

The patient had epiploic appendagitis (EA), an inflammatory process involving the appendices epiploicae.

The radiographic reading:

In the left lower quadrant along the antimesenteric surface of the distal descending colon there is a 29 x 10 x 21 mm oblong fatty structure with a halo of inflammatory change in the surrounding fat. This is a classic location and appearance of epiploic appendagitis. There are a few scattered diverticula in the descending and sigmoid colon but the focal inflammation surrounds this fatty appendage and is unrelated to the diverticula.

The rest of the large bowel, stomach, and small bowel are normal. The appendix is normal.

The liver, gallbladder, pancreas, and spleen appear normal. A small splenule is noted in the splenic hilum.

The adrenal glands, kidneys, and urinary bladder are within normal limits. The prostate is normal.

A nice summary of the anatomy and condition follows:

“First described by Vesalius in 1543 and first recognized on CT scan in 1986, epiploic appendixes are finger-like projections of adipose tissue arranged in parallel rows along the colon. Although the average appendage is 3 cm long in the adult, rare epiploica have grown to 15 cm (3,7,8). Almost 100 appendages adorn the average colon extending from the cecum to the sigmoid. Each appendage is supplied by one or two small arteries from the colonic vasa recta and is drained by a single vein. Historically, this entity has been referred to as appendixes epiploica, hemorrhagic epiploitis, and epiplopericolitis. Acute disease processes of these appendages can include: spontaneous torsion and hemorrhagic infarct, calcification due to aseptic fat necrosis, primary or secondary inflammation, enlargement by lipomas or metastases, and incarceration in hernias.” (Ref. 1)

Most cases do not require surgery. About 50-60% of cases are right sided, involving cecal appendix epiploica, and therefore can mimic appendicitis. Most authors stress that, unless it is an unusually severe case of EA requiring surgery, EA patients are much less sick than pts with appendicitis or diverticulitis (other differential dx). See ref. 2 for a sicker patient with a gangrenous EA.

References:

1. Legome, E. L., A. L. Belton, et al. (2002). "Epiploic appendagitis: the emergency department presentation." J Emerg Med 22(1): 9-13.

2. Patel, V. G., A. Rao, et al. (2007). "Cecal epiploic appendagitis: a diagnostic and therapeutic dilemma." *Am Surg* 73(8): 828-30.