

Epiploic Appendagitis: A Rare Cause of Acute Abdomen

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Abstract: Epiploic appendagitis is a rare cause of acute abdomen. It can mimic other inflammatory processes such as diverticulitis or appendicitis. Diagnosis is based on CT scan. Medical management is the approach of choice in the absence of complications.

Keywords: Appendagitis, epiploic,

Introduction

Primary epiploic appendagitis is a rare cause of acute abdomen. It often occurs as a result of torsion and primary inflammation of the epiploic appendages diagnosed in the preoperative period. Treatment is usually medical. Through this observation and a review of the literature we try to raise the clinical and therapeutic aspects.

Observation

A 45 year old man with no significant pathological history. Admitted to emergency for management of epigastralgia, febrile. On admission patient BMI 29 conscious with a pulse of 90 beats/min, abdominal examination found epigastric defence with palpable mass the rest of the somatic examination was unremarkable. Biologically white blood cells at 20,000 per cubic millimetre and CRP at 200 mg/l. A computed tomography (CT) scan was performed urgently, showing epiploic appendicitis complicated by abscess (Figure 1). The patient was taken to the operating theatre with the intraoperative discovery of an abscessed transverse colon fringe that was sealed by the epiploon, the procedure having consisted of resection of the mass (Figure 2). The after-effects were simple, the patient was discharged on day 3.



Figure 1: epiploic appendagitis of the transverse colon complicated by an abscess



Figure2: appendagitis blocked by the epiploon

Discussion

Primary epiploic appendagitis is a benign, self-limiting inflammation of the epiploic appendages [1]. It is a rare etiology of abdominal pain in adults [2]. The incidence of this condition is not really known and the prevalence is underestimated. It occurs between the ages of 20 and 50 with a slight male predominance [3]. It mainly affects overweight subjects, as they have a greater number and volume of epiploic appendages [4]. These characteristics are present in our patient. Epiploic appendages can occur along the colon, in order of frequency, the order of frequency, the recto sigmoid hinge (57%), the ileocaecal region (26%), the ascending colon (9%), the transverse colon (6%) and the descending colon (2%) [3]. In our case the location was in the transverse colon. Clinically, abdominal pain is always constant and localised depending on the site of the pathological appendix; in 10 to 30% of cases, a subparietal abdominal mass can be palpated [5]. Its palpation causes extreme pain. In our case it was a palpable epigastric mass more lateralized on the left, the palpation of which causes abdominal defence. However, in front of this symptomatology the diagnosis of appendagitis is rarely made due to the interest of the imaging. The diagnosis of certainty is most often made by CT scan without or with injection of contrast medium, but ultrasonography and magnetic resonance imaging (MRI) can also be used [6]. On CT, epiploic appendagitis appears as a round, ill-defined oval lesion adjacent to the colon with a density slightly greater than normal fat [4, 6, 7]. The pathognomonic sign is the "ring sign" which is a peripheral hyperdensity corresponding to inflammation of the serosa. However, the absence of this sign does not exclude the diagnosis of acute epiploic appendagitis [8]. In the majority of cases, epiploic appendagitis is treated medically, based on pain control. Oral anti-inflammatory drugs are usually prescribed for 4-7 days, and antibiotics are not often indicated. Surgery is reserved for patients whose symptoms do not improve with conservative management, as well as those who develop complications. In this case, the inflamed appendix will be ligated and resected [9].

Conclusion

Epiploic appendagitis is a rare cause of acute abdomen. The clinic is characterised by constant and localised pain depending on the location of the pathological appendix.

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