

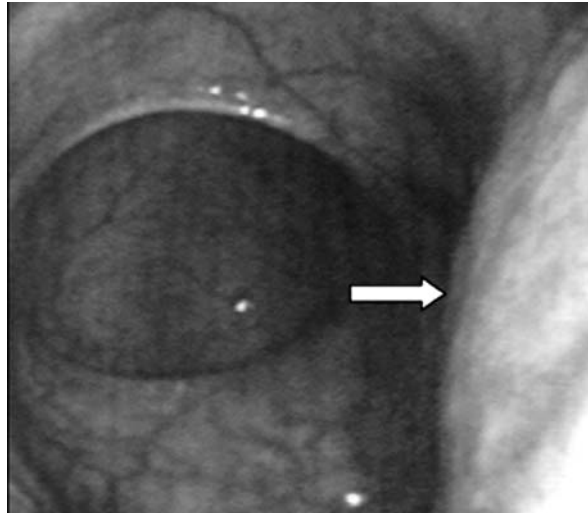
## LETTERS TO THE EDITOR EDİTÖRE MEKTUP

### A case of rectal endometriosis presenting as extramucosal rectal mass

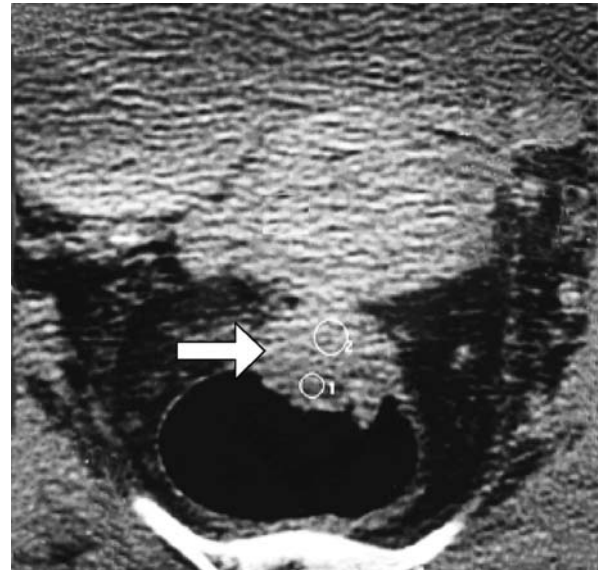
Mukoza dışı rektum kitlesi şeklinde ortaya çıkan bir rektum endometriozişi olgusu

*To the Editor*

A 34-year-old woman was admitted to our surgical department complaining of constipation, tenesmus, pelvic pain, and difficulty in defecation for the last six months. She also had severe dysmenorrhea and dyspareunia with a history of infertility. A mass was detected on digital examination. Colonoscopy revealed an extramucosal rectal mass which caused mild narrowing in the rectal lumen (Figure 1A). Abdominopelvic CT and MRI showed a solid mass including millimetric cystic foci on the anterior rectal wall, which was distinguishable from the uterine wall by fatty tissue (Figure 1B, C). Transvaginal ultrasonography did not provide



**Figure 1. A)** Colonoscopy revealed an extramucosal rectal mass (white arrow)



**Figure 1. B)** CT showed a solid mass (white arrow) including millimetric cystic foci (within the rings) on the anterior rectal wall

any benefit. At surgical intervention, a mass 5 cm in length was found on the anterior rectal wall, extending downwards from the level of the peritoneal reflection. A tissue of 1.5 cm was obtained from the mass without opening the rectal mucosa for intraoperative biopsy that showed an absence of malignant cells and the likelihood of a stromal tumor or endometriosis of the rectum. No endometrial implants were seen in the pelvis. Low anterior resection followed by anastomosis was performed in order to remove the symptomatic mass and to establish an accurate diagnosis. Pathological examination revealed endometrial glands and

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**Figure 1. C)** The mass (white arrow) with high intensity was distinguishable from the uterus on T2- weighted image of the sagittal MRI

stroma within the rectal layers except mucosa, and endometriosis of rectum was thus diagnosed. The patient recovered uneventfully. She has been

symptom-free during the two year follow-up period.

Although endometriosis is a common incidental finding during surgical explorations, intestinal involvement is seen in almost 5% of cases (1, 2). Rectum, sigmoid colon, and the rectovaginal septum are the most common sites of intestinal endometriosis (3, 4).

Symptoms of rectal endometriosis are usually nonspecific such as pelvic and abdominal pain, constipation, and tenesmus. In contrast to the majority of the previous studies, Chapron (5) emphasized the correlation between rectal infiltration by endometriosis and the severity of dysmenorrhea (6). Rarely, patients present with intestinal obstruction or rectal bleeding.

Rectal endometriosis should be considered in the differential diagnosis of extramucosal rectal masses in premenopausal women, particularly if the patient has gynecological complaints or a history of infertility. Endoscopic evaluation is essential in order to rule out rectal cancer rather than for confirming the disease. Although rectal mass is demonstrated by CT or MRI, the precise diagnosis of rectal endometriosis before surgery is a challenge because of nonspecific radiological findings. In the presence of rectal extramucosal mass, segmental resection is sometimes necessary to rule out malignancy and to alleviate the obstructive symptoms.

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