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Case report
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Colic Endometriosis or Colorectal Cancer? : A Case Report

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Abstract

Endometriosis is characterized by the presence of endometrial glands and stroma in extra-uterine locations, primarily within the pelvic cavity. Endometrial lesions affecting the rectovaginal space and/or intestines are classified as deep infiltrative endometriosis. We describe and discuss a clinical case of a 49-year-old female with a family history of early-onset colorectal cancer, presented in June 2024 at the Health Centre (USF Costa do Estoril) with a recent colonoscopy for screening for colorectal cancer. The colonoscopy revealed a 15 mm ovoid protrusion in the cecal fundus, involving the appendiceal orifice, requiring further imaging. A sessile 8mm polyp in the sigmoid was also excised, diagnosed as a tubular adenoma with low-grade dysplasia. An abdominal-pelvic CT scan a month later, revealed irregular thickening of the cecal wall near the ileocecal valve with possible pericolic fat infiltration. She was urgently referred to the Portuguese Institute of Oncology (IPO). In September 2024, at IPO, she was proposed for right hemicolectomy and the pathological examination of the surgical piece revealed a colic endometriosis nodule. This case highlights the need to differentiate colic endometriosis from colorectal cancer, especially in young women.

Keywords: Colic Endometriosis, Colorectal Cancer, Diagnosis.

Introduction

Endometriosis is characterized by the presence of endometrial glands and stroma in extra-uterine locations, primarily within the pelvic cavity. Endometrial lesions affecting the rectovaginal space and/or intestines are classified as deep infiltrative endometriosis, which involves invasion at least to the level of the intestinal muscularis. It may also affect sites such as the diaphragm and pleural cavity. According to the most recent literature - among women with endometriosis, the reported prevalence of rectovaginal or bowel involvement ranges widely, from 5 to 25 percent. Also, in case series of 100 or more women who underwent surgical treatment of endometriosis of the bowel, the distribution of both peritoneal or deep bowel lesions sites was rectum (13 to 53 percent), sigmoid colon (18 to 47 to percent), ileum or other small bowel (2 to 5 percent) and appendix (3 to 18 percent) [1]. Although rare, colic endometriosis, especially at the rectosigmoid level, can present with changes in bowel habits, abdominal pain, weight loss, and blood in the stool, symptoms often associated with malignancy. Sometimes, it can even be asymptomatic. Given the clinical and imaging similarities between these conditions, it is crucial to include colic endometriosis in the differential diagnosis, particularly in women of reproductive age, as highlighted in this clinical case. Failure to achieve an accurate and timely diagnosis may result in unnecessary invasive procedures, exposing patients to avoidable risks.

In this context, we report and discuss a clinical case of a 49-year-old asymptomatic woman which has been identified with a lesion suspicious for colorectal cancer. Further investigation and histopathological analysis revealed the lesion to be a focus of colic endometriosis — a rare and often misleading presentation.

Case Report

This case involves a 49-year-old woman, caucasian, which belonged to a reconstituted family and Duvall's phase IV. She had a medical history of dyslipidemia, hypertension, depressive syndrome, psoriasis under biological therapy, adenomyosis and probable pulmonary hamartoma (identified in 2020). Her usual medication was Rosuvastatin 5 mg + ezetimibe 10 mg; Perindopril 2 mg; Venlafaxine 75 mg; Trazodone 50 mg; Ustekinumab 45mg. She reported a family history of early-onset colorectal cancer, a 30-year-old cousin.

She presented in June 2024 at the Health Centre (USF Costa do

Estoril) with a recent colonoscopy for screening for colorectal cancer, showing a 15 mm ovoid protrusion in the cecal fundus, involving the appendiceal orifice, requiring further imaging – Figure 1 and figure 2. A sessile 8 mm polyp in the sigmoid was also excised, diagnosed as a tubular adenoma with low-grade dysplasia. Her blood tests showed: hemoglobin: 14, ferritin: 15.4, iron: 127 - iron deficiency without anaemia. The gynaecological ultrasound routinely requested, evidenced 10 mm posterior subserosal fundic myoma and mild adenomyosis.

