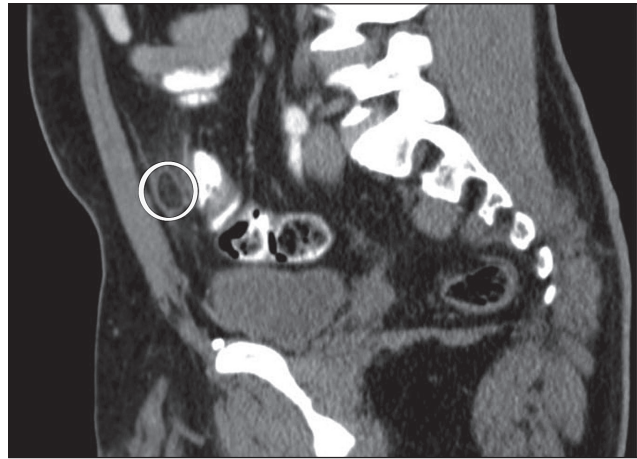
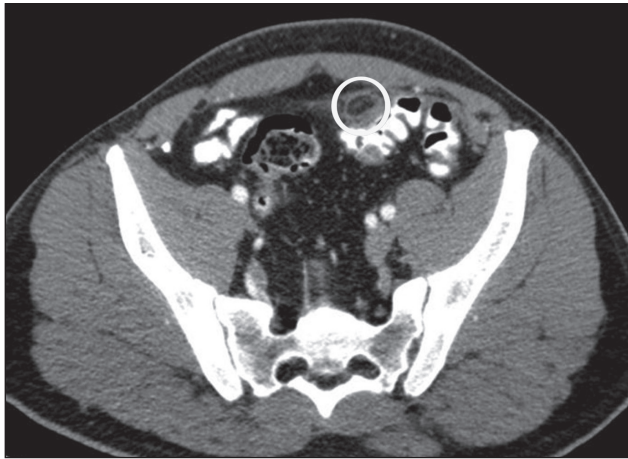


Epiploic Appendagitis: A Diagnosis to Consider



Our patient was a 47 year-old male with past medical history of fatty liver and abdominal wall repair who was in his usual state of health until he felt a sharp left lower abdominal pain. Patient denied fever, nausea, vomiting, diarrhea, constipation, unintentional weight changes, and night sweats preceding this event. Patient also denied taking medications.

Initial labs were normal. Abdominal sonogram and an abdominopelvic CT with oral and IV contrast (Image 1 and 2) were ordered to evaluate the possibility of a medical emergency. Ultrasound was remarkable for underlying fatty liver disease. CT confirmed fatty liver and the stated abdominal wall repair, as well as an oval-shaped fat density structure adjacent to the mesenteric side of the sigmoid colon, measuring 1.6 cm by 0.9 cm. There was surrounding inflammatory pericolic fat stranding and localized mild sigmoidal wall thickening along with a central hyperdense dot representing the thrombosed vascular pedicle. The main working diagnosis for this finding was epiploic appendagitis.

Epiploic appendagitis is a self-limiting condition that occurs when an epiploic appendage undergoes spontaneous torsion or venous thrombosis, with associated inflammatory changes. This condition usually presents with localized sharp pain in the left abdomen without rebound tenderness. Less common symptoms include fever, vomiting, bloating, and diarrhea (1).

Diagnosis is established on abdominal CT and the classic finding is a 2 to 3 cm, oval-shaped, fat density, pericolic mass with thickened peritoneal lining and periappendageal fat stranding. Epiploic appendices may be incidentally found if

surrounded by a sufficient amount of intraperitoneal fluid or inflammation (2).

The differential diagnosis for acute abdomen is a broad list that can be narrowed down with proper history and physical examination, and, while some conditions may be diagnosed based on clinical criteria alone, others may rely on imaging for accurate diagnosis. Imaging can also result challenging to physicians, since many conditions share similarities (3). It is important to consider this diagnosis in cases of abdominal pain since it is a non-surgical condition that is treated with supportive care, usually responding well to NSAIDs (1).

On the other hand acute appendicitis and diverticulitis are treated surgically in some instances. In this case it is easy to misinterpret this finding as an acute diverticulitis. *The author/s has/have no conflict/s of interest to disclose.*

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