

Case Study

Psychological Component in the Context of Endometriosis with Involvement of the Gastrointestinal Tract: A Case Study

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Abstract:

Endometriosis is one of the most prevalent gynecological comorbidities in women of reproductive age and has a significant impact on mental health. The aim of this study is to report a case of a patient with endometriosis with ovarian and intestinal involvement who had a significant psychological component, presenting depressive symptoms and anxiety crises. The patient presented atypical symptoms, characterized by frequent nausea, recurrent vomiting, and sialorrhea, which required a sensitive and more critical look from the professionals who followed her, so that the treatment could be individualized and effective. She referred to dysuria, dyschezia, bloating, deep dyspareunia, and associated with these symptoms, the patient also reported pelvic pain, asthenia, and loss of about 10 kilos during this period. Imaging exams were performed, which showed endometriosis with ovarian and intestinal involvement, and from this she underwent surgical procedure for resection of the endometriosis foci and subsequent and anatomopathological study of the specimens, confirming the diagnosis. After the surgical management, the patient reported a decrease in symptoms, but still had signs that did not allow a complete improvement, leading her to add a psychological and psychiatric treatment, which made all the remaining symptoms and atypical for endometriosis disappear. This demonstrates the importance of the intervention in the treatment for endometriosis being done in a complete and multiprofessional manner.

Keywords: Endometriosis; Differential Diagnosis; Depression; Anxiety; Quality of Life.

Introduction

Endometriosis is a benign gynecological pathology that acts chronically, with a multifactorial, estrogen-dependent, and inflammatory cause, resulting from tissue implants that have a similarity to glands or endometrial stroma outside the uterus, predominantly, but not exclusively, in the region of the female pelvis (FEBRASGO, 2021; DUARTE, RIGHI, 2021; GIANELLA et al., 2021).

It is a comorbidity that widely affects women in their reproductive stage, establishing an occurrence between five to fifteen percent within this group (CONCEIÇÃO et al., 2019). In Brazil, it is estimated that about seven million women are affected by endometriosis. However, such epidemiological data may not yet show the reality of the population, since there is a huge difficulty in collecting this information due to the existing deadlock for diagnosis and trivialization in the symptoms that permeate this pathology (SILVA et al., 2021). Although it is asymptomatic in 2% to 22% of women (ROSA e SILVA et al., 2021), the most commonly reported symptoms are dysmenorrhea, infertility, dyspareunia, constipation, nausea, micturition complications, pain with sacral irradiation, metrorrhagia, irregular menstruation, and chronic pelvic pain (GIANELLA et al., 2021).

In this sense, patients develop a decrease in their quality of

life, which affects not only their physical integrity, resulting from their symptoms, but also significantly affects their psychological wellbeing, which can result from the most diverse factors, such as infertility, affective relationships, social isolation, (BAETAS et al., 2021) and, also, in their professional life, in which many fail to complete their tasks, leading to unproductivity (TEIXEIRA et al., 2022).

In addition, the entire path between the symptoms and the diagnosis provides circumstances of discomfort and suffering, which could be reduced with an early determination of endometriosis (TEIXEIRA et al., 2022). The literature reports the existence of an association between coping, depressive stages and stress levels in patients with endometriosis, indicating that the therapeutic approach to this disease should include psychological care according to the symptoms and their impacts on the lives of patients, so that, in this way, the repercussion on the biopsychosocial well-being of these women is reduced (DONATTI et al., 2017).

In view of this and the scarcity of studies on the subject in the literature, this paper aims to report a case of a patient with endometriosis with ovarian and intestinal involvement and who had a significant psychological component, arising from her diagnosis of depressive disorder, presenting a treatment with a specialized and active team in the physical and mental

context of the patient.

Materials and Methods

This paper is a clinical case study, conducted descriptively and qualitatively, describing a case where the female patient came to a private clinic in the city of João Pessoa/PB, presenting an atypical symptomatology. Information was collected during anamnesis, physical examination, and ultrasonographic reports, anatomopathological analysis and prognosis were recorded.

As far as ethical aspects are concerned, clarification about risks, benefits and prognosis was provided to the patient through the Informed Consent Form (ICF) and authorization for the procedure was obtained by signing such a document, as well as permission to use the ultrasonography and histopathology reports to produce this study, which follows the ethical principles in accordance with the international guidelines described in the declaration of Helsinki.

The bibliographic data used in this work were obtained through a literature review collected from PubMed, Google Scholar and Scielo portals by searching the following keywords: Endometriosis; Differential Diagnosis; Depression; Anxiety; Quality of Life. About 40 articles were studied, of which 16 were considered relevant and mentioned in this work.

Case Study - Body Text

A female patient, 42 years old, white, nursing technician,

Table 1: Findings in ultrasound report.

