±SD: 7.9±5.9

SD: Standard deviation; WBC: White blood cell count; HGB: Hemoglobin; PLT: Platelets; PDW: Platelet distribution width.

DISCUSSION

Endometriosis is a benign gynecological disorder characterized by the presence of endometrium-like tissue outside the uterine cavity, most commonly in the pelvic region. It is an estrogen-dependent, chronic inflammatory condition that primarily affects women of reproductive age and is often associated with infertility.[6,7] Although the exact pathogenesis remains unclear, the theory of retrograde menstruation is the most widely accepted. This theory proposes that endometrial cells refluxed through the fallopian tubes during menstruation, implant on peritoneal surfaces, and subsequently proliferate to form endometriotic lesions.[8] In the gastrointestinal tract, endometriotic implants may adhere to the serosal surface and infiltrate the submucosa, leading to a range of clinical manifestations.[9,10] Most early lesions are small, localized on the serosal surface or embedded within the muscular layer, and often remain asymptomatic. The ovary is the most common site of endometriosis, followed by the pouch of Douglas and the uterosacral ligaments.[11]

The digestive system is the most commonly affected extragenital region, with an incidence of 3%–12% in patients with endometriosis. Digestive tract-infiltrating endometriosis (DSIE), a subset of deep infiltrating endometriosis, displays more aggressive behavior and distinct biological and pathophysiological characteristics compared to superficial endometriosis. Due to its histological similarities to malignant tumors, DSIE is occasionally misdiagnosed in clinical practice, resulting in delays in appropriate treatment. Preoperative diagnosis of intestinal endometriosis remains challenging because of its nonspecific symptoms and imaging findings that often overlap with other gastrointestinal pathologies. While the rectosigmoid junction is the most commonly affected site (50%–90%), the disease may also involve the small intestine (2%–16%), appendix (3%–18%), and cecum (2%–5%).[12] Among small bowel cases, ileal involvement has been reported in approximately 4.1% of patients.[13] These variations in site involvement highlight the need for increased clinical suspicion, particularly in patients presenting with unexplained gastrointestinal symptoms.[14] Patients with intestinal endometriosis may experience constipation, diarrhea, rectal bleeding, and rectal pain, often accompanied by nonspecific abdominal discomfort.[15] The clinical presentation varies depending on the location and extent of disease involvement. In severe cases, mass formation can lead to significant luminal narrowing and result in intestinal obstruction, which occurs in approximately 0.1%–0.7% of cases. Additionally, intestinal endometriosis may lead to serious complications such as gastrointestinal bleeding and bowel perforation.[16,17] Several studies have reported that colonic endometriosis, although rare, can cause acute mechanical intestinal obstruction requiring emergency surgical intervention.[18]

In our study, nine patients (75%) underwent surgery for acute mechanical intestinal obstruction, with lesion localization in the ileocecal region (three cases), ileum (two cases), rectosigmoid region (three cases), and rectum (one case). All patients also had a history of live births. Unlike previous studies, our research provides a focused analysis of surgically managed cases of intestinal endometriosis complicated by obstruction, offering valuable insight into the necessity and timing of surgical intervention.

Appendiceal endometriosis is reported in 0.4% of the general population and in 2.8% of patients diagnosed with endometriosis.[19] It may present as chronic pelvic pain or mimic acute appendicitis. To date, all studies examining appendiceal endometriosis in patients undergoing surgery for suspected acute appendicitis have been retrospective. In a 2023 international literature review by Allahqoli et al.,[20] the prevalence of appendiceal endometriosis among patients operated on for suspected acute appendicitis was found to be 1.7%.[21] These findings highlight that, while rare, appendiceal endometriosis is an important differential diagnosis of acute appendicitis.

In our clinic, endometriosis was identified in three (0.32%) of 1,240 appendectomy cases performed between 2016 and 2023. Among the 12 patients included in our study, three (25%) presented with symptoms of acute appendicitis, and postoperative pathology confirmed full-thickness endometriosis involving the serosa to the mucosa. Notably, none of these patients had a history of chronic pelvic pain, menstrual irregularities, or infertility (symptoms commonly associated with appendiceal endometriosis). No additional endometriotic lesions were identified in the gastrointestinal tract during surgical exploration. These findings suggest that appendiceal endometriosis can present acutely, even in patients without a typical history of endometriosis, reinforcing the importance of including this condition in the differential diagnosis of acute appendicitis.

Surgical resection is the standard treatment for intestinal endometriosis complicated by obstruction. In a 2023 review by Mușat et al.,[22] which included 107 patients who underwent surgery for intestinal obstruction due to endometriosis, the most commonly affected sites were the ileum (38.3%), rectosigmoid region (34.5%), ileocecal junction and appendix (14.9%), and rectum (10.2%). In selected cases of acute intestinal obstruction, colonoscopic stenting and balloon dilatation have been attempted as bridges to surgery. However, these approaches carry a risk of perforation or the need for urgent surgical intervention in the short term.

