probably due to previous surgery. Right tube and ovary clumped to adhesions between omentum, anterior abdominal wall, uterus, cystic was taken up for laparotomy. Intraoperative finding showed dense and enema was started; however, in view of worsening symptoms she management in the form of keeping nil per oral, Ryles’ tube insertion with subacute intestinal obstruction was made and conservative loops suggestive of adhesions. A clinical impression endometriosis cyst extending to the right iliac fossa with obscured adjacent mesentry gut peritoneum, pouch of Douglas, and gastrointestinal (GI) tract. Extra-peritoneal locations include cervical porto vagina and rectovaginal septum, round ligament and inguinal hernia sac navel, abdominal scars after gynaecological surgery and caesarian section.

We report a case with previous history of laparoscopic cystectomy who presented with subacute intestinal obstruction which was found to be due to endometriotic cyst involving cecum and part of ileum. Intraoperative there was iatrogenic injury to ileum while doing cystectomy which required ileocaecal resection. Histopathology report of resected bowel specimen showed ileocaecal endometriosis.

Case report:
A 33 years old unmarried female presented to the emergency department with complain of constipation, vomiting and abdominal pain for 5 days. She had history of chronic pelvic pain and dysmenorrhea since last one year for which she was on some homeopathic medication. Four years back she had laparoscopic cystectomy and polypectomy for some ovarian mass and cholelithiasis. Before presenting to our institute she was prescribed with some symptomatic treatment by local physician which failed to relieve her symptoms. Her physical examination elicited mild diffuse abdominal tenderness with no abdominal mass or enlarged lymph nodes. Auscultation of abdomen revealed increased bowel sounds. On per rectal examination a 6×5 cm cystic mass separate from uterus was felt in the right adnexa. Abdomen X-ray in the erect position showed multiple fluid levels. Ultrasound abdomen showed a 4×4 cm heterogeneous solid cystic mass with few septae abutting uterus. Contrast enhanced computed tomography (CECT) abdomen and pelvis revealed mild to moderate amount of free fluid in pelvis. A large heterogeneous cystic mass seen in the right adnexa extending to the right iliac fossa with obscured adjacent mesentry gut loops suggestive of adhesions. A clinical impression endometriosis cyst with subacute intestinal obstruction was made and conservative management in the form of keeping nil per oral, Ryles tube insertion and enema was started; however, in view of worsening symptoms she was taken up for laparotomy. Intraoperative finding showed dense adhesions between omentum anterior abdominal wall, uterus, cystic mass, colon and appendix. Left fallopian tube and ovary was absent probably due to previous surgery. Right tube and ovary clumped to form a cystic mass of 4×4 cm. Cystic mass was removed after adenoectomy. There was an iatrogenic injury at ileocaecal junction during the procedure that required ileocaecal resection with end ileostomy. Histopathology of the resected specimen confirmed ileocaecal endometriosis along with endometriotic cyst (figure-1,2). Her post operative course was uneventful and she was discharged home on the fifth postoperative day.

DISCUSSION:
Endometriosis can involve both intra- and extra-peritoneal sites. The intra-peritoneal locations are ovaries, uterosacral and large ligaments (fallopian tubes pelvic peritoneum, pouch of Douglas, and gastrointestinal (GI) tract. Extra-peritoneal locations include cervical porto vagina and rectovaginal septum, round ligament and inguinal hernia sac navel, abdominal scars after gynaecological surgery and caesarian section.

Extrapelvic endometriosis affects 4-5% women. Rectosigmoid is most common (70%) while small bowel involvement usually confined to distal ileum is less frequent (1-7%) and exclusive localization on the ileum is very rare (1%). Among patients undergoing bowel resection for intestinal obstruction in abdominopelvic endometriosis incidence is 0.7% (4).

Jubanyk et al reviewed 1000 cases who underwent laparotomy for gynaecological symptoms only 18% had intestinal endometriosis but only one had small intestine involvement (5). Our patient had previous laparoscopic cystectomy. Absence of left ovary and fallopian tube in current surgical finding confirm the excision of these structures. Subacute intestinal obstruction may occur due to adhesion from previous surgery or related other pathological involvement such as in our case small intestinal endometriosis. Differentiation between these although very difficult, it might be helpful in planning treatment option.

Preoperative diagnosis of GI endometriosis is very difficult because a wide spectrum of disease mimic GI symptoms like irritable bowel syndrome, ischemic enteritis/colitis, inflammatory bowel disease and neoplasm.

