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Case Report
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Complications of Endometriosis – Case Report of Fistula Recurrence Postoperative Rectovaginal

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Abstract

Endometriosis is a disease with a poorly known etiology, characterized by the presence of dysfunctional endometrial tissue, which evolves to chronic inflammatory reactions in women of reproductive age, causing a great impact on the quality of life of this population, often leading women of reproductive age to infertility. This project aims to describe the impact of endometriosis on women's health, as well as the complications it can cause. The information was obtained from interviews and access to the patient's medical records, analyzing diagnosis, surgical procedures and complications. However, it is hoped to deepen the existing knowledge about Endometriosis, emphasizing the importance of correct and early diagnosis of this disease and the risks of complications related to diagnosis, surgery and rehabilitation.

Keywords: Endometriosis, Laparoscopy, Colostomy, Rectovaginal fistula

Introduction

Endometriosis is considered a clinical condition that is difficult to diagnose, but recurrent in the female population. Known since the seventeenth century, it was first described by Von Rokitansky in 1860 and a new view emerged with Sampson in 1927, who suggested menstrual flow as a facilitator for endometrial tissue to implant in the peritoneal cavity [1]. It is a gynecological disease characterized by the growth of endometrial tissue outside the uterine cavity, almost exclusively diagnosed in patients of reproductive age in organs such as ovaries, posterior and anterior cul-de-sac, posterior leaflet of the broad ligament, uterosacral ligaments, uterus, fallopian tubes, sigmoid colon, appendix, and round ligaments2. More than 60 years have passed for the approach to the disease to change, thus establishing the concept of lesion infiltration, determining that retrograde menstruation causes the deep infiltrative form of endometriosis in the cavity [2, 3].

As it progresses, the clinical presentation of endometriosis as signs and symptoms varies considerably, as it does not present pathognomonic clinical features, which makes it difficult to suspect and correctly diagnose [1]. Physical examination and clinical history are of little help in concluding the diagnosis, depending on the stage of the disease, thus requiring the use of technological densities such as imaging tests, especially transvaginal and pelvic ultrasound and magnetic resonance imaging [1, 2].

Goal

This is a case report of a patient with deep endometriosis who underwent surgical procedures with complications and is still in the process of rehabilitation due to sequelae.

Methods

The information contained in this clinical case description was obtained through a review of medical records, patient reports, images of diagnostic tests, and literature review.

Case Report

Patient M.S.O.C., 33 years old, sought outpatient health service as a beneficiary of health insurance, on an elective basis on August 17, 2021 at Hospital Ministro Costa Cavalcanti in the city of Foz de Iguaçu-PR, for consultation with a gynecologist. Previously, she had already had oophorectomy on the left due to ectopic pregnancy in 2015, in the consultation the following symptoms were reported, dysmenorrhea in the first three days and urinary urgency and infertility, on specular examination blackish nodules in the bottom of the sac, on touch retroverted uterus, totally fixed, Petro cervical retro cervical nodule with apparent invasion of the vagina, complementary magnetic resonance imaging exam requested.

She returned on September 15, 2021 where she was diagnosed with complex endometriosis of the posterior and left lateral compartment, endometriosis of the lower rectum, sigmoid, appendix, vagina, rectovaginal septum, adenomyosis, fibroid, left hematosalpinx, and left hypogastric plexus involvement. She underwent elective surgery on November 4, 2021 at the same hospital, where rectosigmoidectomy, right colectomy, hypogastric plexus nodule resection, bilateral parametrectomy, adenomyomectomy, colpectomy, appendectomy and enterectomy, rectovaginal septum tumor resection, uterosacral lesions, round ligaments, bladder peritoneum and ovarian fossa, left salpingectomy and vaginal nodule were performed, , a nodule in the ileocecal valve was identified during the intraoperative period and removed due to the risk of obstruction, and a nodule of endometriosis in the left lower hypogastric plexus. On the 5th postoperative day (PO) of endometriosis, the patient presented vomiting, abdominal distension, dehydration and paralytic ileus. On 11/10/2021, a surgical reapproach of Laparostomy with colostomy due to rectovaginal fistula was performed, presenting vaginal bleeding three days later, requiring transfusion of blood products. On the 5th postoperative day of Laparostomy with colostomy, she presented bilateral pleural effusion and was referred to the Intensive Care Unit, received intensive support for 4 days and returned to the clinic. On the 11th postoperative day of Laparostomy with colostomy, the patient presented profuse vaginal bleeding and underwent a new approach of laparotomy and colporrhaphy, and the bleeding persisted in the postoperative period, which was evaluated by the vascular surgeon, who opted for embolization of the right internal iliac branch, after 4 days he was discharged. Hyperbaric treatment was indicated for fistula closure, and in the

