

Clinical Images**Epiploic Appendagitis: A Benign Process at Risk of Unnecessary Hospitalization and Interventions**Stephen E. Kessler, BA¹ and Gladys Martin, MD²¹Keck School of Medicine of the University of Southern California, Los Angeles, CA, USA; ²Department of Medicine, VA Greater Los Angeles Healthcare System, Los Angeles, CA, USA.**KEY WORDS:** clinical images; gastroenterology; radiology.
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A 58-year-old man presented with 2 days of acute left lower abdominal pain and bloating. His medical history was significant for prior appendectomy. On exam, he was afebrile and exhibited tenderness in the left lower quadrant without rebound, guarding or tympany. Lab tests revealed mild leukocytosis and elevated lactate. Abdominal CT showed inflammation of the fat anterior to the distal descending colon. (Fig. 1) The rare diagnosis of epiploic appendagitis was made. The patient was admitted for observation. He was discharged



Figure 1 Abdominal CT showing a fat-attenuating ovoid mass surrounded by a hyper-attenuating rim with inflammatory changes anterior to the distal descending colon (white arrow).

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home the following day, and his symptoms self-resolved within a week.

Epiploic appendagitis is a benign, self-limiting condition caused by torsion of a colonic fat-containing appendage or thrombosis of the central draining vein. Ischemia and infarction ensue. Clinically, patients present with lower abdominal pain similar to acute diverticulitis or acute appendicitis. Abdominal CT is diagnostic.¹ Treatment is conservative and focuses on pain management.² Antibiotics are generally not indicated³, except in rare cases in which colonic bacteria infiltrate and cause localized abscess formation or generalized peritonitis.⁴ Surgical intervention is only necessary in the uncommon event of secondary complications such as bowel obstruction.⁵ Symptoms generally self-resolve within a week.⁶

Increased clinician familiarity with this disease process can prevent unnecessary hospitalization and interventions.

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REFERENCES

1. Sandrasegaran K, Maglinte DD, Rajesh A, Akisik FM. Primary epiploic appendagitis: CT diagnosis. *Emerg Radiol.* 2004;11:9.
2. Schnedl WJ, Krause R, Tafeit E, et al. Insights into epiploic appendagitis. *Nat Rev Gastroenterol Hepatol.* 2011;8:45.
3. Chen JH, Wu CC, Wu PH. Epiploic appendagitis: an uncommon and easily misdiagnosed disease. *J Dig Dis.* 2011;12(6):448–52.
4. Romaniuk CS, Simpkins KC. Case report: pericolic abscess secondary to a torsion of an appendix epiploica. *Clin Radiol.* 1993;47(3):216–7.
5. Puppala AR, Mustafa SG, Moorman RH, Howard CH. Small bowel obstruction due to disease of epiploic appendage. *Am J Gastroenterol.* 1981;75:382.
6. Rioux M, Langis P. Primary epiploic appendagitis: clinical, US, and CT findings in 14 cases. *Radiology.* 1994;191:523.