



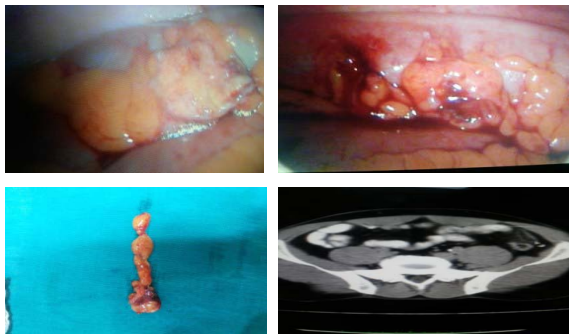
LEFT ILIAC FOSSA PAIN - MYSTERY UNVEILED - EPIPLOIC APPENDAGITIS

ARANYA S

Department of General Surgery, STANLEY MEDICAL COLLEGE AND HOSPITAL

Abstract : 32 year old gentleman presented with abdominal pain and mass in left iliac fossa and was diagnosed as diverticulitis of sigmoid colon. On further evaluation it was found as epiploic appendagitis of descendsigmoid junction. Laproscopic excision of the inflamed appendices epiploicae was done.

Keyword : Epiploic appendagitis, diverticulitis



32 year old gentleman admitted with complaints of abdominal pain in left iliac fossa - 1 week, sudden onset, progressive nature, dull aching pain, not radiating, no aggravating or relieving factors. No h/o abdominal distension/nausea/vomiting/fever/bladder and bowel disturbances/ loss of weight/ appetite. General examination was normal. Abdomen examination revealed single oval well defined, smooth, tender, firm mass of size 3 * 2 cm palpable in left iliac fossa in midclavicular line with dull note over mass. P/R examination was normal. Provisional diagnosis was Diverticulitis of sigmoid colon.

INVESTIGATIONS :

Hemogram, Total count, Differential count, ESR, Platelet count, Blood sugar, Renal function tests was normal. USG abdomen showed 3 * 2 cm fat stranding noted in left iliac fossa. No free fluid. No bowel wall thickening. CECT abdomen showed 3 * 2 cm pericolonic fatty lesion surrounded by hyperattenuating ring in region of descending

colon- sigmoid colon junction. Impression was Epiploic appendagitis. Colonoscopy and Double contrast barium enema was normal. We made a final diagnosis of EPIPLOIC APPENDAGITIS OF DESCENDO SIGMOID JUNCTION and was managed conservatively with antibiotics and analgesics. He had no symptomatic improvement. Decided for surgical management and planned for laproscopic excision. Operative findings: 3 port technique, 3* 2 cm inflamed appendices epiploicae in descending colon sigmoid colon junction. Excision done using bipolar diathermy. Postoperative period was uneventful. Suture removal was done 10 th day. HPE report Macroscopic: Fatty tissue measuring 2 * 2 * 1 cm. external and cut surface yellowish, greasy. Microscopic: Fibrofatty tissue enclosing chronic inflammatory cells only.

DISCUSSION :

Epiploic appendagitis is an uncommon, benign self limiting inflammatory process of epiploic appendices. Epiploic appendices are 1- 2 cm thick and 0.5-5cm long each supplied by one or two small colonic end arteries and a small draining vein (1). They are small, physiologic peritoneal fat pouches attached to the external surface of colon by vascular stalks. They become acutely inflamed as a result of torsion or venous thrombosis (7,8). Very rarely they present as intraperitoneal loose bodies (2). Pain is usually in right or left lower quadrant. In right side it may mimic appendicitis, left side it may mimic diverticulitis. Lab investigations will be normal. CRP will be elevated in few cases due to ischemic fat necrosis (3). Normal epiploic appendagitis are not seen on CT scan (17,18). They typically have fat attenuation and cannot be distinguished from other adipose structures unless they are surrounded by intraperitoneal fluid or inflammation. Epiploic appendagitis is a surgical diagnosis with clinical features that may guide the surgeon to right preopdiagnosis. In patients with localised, sharp, acute abdominal pain which is not associated with other symptoms like nausea, vomiting, fever or typical laboratory values, the diagnosis of epiploic appendagitis should be considered as a rare differential diagnosis to sigmoid diverticulitis or appendicitis. It is a self limiting condition with patients recovering in less than 10 days with oral anti inflammatory medication. There is a tendency of recurrence in

conservatively treated patients. Laproscopic interventions(11) are highly appealing to both patient and surgeon.