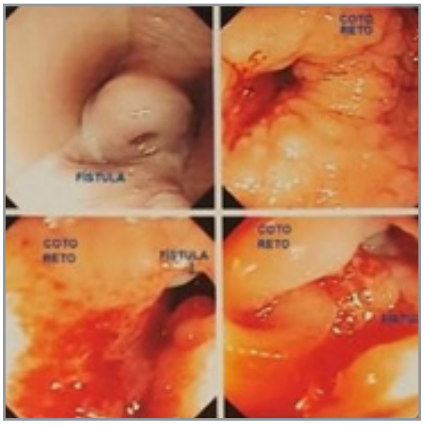

Figure 1: Source: Patient's Private Examinations

5th session there was barotrauma in the right ear, which contraindicated the continuation of the treatment. The patient underwent medical follow-up for one year and two months by means of colonoscopy (Figure 1).

A new medical evaluation was carried out and the re-approach was scheduled for January 30, 2023. A new surgical approach was performed, with partial colectomy with colostomy, lowering surgery, posterior access surgery, enterorrhaphy and removal of adhesions from previous surgery. Medical discharge on the 3rd postoperative day, with collection of subsequent tests (D4 and D7). On the 14th postoperative day, already at home, she presented vaginal and rectal hemorrhage, and was taken to the primary care unit in her hometown, where she had to be referred to the referral hospital in the neighboring city. She was evaluated in the emergency room and requested a vacancy for another hospital that had a higher technological density, during the care she presented severe hypotension and the use of noradrenaline was necessary. The patient was referred from SAMU to another hospital, submitted to computed tomography, red blood cell concentrate was administered and evaluated by surgery and gynecology, where the presence of a new rectovaginal fistula was diagnosed. Patient continues to maintain colostomy (transvers

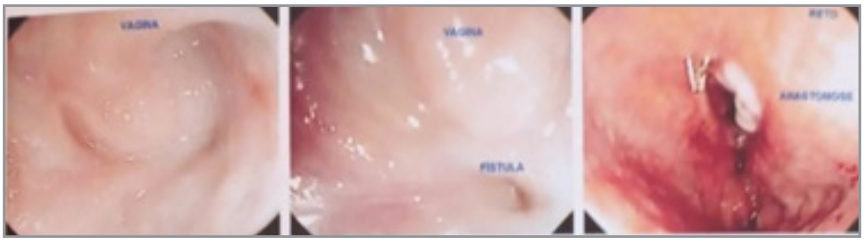

Figure 2: Source: Patient's Private Examinations

ostomy) and fistula rectovaginal infection, which was identified as rectal anastomotic stenosis at the control colonoscopy (Figure 2).

Case Discussion

Rectovaginal fistulas are abnormal communications between the lower gastrointestinal tract and the vagina, they are considered great challenges for colorectal surgeons, as they depend on their complexity, and can be determined by the location, etiology and quality of the surrounding tissues. They are most often caused by obstetric trauma, gynecological surgeries, traumas, inflammatory diseases, among others. Small- diameter, distal fistulas in the rectovaginal septum secondary to traumatic injury or infection are considered simple. Those with a larger diameter, closer to the rectovaginal septum, and associated with underlying inflammatory bowel disease, radiation, neoplasia, or insufficient anterior repairs are considered more complex. There are several well-described surgical approaches that can be divided into trans anal, trans vaginal, trans perineal, and trans abdominal repairs. The type of procedure will depend on the quality of the surrounding tissues, the location, and the etiology of the fistula. In the last decade there has been a growing use of bioprostheses in the form of plugs and gloves in the treatment of fistulas. A small number of cases have shown promising results, but there is still a paucity of long-term data. Therefore, we can verify the difficulty in the management of rectovaginal fistulas, treatment success, and latent risk of recurrence [4-6].

Conclusion

The present work aims to contribute to a deeper knowledge about endometriosis and its complications, since it is a topic of enormous relevance today, with the objective of motivating new health professionals and researchers to delve deeper into the pathology and its sequelae, encouraging them to produce new studies and demonstrate the impact of endometriosis on the quality of life of patients. For this, it is necessary to recognize the importance of early diagnosis and treatment of the disease, in order to avoid possible complications such as the one described in this case report, which directly influences the woman's infertility and fertilization rate, and the development of public policies aimed at the prevention and/or early detection of endometriosis is essential.

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