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Review Article

Peritoneal Nodules: It is not Always Carcinosis

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History

A man, aged 50 years, admitted to our training for management of an undifferentiated carcinoma of nasopharyngeal type known by the acronym UCNT (Undifferentiated Carcinoma of Nasopharyngeal Type). On MRI of the cavum UCNT was classified as T2N1. The patient was started on neoadjuvant chemotherapy and had a thoracoabdomino-pelvic CT scan as part of his extension workup (Figure1).

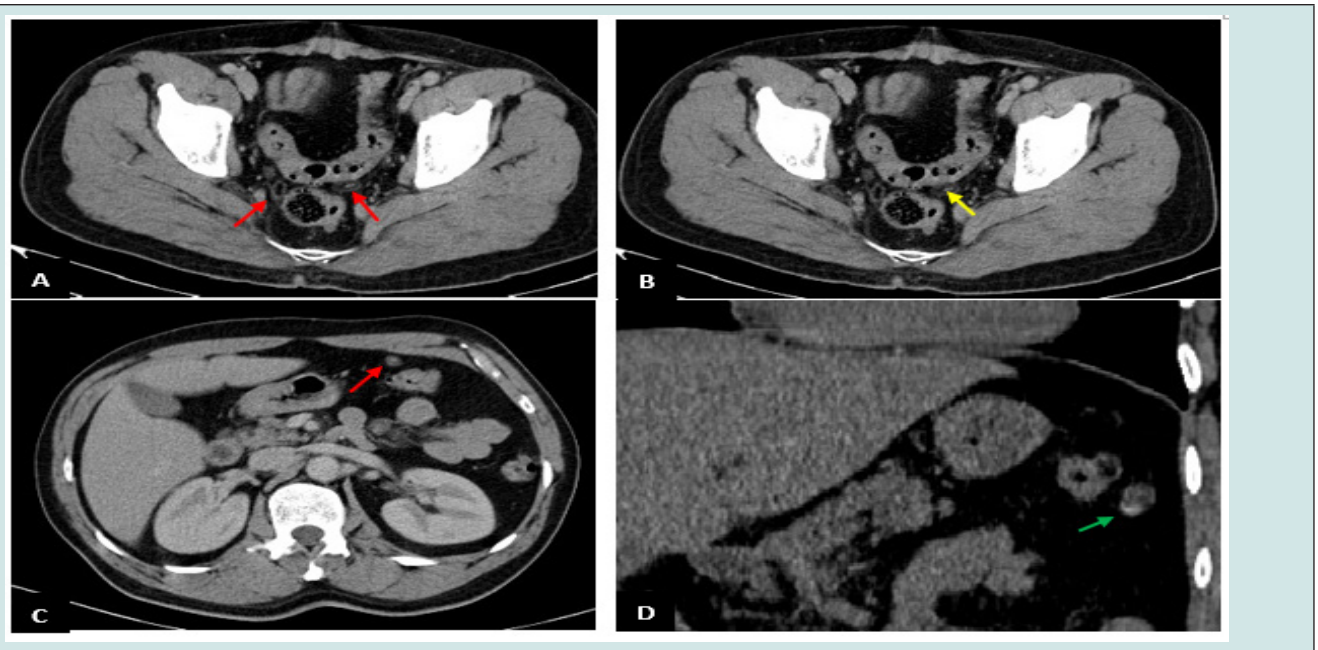

Figure 1: Axial slice CT images (A, B, C, D) showing fat-dense oval shuttle-shaped pericolic formations (red arrows) surrounded by a peripheral hyperdense ring giving a Ring Sign appearance. Some of them have a central hyperdensity making the Central Dot Sign appearance (yellow arrows) and others start to calcify (green arrow).

Diagnosis: Epiploic Appendagitis

Comments

Epiploic appendicitis is an often-unrecognised condition that is one of the aetiologies of peritoneal fatty nodules. Epiploic or omental appendages are pedunculated fatty formations containing vessels from the colonic vasculature, resting on the colonic serosa and covered by the visceral peritoneum. These appendages number 50-100, extending from the cecum to the recto-sigmoid junction with a size that varies between 0.5 and 5cm. They are arranged either anteriorly along the free teniae coli and posterolaterally along the omental teniae coli [2]. A normal epiploic appendix is not seen on either ultrasound or CT. Appendagitis occurs either spontaneously by torsion or thrombosis of this appendix or secondarily to the extension of an inflammation of the adjacent abdominal organs, notably in the case of diverticulitis or appendicitis [2]. The phenomena of torsion and ischaemia are favoured by the pedicle shape of the appendix, by its excessive mobility and by its precarious vascularisation [2]. Clinically, it manifests itself by abdominal pain of sudden onset, which can be demonstrated with a finger [2]. Ultrasound reveals an oval swollen nodule, hyperechoic with central hypoechogenicity corresponding to the thrombosed vessel or haemorrhage, non-compressible and of anterior topography to the colon [3]. This appendix is surrounded by a hyperechoic ring representing the thickened serosa, giving the Ring Sign appearance. The Doppler shows no colour signal within the lesion or in some cases peripheral hyper vascularisation [2]. The CT scan allows a diagnosis of certainty to be made in most cases, showing an oval shuttle-shaped lesion of fat density, most often anterior to the colon. This appendage is surrounded by a 2-3mm thick hyperdense ring, giving a ring sign appearance [1]. This sign is highly suggestive of the diagnosis and is retained as a primary criterion [1]. Other signs have also been described, such as central hyperdensity corresponding to the thrombosed vessel, giving a central dot sign, and thickening of the parietal peritoneum or the colonic wall [1,2]. This infarcted appendage may detach, calcify and subsequently become a loose peritoneal body or so-called peritoneal mouse [3]. The differential diagnosis includes other causes of acute abdominal pain, specifically diverticulitis, torsion of the greater omentum and mesenteric panniculitis [1]. It can occur with tumours with a fatty component such as liposarcoma and exophytic angiomyolipoma or also as in our case with peritoneal metastatic implants [1].

Declaration of Interest

The authors declare that they have no ties of interest.

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