Deep infiltrating rectosigmoid endometriosis. Diagnostic keys

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CASE REPORT

A 36 year-old woman was admitted with dysmenorrhea associated with rectal bleeding. The colonoscopy showed a stenosis at the rectosigmoid (RS) junction which did not exceed the endoscope. A barium enema (Figs. 1 A and B) showed traction of the sigmoid mucosa at the lower margin of the RS junction. CT examination (Figs. 1 C and D) showed an endometrial implant in the Douglas pouch, the pedicle connected to the colon wall and the “mushroom cap” configuration of the endometrial implant in the RS wall, all with a density similar to that of muscle tissue. A sigmoidectomy was performed (Fig. 2) with histological (Fig. 3) and immunohistochemical analysis, which demonstrated deep infiltrating rectosigmoid endometriosis (DIRSE) as the resulting diagnosis.

DISCUSSION

Endometriosis is defined as the presence of functioning ectopic endometrial tissue (endometrial glands and stroma) outside the uterus and at a distance from and unconnected with uterine endometrial tissue. The ectopic endometrium is sensitive to hormonal variation during the menstrual cycle. These results in chronic inflammation that is the cause of cyclic pelvic pain found in these patients. In the DIRSE, the ectopic tissue would respond to the ovarian hormonal cycles causing inflammation, bleeding, fibrosis and metaplasia or hyperplasia of the smooth intestinal muscle possibly affecting the serosa, submucosa and rarely the mucosa, which gives rise to a thickening of the intestinal wall and in some cases may evolve
into an obstruction (1-3). The “mushroom cap” sign has been described in the presumed diagnosis because the tumor grows towards the RS colonic lumen (4). The differential diagnosis is reached from the neoplastic processes seen in this area.

REFERENCES