CASE REPORT

Paracolic echogenic mass in a man with lower abdominal pain. Is epiploic appendagitis more common than previously thought?

J M Hanson, A W Kam

Emerg Med J 2006;**23**:e17 (<http://www.emjonline.com/cgi/content/full/23/2/e17>). doi: 10.1136/emj.2005.028696

The aim of this presentation is to raise awareness of this relatively benign condition when evaluating those patients presenting with lower quadrant pain, in particular, left lower quadrant pain.

The image in fig 1 depicts the typical ultrasound appearance of epiploic appendagitis. Historically a rare surgical diagnosis, it is increasingly being recognised on ultrasound and computed tomography (CT) examinations. Epiploic appendagitis has been diagnosed in 2–7% of abdominal CT examinations done to exclude diverticular disease and 1% of those examinations to rule out appendicitis.^{1,2} Epiploic appendages are fat filled out-pouchings of the colon. Spontaneous infarction of epiploic appendages results in the sudden onset of constant localised pain, typically in the lower quadrant. It occurs in adults of all ages, and both sexes are equally affected. It occurs more commonly in obese people, especially in those who have recently lost weight. Patients are seldom ill; they usually have normal temperature and inflammatory markers.³ The differential diagnosis of epiploic appendagitis includes diverticular disease, appendicitis, omental infarction, renal colic, and gallbladder diseases. Gynaecological presentations and groin hernias often need to be excluded.

Epiploic appendagitis is a self-limiting process that is easily managed conservatively, with reassurance and analgesia. The radiological appearances are characteristic and can persist for weeks.⁴ In patients with localised lower abdominal pain and tenderness, with no associated leucocytosis or elevation of inflammatory markers, a diagnosis of epiploic appendagitis should be considered. This can be confirmed easily by an early ultrasound examination.

Authors' affiliations

J M Hanson, A W Kam, Department of Medical Imaging, Sunnybrook and Women's College Health Sciences Centre, Toronto, ON, Canada

Competing interests: none declared

Correspondence to: Dr Hanson, DIO, St James Hospital, St James Street, Dublin 8, jhanson@stjames.ie

Accepted for publication 13 September 2005

REFERENCES

- 1 Van Breda Vriesman AC, Puylaert JBCM. Epiploic appendagitis and omental infarction: pitfalls and look-alikes. *Abdom Imaging* 2002;**27**:20–8.
- 2 Zissin R, Hertz M, Osadchy A, et al. Acute epiploic appendagitis: CT findings in 33 cases. *Emerg Radiol* 2002;**9**:262–5.
- 3 Sangha S, Soto JA, Becker JM, et al. Primary epiploic appendagitis: an underappreciated diagnosis. A case series and review of the literature. *Dig Dis Sci* 2004;**49**:347–50.
- 4 Molla E, Ripolles T, Martinez MJ, et al. Primary epiploic appendagitis: US and CT findings. *Eur Radiol* 1998;**8**:435–8.

Figure 1 Ultrasound image (ATL 5000), obtained over the area of maximal tenderness using a variable 7–10 MHz frequency linear probe. A well-defined hyperechoic mass with a hypoechoic rim is seen adjacent to the antimesenteric border of a bowel loop (white arrows). The mass was fixed in position and non-compressible. It was avascular with no flow demonstrable on Doppler interrogation.