Torsion of Appendices Epiploicae Masquerading as Ogilvie's Syndrome

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Abstract

Torsion of appendices epiploicae is an uncommon differential diagnosis of a patient presenting with acute abdominal pain and its presentation as a Ogilvie's syndrome or colonic ileus is even rare.The diagnosis requires a keen suspicion on the part of the attending surgeon. Preoperative computrized tomography (CT) may help in the diagnosis but the final diagnosis is established only on the operating table . Adding this pathology to the existing list of the causes of colonic ileus /Ogilvies syndrome may give us a good insight into the understanding of the condition & improvise our management.

This is a case report of 60 year old lady who was referred to us with nonspecific abdominal pain , distention of abdomen and vomiting from orthopaedics department , where she was being planned for surgery for intertrochanteric fracture femur. All our investigations were equivocal and suggested a Ogilvie's syndrome like picture . A trial of neostigmine therapy was also given after excluding physical obstruction and the patient did not respond and the patient was operated upon and intraoperative finding of torsed epiploic appendage was found as the cause of her symptoms. The patient made a good post operative recovery following surgical excision of torsed epiploic appendages.

This case should give us another dimension of thought in the management of such cases and help improvise our management.

Key words: torsion, epiploic appandagitis, Ogilvie' s syndrome

Case Report

A 60 year old lady was admitted in the orthopaedics dept for intertrochanteric fracture of left femur following a trivial fall. She was planned for the fixation of the fracture after preoperative work up. Two days before the planned orthopaedic surgery she developed distention of the abdomen and vomiting. The patient failed to pass stools and flatus and was in a great deal of discomfort for the same. On examination- bowel sounds were heard, there was no guarding or any signs of impending bowel perforation .Rectum was found empty on digital rectal examination. Blood investigations did not show any gross abnormality and electrolytes showed mild hypokalemia (K+3.3 mEq/l). Abdominal erect and supine radiographs were obtained which showed distended ascending, transverse and descending colon. An ultrasound of abdomen showed only dilated bowel loops. Based on the above investigations a diagnosis of adynamic ileus/Ogilvie's syndrome was arrived at.

The patient was given a trial of conservative management with oral restriction of fluids and the flatus tube was passed. The fliud and electrolyte imbalances were corrected. All the major etiologies for the diagnosis were ruled out and it was concluded to be a case of idiopathic colonic ileus/ Ogilvie's syndrome. The patient was also given a trial of neostigmine 2.5mg, for which she failed to respond. With continuing distention and no relief of symptoms a decision was taken to perform an exploratory laparotomy with an intent to perform a decompressive ceacostomy . The patient was taken up for the surgery and to our surprise the only significant pathology found were torsed and gangrenous appendices epiploicae - two in the sigmoid colon and another gangrenous fatty appendage in relation to the mesenteric border of the distal jejunum as seen in figure I and II. There was moderate distention of the ascending colon and

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the transverse colon. The gangrenous appendices epiploicae and the fatty appendage in the jejunal mesentry were clamped ligated and excised and were sent for the histopathological examination as shown in figure III .

The patient also underwent tube cecostomy. The postoperative period was uneventful with the return of bowel function and oral fluids were resumed on 4th post operative day. Patient recovered well. Cecostomy tube was removed on 15th post operative day. Histopathology showed inflammatory cells within and necrosis with thrombosed vessels.

Discussion

The epiploic appendices are small (0.5–5.0 cm long) pouches of peritoneum filled with fat and small vessels that protrude from the serosal surface of the colon. They occur in the rectosigmoid junction (57%), ileocecal region (26%), ascending colon (9%), transverse colon (6%) and descending colon (2%) . Occasionally they are found on the appendix or small bowel[1,2].

Epiploic appendagitis, denoting inflammation of an epiploicae appendix from any cause, may be primary or secondary. Primary epiploicae appendagitis is caused by torsion or spontaneous venous thrombosis of the involved epiploicae appendage. Secondary epiploicae appendagitis is associated with inflammation of adjacent organs, such as diverticulitis, appendicitis, or cholecystitis. Primary epiploicae appendagitis occurs in the second to fifth decades of life without sexual preponderance. Patients may present with localized abdominal pain of variable intensity and duration, rebound tenderness, an abdominal mass, mild fever, and mild leukocytosis. The nonspecific symptoms may mimic appendicitis, diverticulitis, omental infarction, pelvic inflammatory disease, or a ruptured ovarian cyst. Until the advent of sonography and CT, primary epiploicae appendagitis was rarely diagnosed correctly before surgery[3,4,5].

