

Predecidualized Endometriosis Presenting as Rectosigmoid Polyps with Stenosis*

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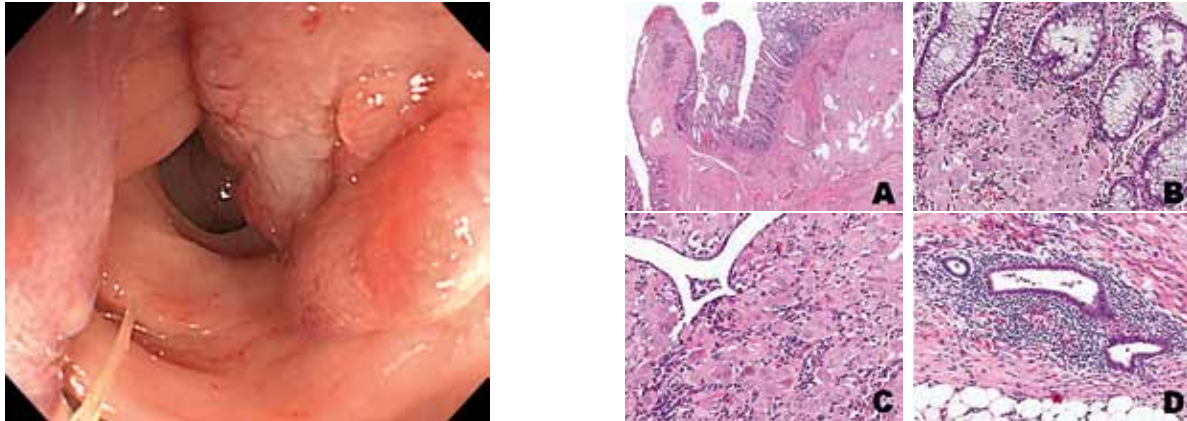


Fig 1. Endoscopy: multiple polyps and a broad-based submucosal mass with hyperemic mucosa causing luminal stenosis.

Fig 2. A. Mucosal polyps protruded by the aggregates of predecidualized stromal cells and the adjacent submucoal mass with cystically dilated glands embedded in the predecidualized stroma (H&E, 100x). B. Aggregates of predecidualized stromal cells, branched crypts and lymphoplasmacytic infiltration in the mucosa (H&E, 100x). C. Submucosal mass composed of aggregates of predecidualized stromal cells and glandular spaces with flattened epithelia (H&E, 100x). D. Foci of endometriosis in the subserosa (H&E, 100x).

A 42-year-old woman presented with lower abdominal pain, diarrhea and hematochezia that were not related to menstruation. She had been diagnosed with tuberculous colitis one year before and treated for 6 months. She had been taking drospirenone/ethynyl estradiol (YAZ®) for the past 10 months and had never been pregnant. Endoscopic evaluation revealed multiple polyps and a broad-based submucosal mass with hyperemic mucosa causing luminal stenosis at the rectosigmoid junction (Fig. 1). Because of the adhesion to uterus, she underwent a lower anterior resection.

Microscopically, the polyps showed intramucosal aggregates of predecidualized stromal cells (Fig. 2A). Branched crypts and lymphoplasmacytic infiltration were noted in the mucosa (Fig. 2B). The submucosal mass was ill-circumscribed and composed of aggregates of sheet-like, predecidualized stromal cells and embedded glandular spaces (Fig. 2C). Aggregates of predecidualized stromal cells were extended from the mucosa to the subserosa. Typical endometriotic foci were present in the subserosa (Fig. 2D). The remaining non-predecidualized stromal cells in the mucosa and submucosa were immunoreactive for CD10.

Intestinal endometriosis mainly involves the muscularis propria and subserosa. However, involvement of submucosa

is found in 66% of intestinal endometriosis and of mucosa in 30% [1]. In cases of mucosa involvement, bleeding, ulceration, stenosis, or polypoid masses on endoscopy as well as microscopic changes of mucosal glands and lamina propria may be present. These clinicopathologic manifestations are sometimes difficult to distinguish from malignancy, inflammatory bowel disease, or ischemic colitis [2, 3]. Taking oral contraceptives may induce predecidualization of intestinal endometriosis as in the present case. Predecidualization was probably responsible for the rapid growth of the lesion to form a mass and may have caused confusion in the differentiation from other tumors.

In **conclusion**, intestinal endometriosis involving mucosa requires differential diagnosis from intestinal inflammatory diseases or intestinal tumors due to its similar clinicopathologic findings, especially when it is accompanied by predecidualization.

References

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