

Letters to the Editor

Rectal bleeding in a young woman

Key words: Rectal endometriosis. Gastrointestinal hemorrhage.

Dear Editor,

We report the case of a 37-year-old female with a 6 month-history of intermittent painless rectal bleeding. During the last three weeks she also complained about abdominal pain. Neither changes in bowel habits nor weight loss were referred, but rectal bleeding episodes coincided with menses.

In the medical history, she had penicillin allergy, anal fissure, endometrial polypectomy four years ago and one pregnancy to term. No significant family history was reported.

Physical examination revealed a healthy-looking adult woman; the abdomen was soft, depressible, slightly distended and painful to palpation in both iliac fossae without guarding or rebound tenderness. Digital and anoscopy anal examination was normal.

Laboratory investigations were within normal limits. Colonoscopy disclosed a 2 cm sessile polypoid mass with a wide base located at 10 cm from the anal verge (Fig. 1). Considering the possibility of malignant tumor, a large number of biopsies were performed. A complete colonoscopy was not conducted due to poor tolerance of the patient.

Computed tomography (CT) colonography revealed an anterior rectum mass that extended to right Houston's valve. The lesion had a wide base and was separated from the uterine wall and the left adnexa through a fat layer. There was no evidence

of densitometric alterations of the perirectal fat, locoregional lymph nodes or synchronous lesions in other parts of the colonic frame.

Microscopic pathology ruled out epithelial dysplasia and malignant cells, and exposed rectal mucosa fragments with disruption of the architecture of the mucosa and partial depletion of mucus and colonic crypts, as well as lymphoplasmacytic infiltration spread to lamina propria.

Given the suspected diagnosis of rectal endometriosis, new biopsies and a magnetic resonance imaging (MRI) were performed. There were no new findings with MRI. Immunohistochemical analysis for CD10 (normal endometrial stromal cells marker) and estrogen receptor in new biopsies were both positive demonstrating rectal endometriosis.

Patient is sent to gynecology for treatment and follow up.

Discussion

Rectal endometriosis symptoms are usually nonspecific: abdominal or pelvic pain, constipation, tenesmus, and more rarely, intestinal obstruction or rectal bleeding. Therefore, rectal endometriosis should be considered in the differential diagnosis of rectal submucosal masses in women of childbearing age, especially if gynecological symptoms or infertility history are referred. It is also important to emphasize the difficulties performing colonoscopy in these scenarios due to adhesions resulting of colonic wall and peritoneum involvement.

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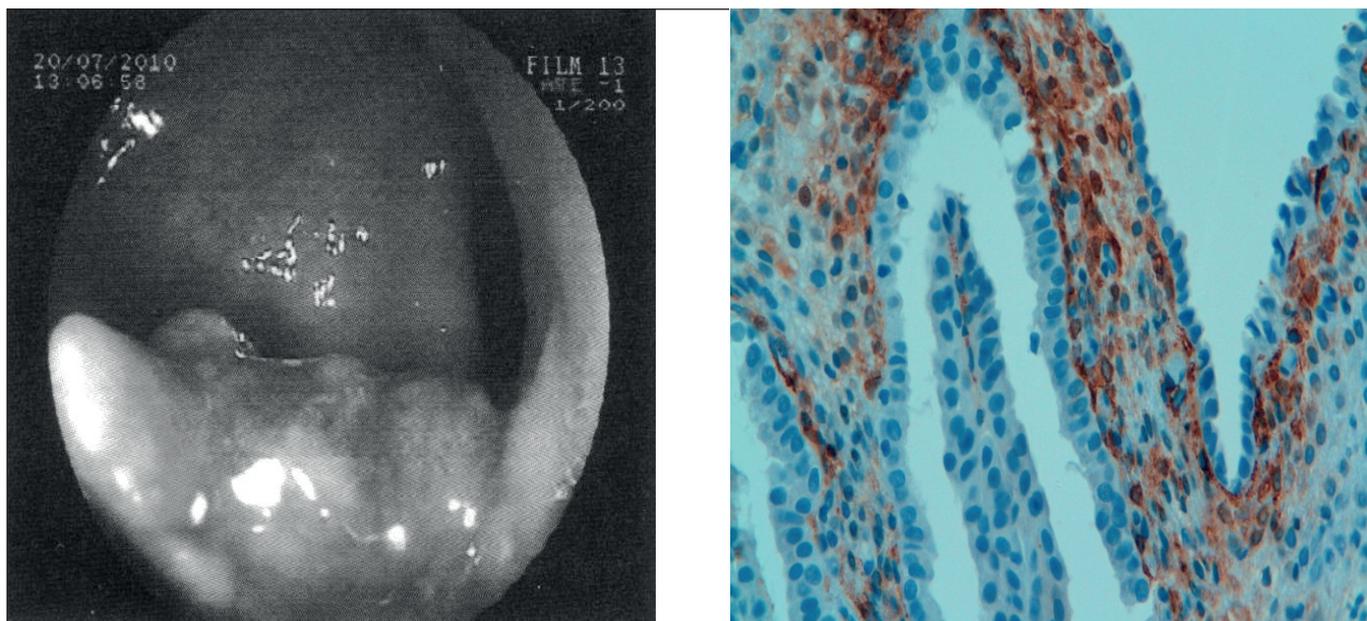


Fig. 1. Correlation between macroscopic image and biopsies (CD 10 receptors).

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