REFERENCES :

1. Vinson DR: Epiploicappendagitis: a new diagnosis for the emergency physician. Two case reports and a review. *J Emerg Med* 1999, 17(5):827-32.
2. Ross JA: Vascular loops in the appendices epiploicae; their anatomy and surgical significance, with a review of the surgical pathology of appendices epiploicae. *Br J Surg* 1950, 37(148):464-6.
3. Ghosh BC, Shatzkes J, Webb H: Primary epiploicappendagitis: diagnosis, management, and natural course of the disease. *Mil Med* 2003, 168(4):346-7.
4. Legome EL, Belton AL, Murray RE, Rao PM, Novelline RA: Epiploic appendagitis: the emergency department presentation. *J Emerg Med* 2002, 22(1):9-13.
5. Carmichael DH, Organ CH Jr: Epiploic disorders. Conditions of the epiploic appendages. *Arch Surg* 1985, 120:1167-72.
6. Lynn TE, Dockerty MB, Waugh JM: A clinicopathologic study of The epiploic appendages. *SurgGynecolObstet* 1956, 103:423-33.
7. Brady SC, Kliman MR: Torsion of the greater omentum or appendicesepiploicae. *Can J Surg* 1979, 22(1):79-82.
8. Shamblyn JR, Payne CL, Soileau MK: Infarction of an epiploic appendix. *South Med J* 1986, 79(3):374-5.
9. Sajjad Z, Sajjad N, Friedman M, Atlas SA: Primary epiploicappendagitis: anetiology of acute abdominal pain. *Conn Med* 2000, 64(11):655-7.
10. Fieber SS, Forman J: Appendices epiploicae: Clinical and pathological considerations. *Arch Surg* 1953, 66:329-38.
11. Unal E, Yankol Y, Sanal T, Haholu A, Buyukdogan V, Ozdemir Y: Laparoscopic resection of a torsioned appendix epiploica in a previously appendectomized patient. *SurgLaparoscEndosc Percutan Tech* 2005, 15(6):371-3.
12. Romaniuk CS, Simpkins KC: Case report: pericolic abscess secondary to torsion of an appendix epiploica. *ClinRadiol* 1993, 47(3):216-7.
13. Ghosh P, Strong C, Naugler W, Haghighi P, Carethers JM: Peritoneal mice implicated in intestinal obstruction: report of a case and review of the literature. *J ClinGastroenterol* 2006, 40(5):427-30.
14. Bhandarwar AH, Desai VV, Gajbhiye RN, Deshraj BP: Acute retention of urine due to a loose peritoneal body. *Br J Urol* 1996, 78(6):951-2.
15. Son HJ, Lee SJ, Lee JH, Kim JS, Kim YH, Rhee PL, Kim JJ, Paik SW, Rhee JC, Choi KW: Clinical Diagnosis of Primary Epiploic Appendagitis. *J ClinGastroenterol* 2002, 34(4):435-438.
16. Boulanger BR, Barnes S, Bernard AC: Epiploicappendagitis: an emerging diagnosis for general surgeons. *Am Surg* 2002, 68(11):1022-5.
17. Gharemani GG, White EM, Hoff FL: Appendices epiploicae of The colon: radiologic and pathologic features. *Radiographics* 1992, 12:59-77.
18. Singh AK, Gervais DA, Hahn PF, Sagar P, Mueller PR, Novelline RA: Acute epiploicappendagitis and its mimics. *Radiographics* 2005, 25(6):1521-34.
19. Molla E, Ripolles T, Martinez MJ, Rosello E: Primary epiploic appendagitis: US and CT findings. *European Radiology* 1998, 8:435-38.
20. Rao PM, Wittenberg J, Lawarason JN: Primary epiploicappendagitis: evolutionary changes in CT appearance. *Radiology* 1997, 204:713-17.
21. van Breda Vriesman AC, de Mol van Otterloo AJ, Puylaert JB: Epiploic appendagitis

