

Bowel Endometriosis (colorectal endometriosis)

Summary

Endometriosis affecting the bowel (colon and rectum) is uncommon but becoming more frequently diagnosed as ultrasound technology improves. The exact incidence is unclear, and this may be due to lack of awareness or possibly “missed diagnosis” at laparoscopy.

Many patients are mistakenly diagnosed as having “irritable bowel syndrome” as basic testing frequently misses bowel endometriosis. Many women have a long history of back pain and have seen various doctors and physiotherapists seeking a diagnosis.

Surgical treatment of bowel endometriosis is eminently possible with the requisite skills and experience, and it is extremely infrequent in my practice to need a temporary ileostomy.

If have been told that you have “adhesions” or endometriosis affecting the bowel and that this cannot be managed surgically, please see me to discuss your options.

What is endometriosis?

Endometriosis is defined as “the presence of endometrial glands and stroma outside the uterine cavity”. It affects 10-15 % of women, or 40-50% of those having trouble conceiving.

Bowel endometriosis (BE) is found in 5-15% of women with endometriosis and represents a different type of disease to that found on the ovaries and other surfaces of the pelvis and abdomen. About 30% of women with ovarian endometriosis may have BE.

Diagnosis

The best test remains laparoscopy, but now ultrasound and MRI can be used to give an indication of the existence and extent of BE.

BE can be divided into two categories

1. Disease between the rectum and vagina (recto-vaginal endo)
2. Disease in the higher parts of the bowel, that is above the sigmoid colon, or appendix.

Symptoms

BE should be suspected in any woman with bowel symptoms (constipation, difficulty using bowels, bloating, lower back pain), pain with using bowels, blood from bowels especially with periods) AND any of the classic symptoms of endometriosis which are painful periods, infertility and pain with sex (dyspareunia).

Disease can be either superficial (involving the peritoneum or coverings of the bowel only) or deeply infiltrating where the endo invades at least to the muscle layer of the bowel.

The impact on purely midline (in the rectum or recto vaginal space) BE upon fertility is controversial. Most women will probably also have endometriosis elsewhere, and this is more important.

Risk of malignancy (cancer)

In one study of 83 cases of bowel resection for endometriosis, 8% had an underlying malignancy. This high percentage has not been repeated in other series and at this time extra testing for cancer in women with BE is not considered mainstream.

Treatment

After appropriate investigation, some women may not choose to pursue surgical treatment. This may apply to women with minimal symptoms, those over 35 with low chance of disease progression, and those having already completed their family. A colonoscopy is recommended to exclude other problems.

These women may either choose to continue with pain relief or hormonal suppression of the disease. This may include the combined oral contraceptive pill (COCP, NOT the progesterone only pill or minipill), letrozole, GnRH agonists (Synarel) or antagonists (Zoladex). I continue to monitor these patients.

Surgery

Careful pre-operative assessment is essential. This includes a detailed history clarifying treatment aims, pelvic examination and ultrasound or sometimes an MRI.

This will then clarify the need for a pre-operative sigmoidoscopy and colorectal surgeon involvement.

The type of surgery needed will depend upon the distance of the endometriosis from the anal verge (where the anal canal meets the outside). Deep or full thickness lesions are usually 15 cm or less from the anal verge. The deeper the endometriosis, the more likely it is to have a broad circumferential extent. This means that there is a greater likelihood of resecting a segment of bowel.

More superficial disease (into the muscle layer only or less) can usually be managed by so called "shaving" or "disc resection". This means that the full thickness of the bowel wall is not removed, rather the endometriosis is cut from it and the bowel repaired when necessary. It is probable that shaving results in less complications but slightly higher recurrence rates.

Bowel resection

This is usually referred to as "anterior resection of the rectum" or simply "anterior resection". This refers to the approach, i.e. from the front. If the BE is full thickness, or sufficient in extent that the bowel cannot be safely repaired, removing a segment of bowel may be necessary.

We refer to "ultra-low" anterior resection, which means the join in the bowel is 5cm or less from the anal verge. These are at increased risk of leaking which can have serious consequences. Therefore, some of these patients need a temporary drainage point from the small bowel (ileostomy) to let the bowel heal safely. This part of the operation is carried out by a colorectal surgeon.

Do some surgeons guarantee to "never" use an ileostomy?

There is no such thing as "never"! However, you can get close to never if you don't operate on difficult cases, don't do ultra-low resections, or don't undertake to remove all of the disease.

Complications

The following have been reported: anastomosis (join) leaks 1-2%, wound infection, pelvic infection, pelvic abscess, ongoing pain. Sometimes problems arise some time after surgery and require further surgery to be performed.