**ABSTRACT**

The etiology causing small bowel obstruction varies by age and sex. Benign disease is the typical cause in children and adolescents while malignant or adhesive disease is far more common in older patients. Gynecological disease and its treatment is a relatively common cause of bowel obstruction. The commonest cause is gynecological malignancy, particularly that of the ovaries and complications of treatment such as radiotherapy and adhesions. Second to the malignancy, endometriosis (adenomyosisternum) is a well-known cause for bowel adhesions leading to obstruction. However, uterine fibroid or leiomyomas are relatively common condition in elderly female but symptomatic in only 35-50% of individuals. However, complications like intestinal obstruction may occur, albeit rarely. This should be considered in elderly women with intestinal obstruction and should be treated with early surgical intervention.

**KEY WORDS:** Endometriosis, uterine fibroid, womb stones.

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**Case Presentation**

**Patient Presentation and History**

A 50-year-old lady presented for surgical consultation after multiple episodes of severe abdominal pain that occurred over a period of 1 week. She reported similar episodes of nearly identical GI symptoms 2 weeks before in a lesser degree and that was subsided by conservative management. The episodes would begin with lower abdomen that would be relatively sudden in onset and initially less in severity. Over a matter of minutes, the pain would crescendo to more severe one and would last for an hour. During this period of time, the patient would pass very little flatus and would develop abdominal distention, severe diaphoresis, and nausea. The pain would settle in the lower quadrant and then would almost completely resolve. The patient would then remain "sore" for a period of one to two additional hours. On a few occasions, she had vomiting. She had a history of constipation for past 1 week. Before the episodes, the patient reported normal bowel habits. She had no history of diarrhea, weight loss, or significant nausea or vomiting. The patient had no history of GI bleeding. She had never undergone a surgery or GI scopy in the past. No previous history of tuberculosis. She was in the post menopausal state.

**Physical Examination and Laboratory Evaluation**

The patient was afebrile, vital signs were stable. The patient's abdomen was soft, and distended.
Tenderness was present over all quadrants of abdomen and visible intestinal peristalsis was noted. There were no palpable masses in abdomen. There were no incisional scars on the abdomen.

Evaluation included a USG scan of the abdomen and pelvis. The USG scan showed dilated small bowel loops and no free fluid. X-Ray abdomen erect showed multiple fluid levels which is suggestive of intestinal obstruction (Fig 1). Laboratory evaluation demonstrated a normal complete blood count and normal renal and liver function studies.

**Treatment and Outcome**

The patient was immediately shifted to the operating room and underwent an exploratory laparotomy. The intraoperative findings consisted of large mass arising from the fundus and body of the uterus, which is densely adhering to the urinary bladder, greater omentum, and sigmoid colon. The large uterine mass occupied the majority of the true Pelvis. Additionally, two loops of distal ileum were involved in the adhesions (Fig.2); the small bowel was dilated proximal to this point of obstruction. The terminal ileum was uninvolved. No obstruction was noted in large intestine. Both adnexa were found to be normal.

The omental and the bladder adhesions were released. Since the small bowel adhesions were so dense, the release was not possible. Hence, the small bowel was resected and end to end anastomosis was done. The patient underwent hysterectomy also. She did well postoperatively and was discharged to home 10 days after surgery.

Histology confirmed a distorted uterus with a subserosal single leiomyoma size about 11x8x5cm with extensive calcification (Fig 3) and no evidence of dysplasia or malignancy.

**Discussion**

The etiology causing small bowel obstruction varies by age. Benign disease is the typical cause in children and adolescents while malignant or adhesive disease is far more common in older patients [1]. Gynecological disease and its treatment is a relatively common cause of bowel obstruction. The commonest cause is gynecological malignancy, particularly that of the ovaries [2] and complications of treatment such as radiotherapy and adhesions. Second to the malignancy, endometriosis (adenomyosisexterna) is a well known cause for bowel adhesions leading to obstruction [3].

Leiomyoma or fibroids are benign smooth muscle tumours of the uterine myometrium and are a common condition in women especially over the age of 40 years. Small leiomyomas are present in more than 20% of women over the age of 40 year and usually remain asymptomatic [4]. However, bowel obstruction secondary to benign uterine leiomyomas may occur, albeit rarely. Intestinal obstruction in uterine fibroid usually occurs by mechanical compression [5] of sigmoid colon or entrapment of bowel in between two subserosal fibroids. Adhesive type of intestinal obstruction in uterine fibroid is a very rare presentation and it usually follows the degeneration of fibroid.

Degeneration develops frequently in leiomyomas because of the limited blood supply within the tumour. Over time, with continued diminished blood supply and ischemic necrosis of tissue, calcium phosphate and carbonates are deposited in myomata. When the degenerative change is advanced, the leiomyoma may become solidly calcified as in our case. Such calcified tumours have been called womb stones [6].

This should be considered early in female patients and if rapid sustained resolution of the clinical features of obstruction does not occur,
the condition should be treated aggressively with surgical intervention.

**References**


