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Intestinal endometriosis without evident pelvic foci treated with gonadotropin-releasing hormone agonist

Dear Editors,

Intestinal endometriosis is not rare; its prevalence varies from 5.3 to 12% of all cases of endometriosis [1]. Gastrointestinal implants are either asymptomatic, or may provoke cyclic or non-cyclic symptoms, such as diarrhoea, constipation, rectal bleeding, dyschezia, abdominal distension, and bowel obstruction. Differential diagnosis includes intestinal carcinoma, metastatic implant, diverticulitis, inflammatory bowel disease and benign polyps.

Intestinal endometriosis generally involves the wall starting from serosal layer and it is associated with pelvic endometriosis. We describe a case of intestinal endometriosis presented as a polypoid lesion, without apparent pelvic foci treated with gonadotropin-releasing hormone analogue (GnRHa). A 42-year-old woman, gravida 3, para 2, complaining of abdominal and pelvic pain, episodic intermenstrual and rectal bleeding, and anemia was referred to the Department of Gastroenterology of our Hospital.

Six months before the patient underwent a colonoscopy, resulting in a polyp in the sigmoid colon, which was snared. Histology revealed endometriosis. Because of recurrence of symptoms, a total colonoscopy was performed, showing the presence of a large multilobate polyp in the sigma, surrounded by a hyperaemic mucosa (Fig. 1). Histology of biopsies revealed endometriotic foci.

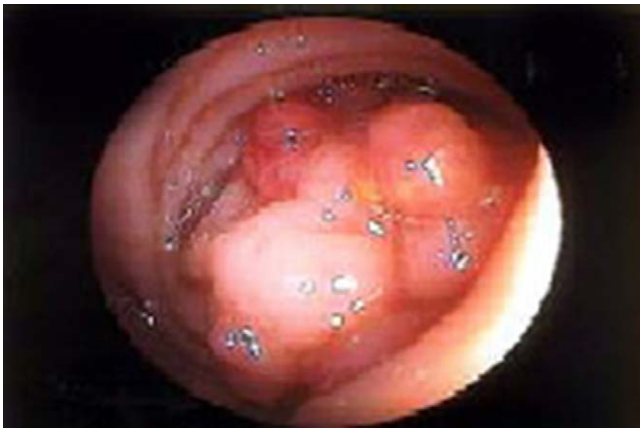

Fig. 1. Colonoscopy: presence of multilobate polyp in the sigmoid colon.

The patient refused surgical resection of the lesion and was referred to our Gynecological Department. Her medical history included uterine myomectomy. Gynecological examination revealed a normal cervix, a mobile anteverted enlarged uterus, and the absence of adnexal masses, confirmed by vaginal ultrasounds. Ca 125 level was normal.

Magnetic resonance imaging (MRI) showed a 1.8 cm area in the sigmoid wall suggestive of endometriosis. The woman refused to undergo diagnostic laparoscopy.

The patient received leuprolide acetate depot 3.75 mg i.m. every 4 weeks for 3 months. Symptoms promptly disappeared after the first injection.

Oral contraceptives were subsequently prescribed, but immediately interrupted because of the occurrence of severe migraine.

After 6 months, colonoscopy showed a flat pale lesion. Histology confirmed the absence of endometriosis. No recurrences were found at colonoscopy, performed every year for 2 years.

Three years later, she underwent hysterectomy with left ovariectomy for severe menorrhagia caused by fibromatosis. Surgical and histological evaluation did not reveal endometriosis in the pelvic organs and on the intestinal serosa. Colonoscopy with biopsy showed a small asymptomatic endometriotic polyp in the sigma which disappeared after treatment with leuprolide acetate depot 3.75 mg for 3 months. It is difficult to assess whether it was a recurrence or a new endometriotic implant.

Since bowel endometriosis generally begins as a serosal implant, mucosal involvement is rare. In our case endometriosis took the form of an endoluminal polyp; a condition only described by few former studies [2,3]. Endometriotic polyps can mimic an intestinal polypoid carcinoma, potentially resulting in inappropriate treatment.

Several hypotheses have been advanced to explain intestinal endometriosis (embryonic, metaplastic and migratory). Our case is compatible with coelomic metaplasia or lymphatic or vascular dissemination [4].

