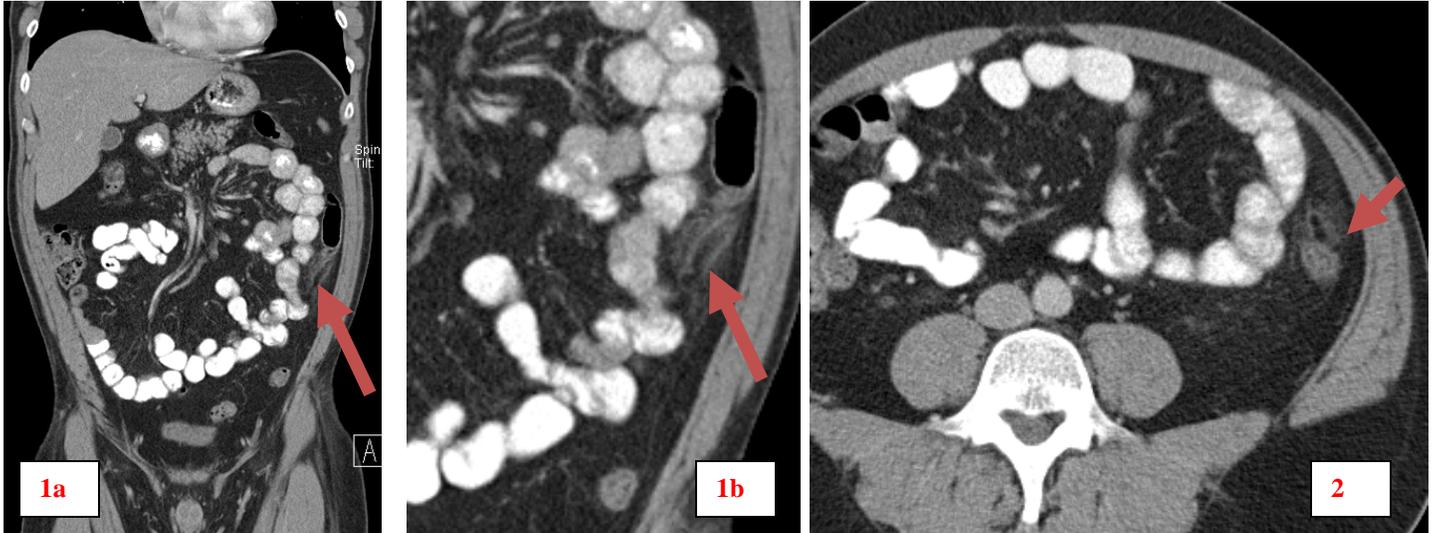


Unknwon Case: LLQ Abdominal Pain



CLINICAL PRESENTATION: This 40-year-old patient presented with 3-day history of LLQ pain. Good appetite and normal bowel movements. Pain not reproduced by stretching, bending. Abdominal exam: Mild but definite localized LLQ pain without guarding. VS normal. No fever. A 64-slice CT of the abdomen/pelvis with/without contrast was performed to rule out diverticulitis.

IMAGING FINDINGS: **Fig. 1a-b:** Coronal image of the abdomen/pelvis with a magnified view (**1b**) of the LLQ. **Fig. 2:** Axial post-contrast view of the lower abdomen.

There is a 1x2 cm abnormality (**arrow**) abutting the descending colon with central fat density and surrounding stranding/inflammation. No fluid collection. No diverticula or colonic wall thickening.

DIFFERENTIAL DIAGNOSIS: LLQ inflammatory changes can be seen with **diverticulitis**. However, lack of diverticula or bowel wall thickening in this case is against this diagnosis. If found in the RLQ, **appendicitis** would be in the DDX. However, the above findings are most compatible with **epiploic appendagitis**.

DISCUSSION: **Epiploic (or Omental) Appendices (or Appendices Epiploicae)** are projections of adipose tissue (peritoneum) that extend from the colon surface into the abdominal cavity. They are 1-2 cm thick and 3-5 cm long. In the average adult, they typically number between 50-100. Normally, appendices epiploicae are not visible on CT scan because they blend with surrounding fat. As a result of limited blood supply, shape and mobility, appendices epiploicae are prone to torsion and subsequent ischemia and infarction. Acute torsion results in a local inflammatory process called **epiploic appendagitis**. This condition clinically presents as localized abdominal pain in one of the lower quadrants, since the sigmoid colon and cecum are more common sites of involvement. **DDX:** CT can help differentiate this clinical presentation from acute appendicitis, diverticulitis, or other causes of an acute abdomen. Treatment is medical. Symptoms typically resolve in 4 to 7 days. NSAIDs and narcotics are typically administered.

Ray Hashemi, MD

Ray H. Hashemi, M.D., Ph.D.

Diplomat American Board of Radiology