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PRIMARY APPENDICULAR ENDOMETRIOSIS: A CASE REPORT

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ABSTRACT

Endometriosis affects 4 to 50% of young women of childbearing age and causes pelvic pain in more than 50% of patients.[1] Defined by the presence of endometrial glands and stroma outside the uterine cavity and uterine musculature.[2] There is no documented case of isolated appendicular endometriosis in the literature. This article aims to describe the case of a woman with primary appendicular endometriosis, revealed by chronic pelvic pain associated with a latero-uterine mass. 43-year-old patient, in the process of genital activity, mother of two living children. She consulted for chronic cyclic pelvic pain, which had been evolving for a year, located in the right iliac fossa. Clinical examination showed a slightly tender, right latero-uterine mass of approximately 10 cm. Pelvic ultrasound revealed a poorly demarcated solido-cystic, hyperechoic, vascularized latero-uterine mass on color Doppler, which measured 100x60 mm, the uterus and ovaries were without abnormality. The CA125 was high. Surgical exploration found an enlarged, reddish appendix with multiple pelvic adhesions. The uterus and appendages were free from macroscopically detectable abnormalities. An appendectomy was performed. The postoperative follow-up was simple. Pathological examination revealed appendicular endometriosis. Clear clinical and ultrasound improvement was noted after the operation. With a 12-month follow-up, no recurrence was noted.

KEYWORDS: Endometriosis, Primary, Appendicular, Casablanca.

INTRODUCTION

Endometriosis affects 4 to 50% of young women of childbearing age and causes pelvic pain in more than 50% of patients.[1] Defined by the presence of endometrial glands and stroma outside the uterine cavity and uterine musculature.[2] There is no documented case of isolated appendicular endometriosis in the literature. This article aims to describe the case of a woman with primary appendicular endometriosis, revealed by chronic pelvic pain associated with a latero-uterine mass.

CASE REPORT

43-year-old patient, in the process of genital activity, mother of two living children. She consulted for chronic cyclic pelvic pain, which had been evolving for a year, located in the right iliac fossa. Clinical examination showed a slightly tender, right latero-uterine mass of approximately 10 cm. Pelvic ultrasound revealed a poorly demarcated solido-cystic, hyperechoic, vascularized latero-uterine mass on color Doppler, which measured 100x60 mm, the uterus and ovaries were without abnormality. The CA125 was high. Surgical exploration found an enlarged, reddish appendix with multiple pelvic adhesions. The uterus and appendages were free from macroscopically detectable abnormalities. An appendectomy was performed. The postoperative follow-up was simple. Pathological examination revealed appendicular endometriosis. Clear clinical and ultrasound improvement was noted after the operation. With a 12-month follow-up, no recurrence was noted.

Figure

Figure 1: Appendicular endometriosis, histological appearance.

DISCUSSION

Endometriosis is defined by the presence of viable endometrial tissue endorsed by the uterine cavity. The true prevalence of extra-genital endometriosis is unknown in the absence of large, well-defined case series. Regarding appendicular endometriosis, its prevalence varies between 0.054 and 0.8% depending on the studies considered.[18,19] No case of primary appendicular endometriosis has been found in the literature. The preoperative diagnosis of appendicular endometriosis is difficult to establish, no paraclinical examination can provide a definite diagnosis. Magnetic resonance imaging can sometimes detect sigmoid lesions, but this examination is limited in other digestive locations. In our case, this examination was not requested due to lack of resources. A definitive diagnosis is only possible by histopathological study on an appendectomy specimen.

Regarding the elevation of CA125, and according to PANEL, the performance of the elevation of this marker for the diagnosis of endometriosis at any stage would be mediocre: for a specificity of 90%, the sensitivity is only 28%. Surgical exploration by laparotomy or laparoscopy remains a standard diagnostic method allowing, among other things, the direct visualization of the macroscopic characteristics of this condition. EA often involves the tip and body of the appendix. The layers of the appendix most often affected are the muscle and seromuscular layers (2/3 of cases), followed by the serosa (1/3 of cases). The American Society for Reproductive Medicine has proposed a classification system that classifies endometriosis into four stages: Stages I to IV: minimal, mild, moderate and severe.[5] Histological features are the presence of endometrial glands, stroma, fibrosis, chronic bleeding, and signs of inflammation. Likewise, in our case, the lesion involved the entire appendix. Microscopic examination showed the presence of endometrial glands, cell stroma expressing CD10, with signs of inflammation. Epiploic and peritoneal biopsies were the site of a congestive change. Appendicular endometriosis is often seen in patients with ovarian endometriosis. Appendectomies performed in patients with ovarian endometriosis revealed appendicular endometriosis in 13 of the 125 appendectomized patients. In our case the ovaries as well as the whole of the peritoneal cavity did not contain an endometriotic site. This result led to a discussion on the advisability of performing elective appendectomies in patients who had undergone gynecological operations due to endometriosis.[6] The most effective treatment is based on the most complete surgical excision possible of the affected organ or tissue. According to recent guidelines, appendectomy should be performed by

laparoscopy, unless contraindicated, due to the reduced incidence of postoperative pain observed by this technique.

CONCLUSION

Appendicular endometriosis is a rare entity, most often diagnosed on a surgical specimen. It can manifest it self with a variety of symptoms ranging from chronic, muted pelvic pain to acute appendicitis episodes in a young woman in childbirth.

Conflict of interest

The authors declare no conflict of interest.

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Consent

Written informed consent was obtained from the patient for publication of this research study. A copy of the written consent of each patient is available for review by the Editor-in-Chief of this journal on request.

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