

Answer

Epiplonic Appendagitis

After the dark mass was detached from the parietal peritoneum, a strangulated omental appendix became apparent and was constrained by 2 additional flanking appendices. After applying a loop to the neck of the appendix, it was removed. Pathological review of the specimen revealed fat necrosis and inflammatory cells within the omental appendix. The clinical course was uneventful, and the patient was discharged after 48 hours.

Omental appendices (also known as *epiploic appendices* or *epiploic appendages*) are peritoneal pouches that arise from the serosal surface of the colon. Composed of adipose tissue and blood vessels, they have an average length of 3 cm. Those next to the sigmoid colon are the largest. The term *epiploic appendagitis* was introduced in 1956 by Dockerty et al¹ to describe inflammation of these appendices. The main cause for inflammation and symptoms is torsion and/or strangulation of the appendages.²

On clinical examination, patients describe a localized strong, sharp pain. The abdominal pain is aggravated by movement but does not migrate. Most often, the patients have abdominal tenderness; otherwise, fever, vomiting, and leukocyte level elevation are absent. In general, the patient does not feel ill, has normal bowel movements, and has an adequately normal appetite. As in the case presented herein, sometimes the omental appendix twists temporally and causes intermittent pain. Historically, the diagnosis was made by laparotomy.³

Since the introduction of cross-sectional imaging, epiploic appendagitis can be diagnosed preoperatively. Computed tomographic features of epiploic appendagitis were first described in 1986 by Danielson et al.⁴ The most common sites (in order of decreasing frequency) are adjacent to the sigmoid colon, the descending colon, and the ascending colon. The most common feature visible on CT is an oval lesion, ranging from 1.5 to less than 5 cm in diameter, with fat-equivalent attenuation abutting from the anterior colonic wall and perifocal fat stranding that represents inflammatory changes. Sometimes, central hypodensity represents venous obstruction. Thickening of the adjacent peritoneal wall is also usually detected. In most cases, the wall of the colon appears unremarkable; in rare cases, wall thickening is seen.³

Therapy for appendagitis is still under debate. Because appendagitis is a self-limiting condition, some authors favor conservative treatment with administration of oral anti-inflammatory medication.^{3,5} However, the literature describes a recurrence rate of up to 40%, and some of these patients require CT follow-up.⁶ The value of minimally invasive surgery in the diagnosis and treatment of acute abdominal pain of unclear etiology is well known,

and laparoscopic interventions are highly appealing to both the patient and surgeon. Furthermore, other abnormalities can be detected or excluded during laparoscopy. Therefore, we favor a laparoscopic approach whenever appendagitis is suspected.

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