AMSER Case of the Month
July 2022

68-year-old male with left lower quadrant abdominal pain

Seong Lee MS4
Michael Pasyk, MD
Peter J. Haar, MD, PhD
Virginia Commonwealth University
Patient Presentation

• **HPI**
  - 68-year-old male presents to ED with left lower quadrant abdominal pain for 3 to 4 days
  - Complains of moderate, non-radiating, dull, constant pain that is worse with ambulation
  - Was seen in ED 1 week ago for chest pain, had negative cardiac workup at that time and chest pain has since resolved

• **Past medical history**
  - CAD s/p stents, HTN, CKD, hernia repair

• **Medications**
  - Aspirin, lisinopril, metoprolol, levothyroxine, rosuvastatin

• **Physical Exam & Labs**
  - Vitals stable, left lower quadrant tenderness to palpation without rebound or guarding
  - No significant lab findings
What imaging should we order?
Select the applicable ACR Appropriateness Criteria

This imaging modality was ordered by ED physician

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Appropriateness Category</th>
<th>Relative Radiation Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT abdomen and pelvis with IV contrast</td>
<td>Usually Appropriate</td>
<td>****</td>
</tr>
<tr>
<td>CT abdomen and pelvis without IV contrast</td>
<td>May Be Appropriate</td>
<td>***</td>
</tr>
<tr>
<td>MRI abdomen and pelvis without and with IV contrast</td>
<td>May Be Appropriate</td>
<td>O</td>
</tr>
<tr>
<td>MRI abdomen and pelvis without IV contrast</td>
<td>May Be Appropriate</td>
<td>O</td>
</tr>
<tr>
<td>US abdomen transabdominal</td>
<td>May Be Appropriate</td>
<td>O</td>
</tr>
<tr>
<td>CT abdomen and pelvis without and with IV contrast</td>
<td>Usually Not Appropriate</td>
<td>****</td>
</tr>
<tr>
<td>Fluoroscopy contrast enema</td>
<td>Usually Not Appropriate</td>
<td>***</td>
</tr>
<tr>
<td>Radiography abdomen and pelvis</td>
<td>Usually Not Appropriate</td>
<td>***</td>
</tr>
<tr>
<td>US pelvis transvaginal</td>
<td>Usually Not Appropriate</td>
<td>O</td>
</tr>
</tbody>
</table>
Findings (Unlabeled)
Findings (Labeled)

Fat containing mass with surrounding stranding adjacent to the descending colon, approximately 30mm
Final Diagnosis

Epiploic appendagitis
Discussion: Background

- Epiploic appendages are normal outpouchings of peritoneal fat on the colonic surface. Epiploic appendagitis is the ischemic infarction of an epiploic appendage caused by torsion or spontaneous thrombosis.

- Acute diverticulitis and appendicitis make up the differential diagnosis of epiploic appendagitis. In fact, epiploic appendagitis is reported in 2-7% of patients initially suspected of having acute diverticulitis and 0.3-1% of patients suspected of having acute appendicitis.

- Mean age of diagnosis is 40 years with 4x higher incidence in men compared to women.

- Epiploic appendagitis can arise in any segment of the colon, but most common in the rectosigmoid colon.
Discussion: Clinical Presentation and Treatment

• Clinical Presentation
  • Epiploic appendagitis most commonly present with acute or subacute onset of lower abdominal pain, 60-80% of patients report left sided pain
  • Physical exam localizes pain to affected area, otherwise patients are usually non-toxic appearing, afebrile, without peritoneal signs
  • Other less common symptoms may include vomiting, bloating, diarrhea, and low-grade fever

• Usual Treatment
  • Can be managed conservatively with oral anti-inflammatory medications (NSAIDS, acetaminophen) for 4-7 days, usually does not require hospitalization or antibiotics
  • If conservative management fails or symptoms worsen, surgery should be performed
Discussion: Our Patient’s Course

- Patient was discharged in stable condition with instructions to take NSAIDs for 5 days then follow-up with his PCP and to return to the ED if symptoms worsened
References