In the past, diagnosis of epiploic appendagitis was often the result of an unexpected finding during an exploratory laparotomy. Today this condition is usually diagnosed by ultrasound or CT, with the latter more sensitive and specific. Although ultrasound has the advantage of correlating the location of the lesion with the location of maximum tenderness, CT should be used to confirm the fatty nature of the lesion before making a definite diagnosis of primary epiploic appendagitis. With the increasing use of CT for assessing cases of acute abdominal pain, the diagnosis of epiploic appendagitis is now more common. Diagnostic laparoscopy is now considred as a good diagnostic modality that offers an accurate assessment of this obscure pathology with the benefits of minimal risk and rapid recovery. In recent times, laparoscopic detection and treatment (by excision) has been reported from several centres [6,7,8,9].

This case gives us another rare but a definite cause of idiopathic pain abdomen, which a surgeon should keep in the long list of differential diagnosis. In view of the rarity of the entity, we could not diagnose it pre operatively. So this case should alert one to keep this diagnosis in mind whenever we deal with cases of this type. It also highlights the need for multi speciality approach to such patients, else it is impossible to handle such cases.

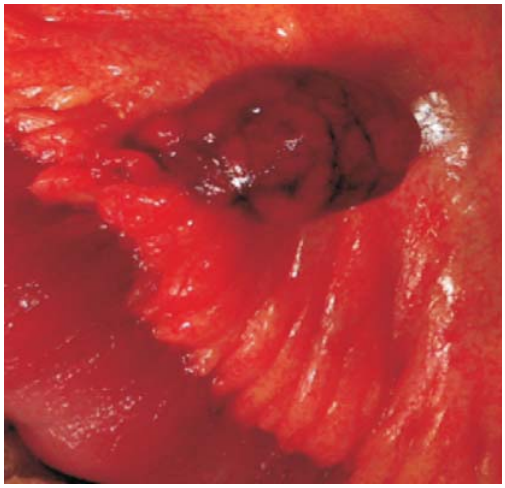

Figure I Torsion of epiploic appandage near jejunal mesentery

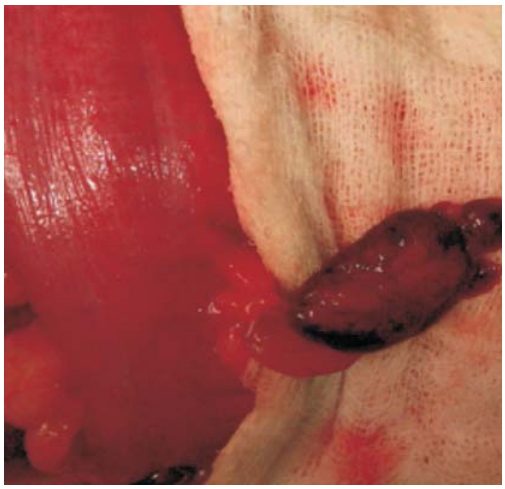

Figure II appendices epiploicae of sigmoid colon showing torsion

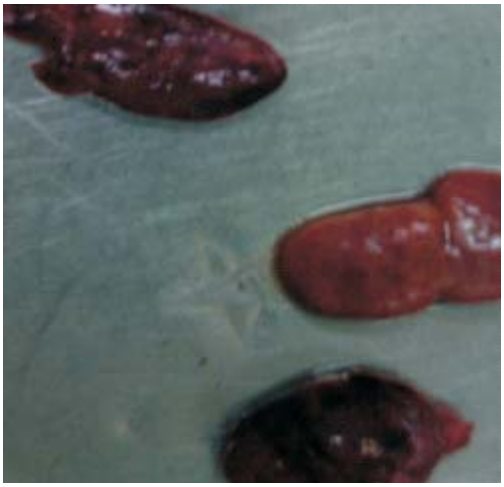

Figure III Excised specimen of appendices epiploicae

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