Gastrointestinal endometriosis patients present with relapsing bouts of abdominal pain, abdominal distension, tenesmus, constipation and diarrhea. Endometriosis infiltrating the muscularis propria may lead to localized fibrosis in the bowel wall, strictures, and small or large bowel obstructions. The incidence of intestinal resection for bowel obstruction

ABSTRACT
Endometriosis is the presence of endometrial glands and stroma outside the uterine cavity. Although it is common in women in the reproductive age, intestinal endometriosis is extremely rare and may lead to serious clinical problems. In this article we present a case of ileocaecal endometriosis presenting as subacute intestinal obstruction in emergency requiring ileocaecal resection.

KEYWORDS
ileum, endometriosis, obstruction

INTRODUCTION:
Endometriosis is a condition where cells of the endometrium lining are found elsewhere, usually in the pelvis and around the womb, ovaries and fallopian tubes. The prevalence of endometriosis is about 6-10% in reproductive age group (1). It can affect in both intra- and extra-peritoneal abdominal sites and rarely extra-abdominal organs such as the lungs, urinary system, skin and the central nervous system. Gastrointestinal involvement has been found in 3-37% of women, most commonly in the sigmoid colon, rectum and terminal ileum. Exclusive localization of terminal ileum is very rare (1-7%) (2,3).
obstruction is 0.7% among patients undergone surgical treatment for abdominopelvic endometriosis.

Endometriosis of the small bowel should be suspected in young, nulliparous patients with abdominal pain, in conjunction with signs of obstruction. Mussa et al reported a case of small bowel endometriosis with intestinal obstruction, protein-losing enteropathy and anasarca (6). Our patient too had features of intestinal obstruction Wong et al described a case of endometriosis of the small bowel mimicking pancreatitis (7).

Anaf et al (8) considering bowel endometriosis an “infiltration or invasion phenomenon”, found that there is a histological continuity between the superficial and underlying deep lesions of the large bowel wall, suggesting that lesions originating from the serosa progressively invade the muscularis propria. The mucosa is rarely involved as it is poorly innervated. Pelvic, pericolonic and para-aortic lymph node involvement of endometriosis has also been reported, often coexisting with endometriosis of the bowel wall. Lymph node involvement may be a consequence of lymphatic dissemination from endometrial foci in the intestinal wall.

The diagnosis of intestinal endometriosis may be suspected on the basis of the clinical history. Less than 50% of patients have concurrent pelvic endometriosis as in our patient. Endoscopic biopsies usually yield insufficient tissue for a definite pathologic diagnosis as endometriosis involves deep layer of the bowel wall.

Radiologically, lesions of endometriosis are either of constricting, and polypoidal type or both (9). On barium studies, radiographic findings caused by implantations in the ileum are similar to those in the colon. Rectosigmoid or caecal endometriosis on double contrast barium enema studies is seen as an extrinsic mass with spiculation and tethering of folds.

Magnetic resonance imaging (MRI) has a high sensitivity (77%-93%) in the diagnosis of bowel endometriosis.

CT is not the primary imaging modality for evaluation of bowel endometriosis, although it can occasionally demonstrate a stenosing rectosigmoid mass (10).

Multislice CT (MSCT) has a great potential for detecting alterations in the intestinal wall, especially if it is combined with enteroclysis (MSCTe). Biscaldi et al carried out a study on 98 women with symptoms suggestive of colorectal endometriosis and found that MSCTe could identified 94.8% of bowel endometriotic nodules in women with symptoms suggestive of colorectal endometriosis. Magnetic resonance imaging (MRI) has a high sensitivity (77%-93%) in the diagnosis of bowel endometriosis.

Surgery is the choice of treatment for intestinal endometriosis in most cases. For the accidental finding without symptoms of obstruction, hormone therapy with danazol or gonadotrophin-releasing hormone (GnRH) analogs may be considered. Surgical treatment should be indicated for women with pain, bleeding, changes in bowel habits and intestinal obstruction. In the small bowel, the treatment of endometriosis is surgical resection of the involved bowel, as done in our patient. Medical therapy is only a temporary treatment.

CONCLUSION:
In case of endometriosis lower abdominal pain in an infertile women must invite the attention of the surgeon or gynecologist to entertain the possibility of intestinal endometriosis a mimicker of many diseases like Koch’s. Intestinal endometriosis should be suspected in patients with abdominal and/or pelvic pain, in conjunction with signs of obstruction and managed surgically if needed.