Region	Specifications
Uterine Body	Uterus centered in the pelvis in retroflexion, volume 103 cm ³
Endometrium	Hypoechoic, measuring 6.2 mm, with a thick, irregular junctional zone and subendometrial cysts, mainly on the posterior wall, suggesting adenomyosis.
Back compartment	Irregular hypoechoic tissue formation in mantle in the retrocorporeal/retrocervical uterine region, infiltrating the myometrium of the posterior uterine wall. There is important extension to the uterosacral ligaments bilaterally that are thickened and irregular. This lesion is difficult to measure, with estimated dimensions of 8.5 (length) x 1.1 (height) x 3.2 cm (width).
Ovaries	Posterior and medianized, enlarged volumes fixed to the retrouterine endometriotic lesion, completely obliterating the posterior sacral fundus. They present bulky cysts with ground glass-like debris compatible with endometriomas, characterized by: ? Right ovary: three, measuring 7.1 x 3.4 cm; 3.1 x 3.3 cm and 2.6 x 1.6 cm. ? Left ovary: two, measuring 7.0 x 6.1 cm and 5.9 x 5.7 cm There is also an endometriotic nodule centered in the rectovaginal space, attached to the inferior aspect of the left ovary, measuring 1.3 x 0.9 x 0.9 cm
Straight	Endometriotic plaque on the anterior wall of the high rectum, adhered to the posterior aspect of the left ovary, 12 cm from the anal border, measuring 4.4 x 0.7 x 1.3 cm, with depth to the muscular layer proper, in involvement of 26% of the circumference of the loop. Attached to the endometriotic nodule in the rectovaginal space, there is a cyst with a ground-glass (endometriotic) appearance centered on topografia of the muscular layer proper of the middle rectum, 10 cm from the anal border, measuring 1.4 x 1.1 x 1.0 cm

After the requested ultrasonography report, foci of endometriosis were seen that explained all the symptoms previously reported by the patient. Thus, treatment guided by a multidisciplinary team was suggested, and the patient was also

married, G0P0, 50 kg, without any other comorbidity, living in the rural area of the State of Paraíba, sought gynecological care, referred by the digestive system surgeon and motivated by complaints of chronic pelvic pain, gastrointestinal symptoms and intense dysmenorrhea.

Ten years ago she was diagnosed with infertility, and underwent a videolaparoscopy, in which myomectomy, lysis of pelvic adhesions, and resection of endometriosis foci were performed.

However, she reports that in August 2021 she began to present epigastralgia, asthenia, sialorrhea, intense abdominal pain, nausea, and constant vomiting (about 5 episodes in 1 day), causing sensations of anguish that made her not eat, reaching a weight loss of 10kg in this period, which led her to seek emergency care, presenting partial improvement of the condition with the use of medications.

With this condition, the patient sought a gastroenterologist, who performed an upper digestive endoscopy and showed *H. pylori*, which was treated twice, in addition to the diagnosis of gastritis, however, there was no improvement in gastric symptoms.

Thus, she sought a digestive system surgeon, who, after a detailed anamnesis and physical examination, highlighted the suspicion of endometriosis due to her history of laparoscopic surgery for infertility treatment, requesting imaging exams such as transvaginal ultrasonografia with bowel preparation for the mapping of endometriosis and better investigation of the case, presenting its most important findings in table 1.

referred to gynecological care. The treatment plan included hormonal blockade and laparoscopic surgery for resection of the endometriosis foci, with subsequent removal of tissue for anatomopathological analysis.

Given the high complexity of the case, two teams participated in the surgery for a better approach to the case, the gynecological surgery team and the digestive tract team. During the surgical procedure, as an intraoperative finding, the rupture of the endometrioma was verified, which would justify the epigastralgia, the abdominal pain, the difficulty in feeding and the other symptoms reported.

Lysis of pelvic adhesions, right and left oophorectomy to excise endometriomas, left salpingectomy, rectosigmoidectomy were performed, removing about 7cm in length, with involvement of the muscular and subserosal layer. After these procedures, a retrocervical nodule was dissected next to the uterosacral ligaments and the nodule present in the rectovaginal endometriotic was dissected.

The entire procedure occurred uneventfully, the patient was clinically stable, with few complaints related to the postoperative period, and hospital admission was necessary for 48 hours to assess acceptance of the diet progression and return of bowel function, among other aspects.

Thus, presenting a good prognosis, the patient was discharged from the hospital after the observation time and followed up with supportive measures, lifestyle changes, and hormonal blockade by the use of oral contraceptive.

On anatomopathological examination, in ovarian tissue, a diagnosis of endometriosis involving the ovarian tissue with no signs of malignancy was presented. In the rectosigmoid tissue, intestinal endometriosis involving the muscularis propria and subserosa layers was shown, with edematous overlying mucosa and mild chronic inflammatory infiltrate in the chorion and associated lymphoid tissue hyperplasia, with no signs of malignancy.