In up to 80% of cases of bowel endometriosis, genital endometriosis is also present. Few cases of isolated intestinal endometriosis have been reported [5]. Nevertheless, in our patient, the presence of pelvic lesions before

the medical treatment or of sub-peritoneal implants cannot be ruled out.

Treatment options include surgery or hormonal therapy. In case of symptomatic advanced endometriosis, the treatment of choice is surgical resection.

In the present case, GnRH agonist treatment was effective on the lesion and related symptoms. At the best of our knowledge this is the first case of intestinal endometriosis treated only with this therapy.

In conclusion, isolated intestinal endometriosis showing up as a colonic polyp rarely occurs. It can be difficult to diagnose and treat. In selected cases medical therapy can be a valid therapeutic option.

References

[1] Del Cimmuto P, Schietroma M, Capanna A, et al. L'endometriosi digestiva: su un caso a localizzazione ileale, isolata ad evoluzione occlusiva. Minerva Chir 1996;51:701–5.
[2] Yantiss RK, Clement PB, Young RH. Endometriosis of the intestinal tract. A study of 44 cases of a disease that may cause diverse challenges in clinical and pathologic evaluation. Am J Surg Pathol 2001;25(4): 445–54.
[3] Jones KD, Owen E, Berresford A, Sutton C. Endometrial adenocarcinoma arising from endometriosis of the rectosigmoid colon. Gynecol Oncol 2002;86:220–2.
[4] Dimoulios P, Koutroubakis IE, Tzardi M, Antonion P, Matalliotakis IM, Kouroumalis EA. A case of sigmoid endometriosis difficult to differenziate from colon cancer. BMC Gastroenterol 2003; 3:18.
[5] Croce P, De Giorgi O, Votta P, Zangrandi A, Semeraro G. Endometriosi dell'ileo e del colon complicata da occlusione intestinale. Due casi clinici. Minerva Ginecol 1999;51:189–92.

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Mistakes prevent mistakes: Experience from intraoperative consultation with frozen section

Dear Editors,

We routinely review our frozen section diagnoses of gynecological specimens annually to evaluate the factors that lead to inaccurate or false interpretations. During the year of 2002, 1418 operations took place in the Gynecology Department of Hacettepe University Faculty of Medicine. One hundred and seventy-four (12.3%) of these were sent to the Pathology Department for intraoperative evaluation. In 163 of the cases (93.7%), the frozen section diagnosis was compatible with the final diagnosis, an accuracy rate in accordance with the literature [1–3]. There were no false positive or overestimated frozen section diagnoses. Seven of the cases (4%) could not be interpreted during the operation and the diagnosis deferred, usually due to technical limitations. In four of the cases (2.3%), the frozen section diagnosis was incompatible with the final diagnosis. This is the group of concern which we wanted to discuss, so that others can also learn from our mistakes.

The first case was an interpretation error. The tumor was an indifferentiated carcinoma and because of the frozen artifacts and well circumscribed shape of the nodule, was misinterpretated as a lymph node. The second case was of an endometrial adenocarcinoma, where initially a curettage specimen was sent for intraoperative consultation, which we regrettably were reluctant to evaluate for fear of losing diagnostic material during frozen sectioning. The microscopic examination was done just for one section taken from the uterus, which showed a proliferative endometrium. The superficially invasive focus of endometrial adenocarcinoma was missed due to sampling error, because of the previous curetage, in the hysterectomy specimen that followed. This case emphasizes the importance of an intact specimen.

The other case was an ovarian clear cell carcinoma. The cut surface of the ovary revealed a unilocular cyst with soft creamy tan colored material in the center, which macroscopically resembled pus. This material had no connections with the cyst wall and was sampled together with a sample from of the cyst wall. The pus-like material was difficult to cut and only fibrinoid material and acute inflammatory exudation was seen in the frozen section slides. The frozen section slides of the sample from the cyst wall demonstrated areas of endometriosis; however, a focal area lined by somewhat more clear to foamy appearing cells attracted attention which we interpreted as histiocytes (Fig. 1a). Permanent sections of the pus-like material however revealed areas of clear cell carcinoma in between the fibrinoid material, which had probably fallen off during preparation of the frozen section slides and the focus which we had interpreted as a lining of histiocytes turned out to be a focus of clear cell carcinoma (Fig. 1b).

The fourth case was a 21-year-old girl with a cystically enlarged right ovary. Her AFP level was 20.2 ng/ml. The cut