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Unusual course of epiploic appendicitis

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Dear Editor,

We present the case of a 52-year-old woman diagnosed with fibromyalgia and renal colic. She had a history of 3 cesareans, right oophorectomy, adhesiolysis and appendicectomy. She was allergic to non-steroidal anti-inflammatory drugs (NSAIDs). She was admitted for 48 hours abdominal pain initially in the left renal fossa radiated to the inguinal region. Afterwards she referred continuous left lower quadrant pain not related with intake, which worsened in sitting and improved in supine and standing. She also referred nausea and anorexia without weight loss or changes in bowel habits. Our patient had normal vital signs and no fever. An abdominal examination revealed tenderness of the left lower quadrant. Abdominal ultrasonography was normal. An abdominal computed-tomography (CT) scan visualized a 2.4x0.8 cm fat oval image located in the anterior inferior splenic’s edge that protruded in the colon (Fig. 1).

She was diagnosed with epiploic appendicitis and treatment with antibiotics and corticosteroids were initiated. However she had persistent abdominal pain so she required three hospital admissions and she had to be assessed by the Pain Unit.
Steroids and opioids were prescribed. Finally laparoscopic surgery was performed with removal of the inflamed appendix and the patient remained asymptomatic (Fig. 2).

Epiploic appendices are peritoneal pouches that arise from the serosal surface of the colon with an unknown function (1-3). Epiploic appendicitis was first described in 1956 by Lynn and it is a cause of acute abdomen in 0.6% of the cases. It predominates in the second and fifth decade, with a similar incidence in both sexes and can be primary or secondary (1-3). The secondary form is the most common and it happens when the appendix tries to form a plastraon around a swollen structure (appendicitis, diverticulitis) to limit inflammation (5). Primary epiploic appendicitis results from twisting of an appendageal draining vein. The 75% of the cases are seen on the left side (6). Clinical features depend on the speed of the torsion. If it is gradual the patient is usually asymptomatic. The acute and self-limited presentation is the most common, lasting from 3 to 14 days. The main clinical feature is a sudden and sharp abdominal pain located in the left lower quadrant. When it is on the right lower quadrant it may mimic acute appendicitis, but pain is better located and more cranial than in appendicitis. It is a local process, without malaise or constitutional syndrome in most cases (3,4). Only 25% of the patients have changes in their bowel habits, usually constipation. Fever is exceptional and in 25% of the cases there is febricula. Clinical examination reveals pain predominantly in the left abdomen with peritoneal irritation if there is involvement of the parietal peritoneum with mass presentation in 10-30% of the cases (3,4). Laboratory values are within normal limits, except for slight leukocytosis and elevated acute phase reactants. A thorough and careful radiological workup may help in resolving the diagnostic dilemma. Ultrasound is usually the first exploration due to its availability and no radiation (7), but computer tomography is the best radiologic evaluation. Differential diagnosis must be made with diverticulitis, acute appendicitis (8), Meckel’s diverticulum, omental infarction, mesenteric adenitis, ileitis and gynecological disease, although they present with malaise and constitutional syndrome (2,3,7,8).

As a self-limiting condition, patients are treated conservatively with oral analgesics and anti-inflammatory medication (1-8). Antibiotics are not usually used. Some authors advocate surgery and resection of the epiploic appendix; however complications
obstruction, intussusception, abscess) and recurrence are exceptional. Our case raises the question of whether NSAIDs alter the evolution for its anti-inflammatory properties. However, she received steroids as they are also anti-inflammatory. It is the first case published with pain resistant to analgesics and eventually resolved with surgical intervention.

References

Fig. 1. Epiploic appendicitis on CT scan
Fig. 2. Adipose tissue with intense esteronecrosis corresponding with necrotic epiploic appendix.