An urgent abdominal-pelvic CT scan was required, which revealed "Irregular thickening of the parietal wall of the cecum near the ileocecal valve, extensive, appearing to extend beyond the limits of the colonic serosa, with possible infiltration of the pericolic fat and no cleavage plane with the last ileal loop". The Carcinoembryonic Antigen (CEA) was 1.7 ng/ml (low). At this time, the patient was urgently referred to the Portuguese Institute of Oncology (IPO) - General Surgery.

After assessment by General Surgery of IPO, the patient was proposed for right hemicolectomy in September 2024. The patient also performed a PET-scan, and the lung lesion previously known, was considered benign, due to absence of volumetric evolution and hyperuptake. Two weeks after the surgery, the histology of right hemicolectomy revealed a colic endometriosis nodule.

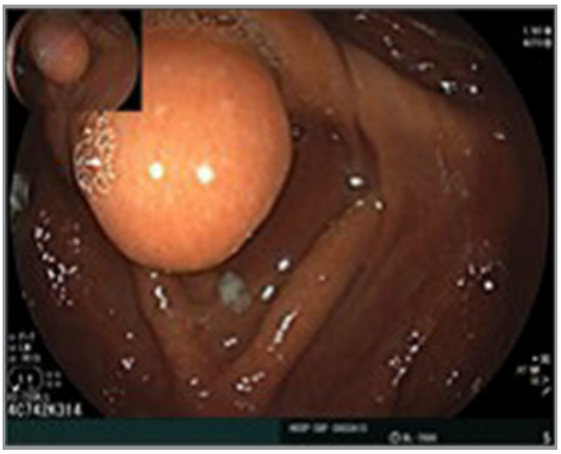

Figure 1: Ovoid protusion in the cecal fundus (colonoscopy images)

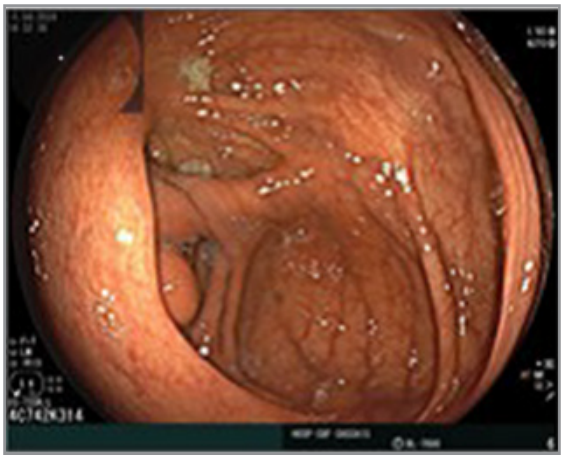

Figure 2: Ileocecal valve and ovoid protusion (colonoscopy images)

Discussion

This article presented the clinical case of a 49-year-old asymptomatic woman with a family history of early-onset colorectal cancer, who underwent a routine colorectal cancer screening colonoscopy in primary care. A lesion suspicious for colorectal cancer was identified, requiring further investigation. At Health Centre, an urgent abdominal-pelvic CT scan was required, which revealed later alterations highly suggestive of malignancy - irregular thickening of the cecal wall near the ileocecal valve, with possible pericolic fat infiltration. The patient was urgently referred to the Portuguese Institute of Oncology (IPO) and proposed for right hemicolectomy, which histopathological analysis revealed the lesion to be a focus of colic endometriosis — a rare and often misleading presentation that can closely mimic neoplastic processes on imaging and colonoscopy. The patient also performed a PET-scan, and the lung lesion previously known, was considered benign, due to absence of volumetric evolution and hyperuptake. We also wondered: whether this pulmonary nodule could be another focus on endometriosis? Currently, the patient remains under follow-up at the IPO by a multidisciplinary team for monitoring of the pulmonary nodule and decision regarding possible surgical intervention or an expectant approach, given her age and possible menopause in the short term.

Conclusions

This case report demonstrates an example of suspected colorectal cancer in a young female patient with a family history of colorectal cancer at an early age, which the pathological anatomy of the surgical piece revealed to be a focus of endometriosis colic. This case highlights the importance of understanding and

including intestinal endometriosis in the differential diagnosis of colic lesions, especially in young women (even if asymptomatic).

References

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