Perineal Endometrioma with anal sphincter involvement. A case report

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Abstract

Perineal endometriosis is a disease characterized by the presence of endometrial tissue in the perineal region. Perineal endometriosis with anal sphincter involvement is an infrequent occurrence. The best treatment to obtain satisfactory cure consists in the wide excision, but it may cause incontinence if the anal sphincter is involved. In this paper we describe a 45 year old patient, with diagnosis of perianal endometrioma with anal sphincter involvement. The patient went through surgery with wide excision and preserved anal sphincter. After one year follow-up there were not complications reported by fecal incontinence. In contrast, the perineal endometriosis is considered an infrequent occurrence of pelvic endometriosis

KEYWORDS: Endometriosis, perineal endometriosis, scar episiotomy
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ABSTRACT

Perineal endometriosis is a disease characterized by the presence of endometrial tissue in the perineal region. Perineal endometriosis with anal sphincter involvement is an infrequent occurrence. The best treatment to obtain satisfactory cure consists in the wide excision, but it may cause incontinence if the anal sphincter is involved. In this paper we describe a 45 year old patient, with diagnosis of perianal endometrioma with anal sphincter involvement. The patient went through surgery with wide excision and preserved anal sphincter. After one year follow-up there were not complications reported by fecal incontinence. In contrast, the perineal endometriosis is considered an infrequent occurrence of pelvic endometriosis.

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INTRODUCTION

Endometriosis is a disease characterized by the presence of endometrial glands and stroma outside the uterine cavity. (1). The most frequent location is the region pelvis, including ovaries (60%), uterine ligaments (30-65%), rectovaginal septum and peritoneum. (2). Endometriosis is one of the most common conditions requiring surgery in women during their reproductive years, may be associated with disabling pain and intractable infertility (3). The true prevalence of endometriosis is unknown. Recent studies indicates that this is due to autologous transplantation of vital endometrial cells to an open episiotomy wound during vaginal delivery especially when manual uterine exploration and postpartum curettage are performed, it seems to be the pathogenic mechanism of perianal endometriosis (4). Endometrial lesions have a typical appearance of blue nodules. At the level of the ovaries, the disease is progressive, leading to form the so-called "chocolate cysts" (5).
CASE REPORT

A 45 year old female patient, who was referred with history of severe perineal pain and tenesmus of two year of evolution associated with evacuations, correlating with her menstrual periods. The symptoms worsened during last months, resulting in functional limitation and discomfort during her sitting and daily activities, often needing the administration of several antibiotics for presumed perineal infection process. Her medical history was significant due to previous pregnancies with two vaginal delivery requiring episiotomy. Anorectal examination was performed with the patient in the left lateral position without previous anorectal preparation. The anal region had normal appearance. At palpation we could see a hard nodule measuring 3 x 4 cm in the right anterior perineal region, irregular and very painful, was palpated in the right ischiorectal fossa area, intimately associated to the scar of episiotomy. The patient had a good sphincter squeeze tone and a good resting tone at digital rectal examination. Endorectal ultrasound revealed a hypoechoic mass containing cystic anechoic areas in the anterior perineal intimately associated with the external anal sphincter (Fig. 1).

The examination was performed under spinal anesthesia and jack knife position. Radial incision, including a portion of the episiotomy scar was performed, it showed a mass in the right anterior position which included outside portion of the site of the episiotomy scar (Fig. 4). The mass was dissected and the resection medially was completed from the ischiorectal space was attached, incorporating a small portion of external anal sphincter.
The mass had clear and well defined borders. It was removed without injury to the anal sphincter (Fig. 3). The divided excised specimen showed characteristic chocolate cysts (Fig. 4). Histopathological examination confirmed endometriosis with endometrial glands and typical stroma, blood and hemosiderin macrophages. The postoperative course had no complications, and the patient remained in the one day hospital. The patient is asymptomatic without evidence of any signs of recurrence after one year follow up of surgery and has excellent functional results (good resting and squeeze tone).

**DISCUSIÓN**

The first reported case of endometriosis with perineal involvement was in 1923 by Schickele (6). Endometriosis is a very common gynecological disease, because in the majority of women is associated with pelvic pain, dyspareunia and dysmenorrhea, may be asymptomatic or cause symptoms related to inflammation, obstruction or bleeding. The incidence of endometriosis occurs between 30 and 40 year old (5), as it was in this case. The perineal endometrioma with affectation the anal sphincter appears after the episiotomy or laceration during childbirth. The scar of episiotomy is a site uncommon of occurrence of endometriosis and the affectation of anal sphincter occurs infrequently (7). The contact of the endometrium tissue with a episiotomy scar plays an important role in the origin of endometriomas. The diagnosis may be difficult, but it is necessary a careful medical history, with symptoms correlated to the menstrual cycle. The objective is to excise the endometriomas completely, which may compromise the anal sphincter. When
the lesion was incomplete or narrowly excised, subsequent hormonal therapy was required to avoid symptomatic recurrence. A definitive histologic diagnosis of perineal endometrioma usually requires two of the following three features: stroma, glands and hemosiderin pigment. Correct preoperative diagnosis may be difficult (8). The endorectal ultrasound allows and makes easier an appropriate surgical procedure and provides perineal endometriosis patients with a good clinical outcome (4) consider that this procedure is essential for diagnosis and operative management of perineal endometriosis. Although hormonal suppression is often the therapy of choice for extrapelvic endometriosis, surgical excision, keeping the anatomical fiber architecture of the anal sphincter, is the best treatment for perineal endometriosis (4, 9). Wide excision, in which a margin of normal tissue and muscle is excised with the mass, provides the best chance of cure but may cause incontinence (10), when the anal sphincter mechanism is involved (7). Narrow excision or a very tiny margin is removed, may result in incomplete removal, with an increased risk of recurrence and need for additional therapy. Perineal endometriosis with involvement of the anal sphincter occurs infrequently (11). This patient did not present postoperative fecal incontinence in a follow-up period of 16 months.

REFERENCES

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