In our study, all patients underwent emergency surgery, and resection with anastomosis was performed in those with obstruction. However, segmental intestinal resection was not performed in every case; surgical management was individualized based on intraoperative findings. Most cases of gastrointestinal endometriosis presenting with ileus have been documented through case reports and retrospective analyses. Therefore, large-scale case series or multicenter studies are essential to improve understanding of disease patterns and to establish standardized treatment protocols.

Ethical Consideration

This study was conducted in accordance with the principles of the Declaration of Helsinki. Ethical approval was obtained from the Ethics Committees of İstanbul University-Cerrahpaşa, Cerrahpaşa Medical Faculty (Approval Number: 2024/1184324).

CONCLUSION

Preoperative diagnosis of intestinal endometriosis is difficult due to its nonspecific clinical presentation. Therefore, in women of reproductive age presenting with acute abdomen or intestinal obstruction, intestinal endometriosis should be considered in the differential diagnosis. Surgical intervention is recommended in cases involving stricture, obstruction, or perforation.

Our study highlights the importance of a multidisciplinary approach in managing intestinal endometriosis. For patients with a prior diagnosis of endometriosis, pre- and postoperative consultations were conducted with the Department of Gynecology and Obstetrics. In cases without a preoperative diagnosis, a multidisciplinary evaluation was carried out following pathological confirmation. This underscores the necessity of collaborative management between general surgeons and gynecologists to optimize treatment strategies and follow-up care.

Future studies involving larger patient cohorts are needed to establish standardized treatment guidelines and improve patient outcomes.

Ethics Committee Approval: This study was approved by the İstanbul University Cerrahpaşa-Cerahpaşa Medical Faculty of Medicine Ethics Committee (Date: 04.12.2024, Decision No: 2024/1184324).

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ORİJİNAL ÇALIŞMA - *ÖZ*

Bağırsak endometriozisi: Acil cerrahinin nadir bir nedeni

AMAÇ: İntestinal endometriozis genellikle karın ağrısı, kabızlık, ishal gibi gastrointestinal sistem yakınmalarına sebep olabilen nadir görülen bir hastalıktır. İntestinal endometriozis endometriozisli kadınlarda ortalama %5-15'inde görülebilmektedir. İntestinal endometriozis çok nadir olarak obstrüksiyon ve perforasyona neden olabilmektedir. Endometriozisin tedavisinde öncelikli olarak hormonal tedavi tercih edilmekte iken intestinal endometriozisin tedavi sürecinin yönetiminde kesinleşmiş bir fikir birliği bulunmamaktadır. Bu yazıda, akut karın nedeniyle ameliyat edilen intestinal endometriozisli hastaların tedavi süreci değerlendirildi.

GEREÇ VE YÖNTEM: İstanbul Üniversitesi-Cerrahpaşa, Cerrahpaşa Tıp Fakültesi Üniversitesi, Acil Genel Cerrahi kliniğinde şubat 2016-Nisan 2023 yılları arasında akut karın tanısı ile acil cerrahi yapılan intestinal endometriozisili 16 hasta saptandı, 4 hasta kendi isteğiyle çalışmadan ayrıldı. 12 hasta çalışmaya alındı. Hastaların demografik verileri, laboratuvar değerleri, ameliyat notları, hastanede kalış süreleri, patoloji raporları, ameliyattan sonrasındaki ilk 30 gün içinde ameliyata bağlı komplikasyonlar ve bu komplikasyonların yönetimi incelendi. Hastaların son durumları hakkında telefon görüşmeleriyle bilgi alındı.

BULGULAR: Hastaların yaş ortalaması 39.3±9.2 idi. Hastalardan 9'u intestinal obstrüksiyon ön tanısıyla, 3'ü ise akut apandisit ön tanısıyla ameliyata alındı. İntestinal obstrüksiyon nedeniyle ameliyat edilen hastaların 3'üne laparoskopik ileoçekal rezeksiyon, 3'üne segmenter ince bağırsak rezeksiyonu, birine anterior rezeksiyon ve appendektomi, birine anterior rezeksiyonla beraber ileoçekal rezeksiyon ve ileokolostomi açılması, bir hastaya sol hemikolektomi yapıldı. Ortalama hastanede kalış süresi 7.9±5.9 gündü. Hastaların 3'ünde (%25) komplikasyon görüldü. Komplikasyon olan grupta hastaların yaşı komplikasyon olmayan gruptan anlamlı ($p<0.007$) olarak daha yüksekti. Patoloji tüm hastalarda iyi huylu ve tam kat endometriozis tutulumu olarak saptandı. Ortalama takip süresi 50.6 ay olup takip sırasında nüks gözlenmedi.

SONUÇ: İntestinal endometrozisin obstrüksiyonla akut karın nedeni olması oldukça nadir görülen bir klinik tablodur. Akut karın tanısı olan üreme çağındaki kadınlarda intestinal endometriozis akılda tutulmalıdır. Klinik şüphe halinde ameliyata bir kadın doğum doktorunun davet edilerek hastanın değerlendirilmeli ve multidispliner yaklaşımla tedavi yönetimi planlanmalıdır.

Anahtar sözcükler: Akut karın; tanı; acil cerrahi; bağırsak endometriozisi; tedavi yaklaşımı.

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