Gastrointestinal and Urinary Tract Endometriosis: A Review on the Commonest Locations of Extrapelvic Endometriosis

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Abstract

Introduction: Pelvic endometriosis usually refers to lesions proximal to the uterus such us the ovaries, the fallopian tubes, the uterine ligaments, and the surrounding pelvic peritoneum. Extrapelvic endometriosis on the other hand, is affecting other areas of the body, including the vagina, vulva, cervix and perineum, the urinary system, the gastrointestinal tract, the thoracic cavity including lung and pleura, extremities, skin, and central nervous system. Nevertheless, the term of extragenital pelvic endometriosis describes in a more accurate way endometriotic lesions involving pelvic organs such as rectum, sigmoid, and bladder. Diagnosis and treatment of extrapelvic endometriosis is complex due to the variety of affected sites, the lack of accurate diagnostic methods, and the management of the disease by different specialties. Epidemiology. Extrapelvic endometriosis is a fairly rare phenomenon. The exact prevalence is basically unknown due to the small number of well-designed epidemiological studies. The incidence of the disease depends on the population studied, methods used to make the diagnosis, and the expertise of the surgeon. Data derive mostly from case series and case reports that describe endometriotic lesions in virtually every part of the female body and in some cases in the male body. There are no reports however of endometriotic disease in the heart or spleen. In general endometriosis affects 5–10% of women of child-bearing age, but only a small proportion of these women are diagnosed as having the extrapelvic type of the disease. Extrapelvic endometriosis is generally diagnosed in a slightly older population than pelvic endometriosis. The median age at time of diagnosis is 34–40 years, whereas pelvic endometriosis is commonly diagnosed a decade earlier. The frequency of the disease decreases while the distance to the uterus increases

Background: The gastrointestinal tract is the most common location of extrapelvic endometriosis (and extragenital pelvic endometriosis when referring to rectum, sigmoid, and bladder). Gastrointestinal involvement is reported in up to 3.8–37% of women diagnosed with endometriosis. Adolescent women, women of reproductive age, as well as menopausal women may be affected. The sigmoid colon is most commonly involved, followed by the rectum, ileum, appendix, and caecum. The rectum and the sigmoid are the most common locations in 95% of the patients. Appendiceal endometriosis is found in 5 to 20% of patients. Small intestine lesions mostly involve the terminal ileum and account for up to 5–16% of gastrointestinal endometriosis cases. Extremely rare locations that have been reported include the gallbladder, the Meckel diverticulum, stomach, and endometriotic cysts of the pancreas and liver. Twenty-one cases of cystic liver masses were diagnosed as hepatic endometriomas

Method:- The second most common site of extrapelvic endometriosis involves the urinary system. Endometriosis has been estimated to affect the urinary tract in approximately 0.3 to 12% of cases. Bladder and ureteral involvement are the most common sites, with the former representing 80–90% and the latter concerning up to 50% of cases with deep infiltrating endometriosis and 92% of colorectal endometriosis. Renal and urethral endometriosis are extremely rare entities, with an incidence of 4% and 14%, respectively. Women with urinary tract endometriosis are usually on their 30's or 40's and half of them have had prior pelvic surgery. There are several reports of vesical endometriosis arising after a caesarean section. Estrogen replacement therapy has been implicated in increasing the likelihood of developing urinary tract endometriosis even in women with no prior history of endometriosis

Results: Extrapelvic endometriosis is a rare phenomenon. Most cases of extrapelvic endometriosis are presented to specialties other than gynaecologists. Areas that are close to the uterus are more likely affected by the disease (e.g., bladder and colon) than more distant locations. Both gastrointestinal and urinary tract endometriosis diagnosis is often delayed due to the atypical and nonspecific symptoms. There is a wide spectrum of imaging findings depending on lesion location, morphology, and organ involvement. Diagnosis requires a high degree of suspicion while no accurate diagnostic modality exists that would justify widespread use. Medical history of recurrent symptoms related to the menstrual cycle and imaging abnormalities suggesting the presence of chronic blood products should help in making a correct diagnosis. Histology remains the cornerstone of diagnosis. Surgical treatment is preferable in most cases since all the known medical regimens provide short-term symptomatic relief. Advances in surgical techniques allow a more definite treatment of the disease, although the systematic nature of endometriosis warrants the need for adjunctive treatment in selected cases where radical surgery is not an option.

Extended Abstract

Biography: Dimitra Charatsi is working in Department of Obstetrics and Gynecology, University Hospital of Larissa, essaly, Larissa, Greece

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