Case	(278) Left lower quadrant abdominal pain: beyond diverticulitis.
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CASE PRESENTATION

We present two patients who came to our Emergency Department (ED) with pain in lower left abdomen from a few days before. Clinical suspicion was acute diverticulitis.

In the first case, the patient was a 63-year-old woman in second visit to ED with left lower quadrant abdominal pain (LLQAP) and fever for two weeks. She was previously diagnosed of urinary tract infection and treated with antibiotic therapy without clinical improvement. Leukocytosis in laboratory tests was present. The second patient was a 39-year-old man consulting because of one week left-sided lower abdominal pain and nausea. No vomiting, no fever. Normal white blood cell count.

For both patients a CT scan was requested and showed two intestinal perforations due to calcified foreign bodies from a probably animal origin. In the first case a chicken bone produced a perforation in a small bowel loop with severes inflammatory changes and fat stranding. In the second case the perforation was located in sigma and it was produced by a fish bone. Also it was associated an important thickness of sigma wall and surrounding inflammation.

One thing in common for both patients was that bowel perforations were contained by inflammatory reaction so there was no pneumoperitoneum or secondary peritonitis. Both patients underwent emergency surgery with completed extraction of foreign bodies. There were no complication in postoperative period.

DISCUSSION

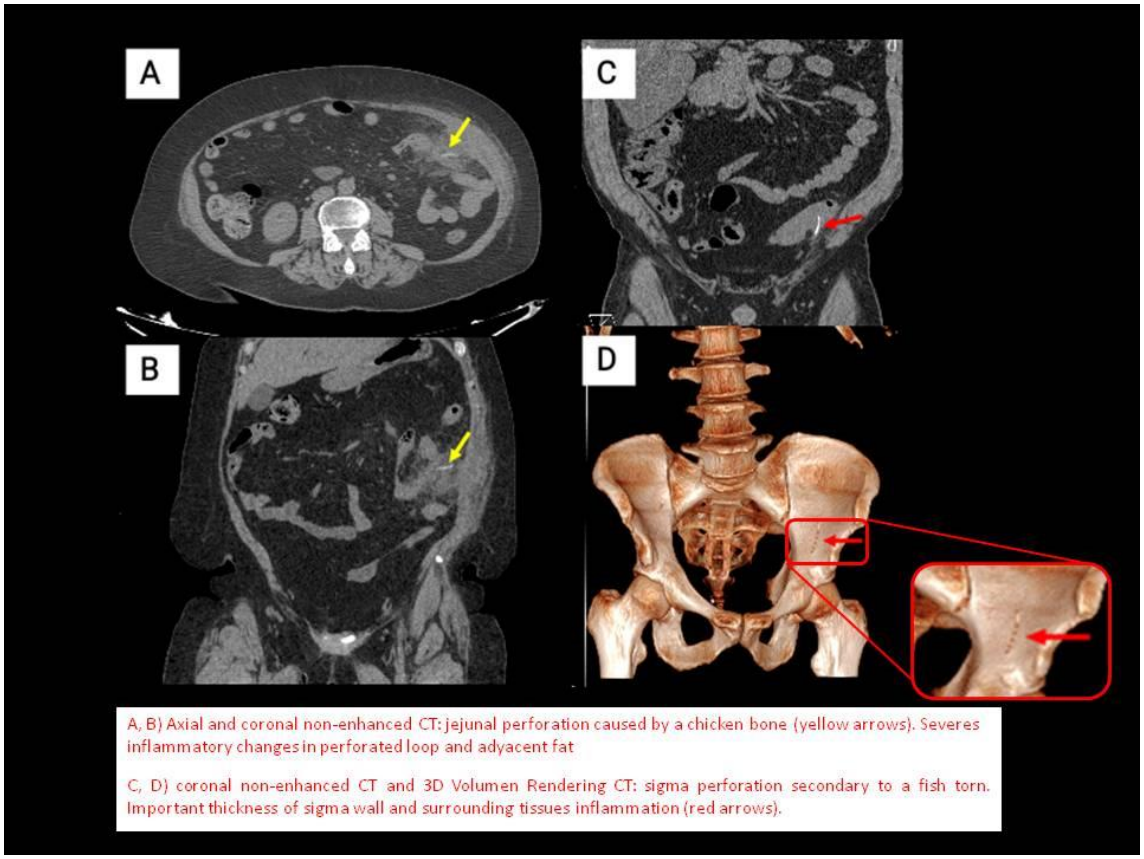
Left lower quadrant pain (LLQP) is one of the most frequent reason for an emergency department visit in our country and acute diverticulits is suspected in most of the patients overall if exist diverticulosis previously diagnosed by colonoscopy.

Differential diagnosis must include mainly renal colic, infectious colitis, strangulated hernia and gynecological diseases (ectopic pregnancy, ruptured ovarian cysts, ovarian torsion, salpingitis…).

However, it can not be forget that foreign bodies ingestion, organic or inorganic, may cause diseases like bowel obstruction, perforations or toxicity secondary to toxic substances absorption. Radiologic modalities such plain radiographs and CT scan often play a definitive role in determining correct diagnosis and defining location, etiologyand presence of complication. Key learning points: left abdominal pain;diverticulitis,foreign body;CT.

CONCLUSION

In patients with LLQP acute diverticulitis must be suspected but differential diagnosis must include urological and gynecologic pathology as well as ingestion of some objects that can produce gastrointestinal complications.



A, B) Axial and coronal non-enhanced CT: jejunal perforation caused by a chicken bone (yellow arrows). Severes inflammatory changes in perforated loop and adyacent fat

C, D) coronal non-enhanced CT and 3D Volumen Rendering CT: sigma perforation secondary to a fish torn. Important thickness of sigma wall and surrounding tissues inflammation (red arrows).

BIBLIOGRAPHY

- Horton KM, Corl FM, Fishman EK.CT Evaluation of the colon: inflammatory Disease. RadioGraphics 2000;20:399-418.

- Gayer G, Petrovitch I, Jeffrey RB.Foreign objects encountered in the abdominal cavity at CT. RadioGraphics 2011;31:409-428.