Fellows' Corner

by Nyree Thorne and Devjit Nayer, assisted by Bonnie Pollack

CASE REPORT

A 50-year-old woman presented to the emergency department complaining of two days of left lower quadrant abdominal pain and diarrhea. The pain was crampy, intermittent and non-radiating. The patient denied nausea, vomiting, hematochezia or melena. There was no history of diverticular disease, or any prior abdominal surgery except for c-section. The patient had been in good health and denied recent travel.

On physical examination the patient was afebrile. There was moderate left lower abdominal tenderness without rebound tenderness or guarding. Rectal exam revealed normal tone with guiaic negative brown stool. Laboratory tests were unremarkable. Enhanced computed tomography scanning of the abdomen (Figure 1) demonstrated a paracolic oval mass with peritoneal thickening (arrow).

Question 1: What is the most likely diagnosis?
Question 2: What other diagnosis' could this commonly be mistaken for?
Question 3: What is the appropriate therapy?
Question 4: Are antibiotics useful in this situation?

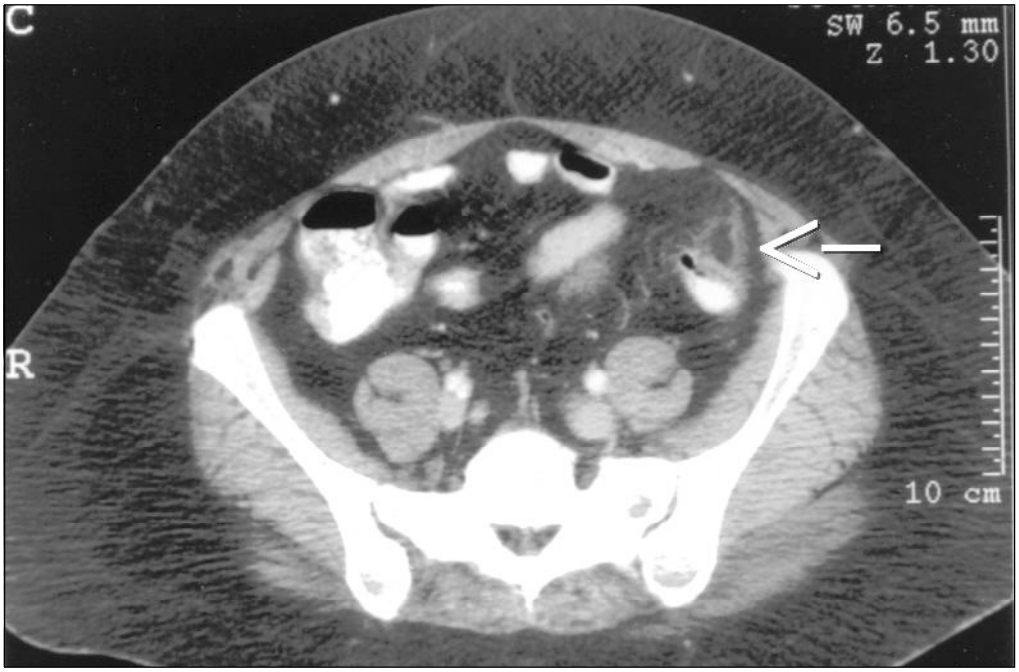

Figure 1.

(Answers and DIscussion on page 56)

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DISCUSSION

Epiploic Appendagitis is an uncommon cause of abdominal pain. It is caused by torsion of an appendage or thrombosis of a draining vein. Epiploic appendages are small pouches of peritoneum filled with soft fat, located on the surface of the colon and appendix (1). Each appendage contains an artery and vein. Rarely these appendages can undergo torsion or thrombosis of the draining vein, which can lead to infarction. Infarction can cause abdominal pain and mimic more common causes of abdominal pain, such as acute appendicitis, acute diverticulitis and omental infarction.

Epiploic appendagitis is often misdiagnosed as diverticulitis or appendicitis. Son, et al composed clinical and radiologic characteristics of eight patients with epiploic appendagitis (2). They were retrospectively compared with 18 patients with acute diverticulitis. Patients with epiploic appendagitis had well localized tenderness without fever, vomiting or peritoneal signs. Blood tests in these patients were not significant. Pain was more diffuse in patients with acute diverticulitis and also associated with leukocytosis, nausea and fever. Omental infarction, or segmental necrosis of the omentum is a rare entity that may mimic the presentation of epiploic appendagitis. Etiologies for omental infarction include anomalous arterial supply to the omentum, kinking veins secondary to increased intra-abdominal pressure and post-prandial vascular congestion have been proposed (3). Computed tomography findings can help to differentiate these entities.

The treatment of epiploic appendagitis is conservative. Initially, patients should remain nil per oral and receive intravenous fluids and analgesia. Antibiotics have not been shown to be beneficial. Rarely, surgical exploration is required in patients who do not improve with conservative measures. Establishing the correct diagnosis is important to avoid unnecessary surgery. This patient initially received empiric antibiotics for presumed diverticulitis. She improved with conservative treatment and was discharged on hospital day four. ■

References

1. Morson BC. *Morson & Dawson's Gastrointestinal Pathology.* 3rd Edition, Oxford: Blackwell Scientific Publications, 1990; 639.
2. Son, et al. *Journal of Clinical Gastroenterology,* 2002; *Clinical Diagnosis of Primary Epiploic Appendagitis, Differentiation form Acute Diverticulitis;* 34 (4); 435-438; Lippincott Williams & Wilkins, Inc.
3. McClure MJ, et al. *Radiological Features of Epiploic Appendagitis and Segmental Omental Infarction; Clinical Radiology,* 2001; 56:819-827.