Epiploic Appendagitis: A Red Herring?

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Introduction:

- Epiploic appendagitis (EA) is one of the rare cause of abdominal pain with a relatively benign course.
- The importance of identifying EA as a clinical mimicker is crucial to avoid unnecessary hospitalizations, antibiotic use, and surgery.
- Although no trigger has been identified or established as a cause for EA, it has been hypothesized that systemic inflammation can lead to epiploic appendagitis attack.

Case Discussion:

- A 43-year-old Caucasian woman with no previous GI history presented with sudden, sharp LLQ abdominal pain and nausea that progressively worsened over 2 days.
- CT abdomen revealed a hyperattenuating ring lesion along the antimesenteric margin of the distal descending colon with mesenteric lymphadenopathy as seen in Fig,1.
- This initial episode of epiploic appendagitis was treated conservatively with complete resolution of symptoms.
- Over the next few years, she had similar recurrences all of which spontaneously resolved.
- With her most recent episode a CT abdomen revealed recurrence of the epiploic appendagitis as seen in Fig.2, with green arrow showing colonic wall thickening adjacent to the EA.
- She again improved with symptom control.
- Given the recurrent episodes of EA and that she now met criteria for age related screening, a colonoscopy was performed.

Fig.1

Fig.2

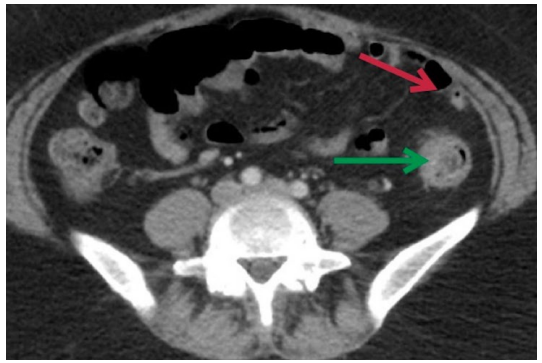

Fig.3

Case Discussion:

- Colonoscopy revealed a large circumferential mass in the sigmoid colon, with an apple core lesion in the proximal sigmoid colon with luminal narrowing as seen in Fig.3. No lymph node involvement was noted. Biopsy revealed adenocarcinoma of the sigmoid colon.
- The TNM staging was pT3 N0 M0, hence she underwent local resection with end-to-end intestinal anastomosis.

Conclusion:

- Epiploic appendages are fat-filled serosal outpouchings of the colonic surface with a vascular stalk. Acute EA is theorized to be caused by torsion, underlying inflammation or venous occlusion.
- CT is the gold standard for establishing the diagnosis of EA and does not require further testing.
- Recurrent and persistent EA is very rare with only 20-25 reported cases and can mask an occult abdominal pathology that could trigger it.
- There have been no reported cases of CRC that are associated with and possibly trigger EA raising the question whether colonoscopy should be added to the workup of recurrent EA.

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