Even after the surgical procedure, the patient showed improvement, but not cessation, of the symptoms associated with the anxiety crisis, and still had complaints of nausea, vomiting, and sialorrhea. Thus, she was referred for psychological and psychiatric follow-up, in which she was diagnosed with depressive disorder. For this, the use of escitalopram for 3 months was indicated, which triggered a significant improvement in gastric symptoms presented by the patient.

Currently, the patient reports the total disappearance of her gastric symptoms, with an improvement in her quality of life, mainly due to the reduction in pelvic pain and the other symptoms she presents.

Result and Discussion

Endometriosis presents the most diverse symptoms, without showing specific signs, so that these variations even hinder a faster diagnosis. As a highlight, infertility and pain are among the main reports of affected women and, furthermore, when there is involvement of extreme pain, these bring with them social, physical and psychological losses, because they change the daily life and well-being of these patients (RODRIGUES et al., 2022).

The great effectiveness of therapies for endometriosis focuses on pain relief and better chances of maintaining fertility in patients. However, due to the great impact of this pathology in

the lives of patients, just taking into account the elimination of these signs may not be enough to have an effective response to treatment (MENGARDA et al., 2008).

It is highlighted in the literature that all these impacts caused by endometriosis should be taken into account for a correct diagnosis and proper treatment (BAETAS et al., 2021), including their psychological state and well-being, because they are important points and that influence the course of the disease, and the professional should analyze these patients as a whole (OLIVEIRA, BRILHANTE, and LOURINHO, 2018).

Added to this, going through the course of a chronic disease is a non-normative occurrence in women's lives, which can cause a psychological maladjustment and, consequently, provoke negative emotional feelings (ROCHA, 2021). It is known that women with endometriosis have a higher propensity to develop depressive symptoms, anxiety and stress when they are placed compared to those who do not have the disease (DONATTI et al., 2022).

Still, even after the diagnosis of endometriosis, depression is still common, because within the painful symptomatology are mood swings and anxiety, which are factors directly linked to improve or worsen the health condition of these patients (OLIVEIRA, BRILHANTE, & LOURINHO, 2018).

The literature mentions that, despite being disorders with different symptomatology, it is common for anxiety and depression to affect affected patients simultaneously (OLIVEIRA, BRILHANTE, and LOURINHO, 2018), corroborating with the present patient who was diagnosed with depression associated with episodes of anxiety crisis.

This corroborates a study conducted in 2002, by Lorençatto and collaborators, in which they evaluated 50 adult women with endometriosis and, through a questionnaire, identified a prevalence of depression in 92% of this sample. This percentage may demonstrate the high incidence of depressive signs in this public, agreeing with what was presented in this case, in which the patient began to develop these symptoms.

She also began to report worsening endometriosis symptoms in association with symptoms of depression and anxiety, which led to a worsening of the case, in agreement with Oliveira, Brilhante, and Lourinho (2018), who report that all the changes related to living with the disease can trigger these depressive conditions that, if not identified correctly, have an exponential influence on the treatment of endometriosis, which, consequently, can accentuate depressive symptoms.

Thus, it is possible to observe that, in the present report, the patient, despite having received drug and surgical therapy, presented symptoms of anxiety and depression crises, which worsened over time and only ceased after the association of her treatment with psychological and psychiatric therapy.

The patient had the classic signs of endometriosis, such as pelvic pain and dysmenorrhea, but also reported asthenia, sialorrhea, nausea and constant vomiting. No reports associating these symptoms specifically with endometriosis were found in the literature; however, it is known that endometriosis is often diagnosed late because it has a very diverse and nonspecific symptomatology, creating possibilities of being confused with other diseases (MENDONÇA et al.,

2021).

However, this nonspecificity of signs may also be caused according to the sites of implantation of the endometrium (MENDONÇA et al., 2021) and a patient with intestinal endometriosis may present several gastrointestinal symptoms that may also vary according to the menstrual cycle (VIEIRA, LOPES, WATANABE, 2018). Since the patient had deep endometriosis with intestinal involvement, this may be an explanation for the gastric symptoms she reported feeling.

Conclusion

Endometriosis is a chronic disease that affects several segments of the lives of affected women. It is well reported in the literature the influence that this pathology has on quality of life, and it can significantly affect mental well-being, which increases the chances of depressive and anxiety symptoms in these women.

Thus, in the present case, the importance of multi-professional care and the analysis of the patient as a whole can be seen, so that the treatment is done in a complete way, for both the physical and the psychological aspects, since, even after the surgical management, the patient only improved after associating the psychological and psychiatric treatment.

In addition, the signs of endometriosis are thought to be nonspecific, and the sites of implantation of endometriotic tissue also depend, which would explain the atypical gastrointestinal symptoms experienced by the patient.


Conflicts Of Interest

The author(s) declare(s) that there is no conflict of interest regarding the publication of this paper.

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