

A rare cause of abdominal pain

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A 65-year-old woman, without relevant medical history, presented at the emergency department complaining of acute abdominal pain in the left lower quadrant. The pain increased on acute movements and coughing. She did not experience nausea, vomiting or fever. Physical examination revealed tenderness to palpation in the left lower abdominal quadrant with rebound tenderness and guarding. Further physical examination was unremarkable. Laboratory results showed slight leucocytosis ($16 \times 10^9/l$) with a normal urinalysis. Under the suspicion of diverticulitis we performed contrast-enhanced computer tomography (CT) of the abdomen. This revealed a fat lobula surrounded by an enhanced rim with infiltration of the adjacent adipose tissue (figures 1 and 2).

Figure 2. Fat lobula surrounded by an enhanced rim



Figure 1. Fat lobula surrounded by an enhanced rim



WHAT IS YOUR DIAGNOSIS?

See page 476 for the answer to this photo quiz.

DIAGNOSIS

The diagnosis is epiploic appendagitis. This is a clinical entity that can be easily misdiagnosed as acute appendicitis or diverticulitis. It is mainly caused by torsion of the epiploic appendages, resulting in ischaemia and subsequently irritation of the peritoneum.¹ The reason for the torsion remains unknown. The sigmoid colon and the caecum are the predominant physiological sites of appendageal occurrence. Therefore the pain is usually located in the left or right lower abdominal quadrant, mimicking appendicitis or diverticulitis.¹ The abdominal pain is often rapid in onset and very localised. Coughing, deep breathing and acute movements may exacerbate the pain. Localised tenderness and guarding of the abdomen is usually found on physical examination. The leucocyte count can be normal or slightly elevated.²

The diagnosis of epiploic appendagitis is difficult due to the nonspecific presenting symptoms and physical examination and the lack of a pathognomonic clinical feature. Additional ultrasound or abdominal CT scan are necessary to establish the diagnosis. Pathognomonic CT findings are a 1 to 4 cm oval-shaped fat density lesion surrounded by inflammatory changes.³ Thickening of the parietal peritoneum wall can sometimes be observed. In contrast to diverticulitis, the diameter of the colonic wall is mostly regular without signs of thickening.³

Epiploic appendagitis is a self-limiting disorder. The symptoms usually resolve spontaneously within five to

ten days. Conservative management is indicated when an accurate radiological diagnosis is established. As we expected, the symptoms resolved after seven days in our patient.

Concluding, in patients with localised, acute abdominal pain which is not associated with other symptoms such as nausea, vomiting, fever or typical laboratory findings, the diagnosis of epiploic appendagitis should be considered as a rare differential diagnosis to sigmoid diverticulitis and appendicitis.

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