

# A

## Postgraduate Educational Programme

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Presentation numbers are prefixed by the letter A

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**Mon, March 7, 08:30 - 10:00**

**Room A**

**Abdominal Viscera**

**CC 1517**

**The acute abdomen**

*Moderator:*

*J.-M. Bruel; Montpellier/FR*

**A-454** 08:30

**A. Abdominal hernias**

*G. Brancatelli; Palermo/IT*

Abdominal hernias are common in daily practice and can be divided into: external or abdominal wall hernias, internal hernias and diaphragmatic hernias. External hernias typically involve protrusion of abdominal contents through a defect in the abdominal wall. Internal hernias involve protrusion of viscera through congenital or acquired defects in the mesentery or the peritoneum. Diaphragmatic hernias involve protrusion of abdominal contents into the chest. Among these conditions, the diagnosis of internal hernia is the most challenging. Bariatric surgery and liver transplantation with biliary-enteric anastomosis, with the Roux-en-Y loop placed in a retrocolic position, are recognised predisposing factors for internal hernia development. Symptoms of hernia are nonspecific and vague, and clinical and radiologic diagnosis can sometimes be challenging. Immediate diagnosis is mandatory because misdiagnosis can be complicated by bowel obstruction, volvulus, strangulation, incarceration, or trauma. MDCT with its multiplanar capabilities is widely believed to facilitate this diagnosis, because it is able to delineate hernia type, location, size, and shape and is particularly useful to diagnose unsuspected hernias. It also allows distinguishing hernias from masses of the abdominal wall, such as tumours, haematomas and abscesses. As a result, knowledge of the CT findings of abdominal hernias may allow early and more accurate diagnosis, with a resultant decrease in the mortality rate.

**A-455** 09:00

**B. The wrong twist: mesenteric and omental torsion**

*S.C. Efremidis; Ioannina/GR*

The title of this talk limits the discussion of torsion to the mesentery and omentum. It has to be mentioned, however, that an abnormal twist (torsion) can involve any peritoneal reflection of those suspending and fixating hollow viscera, (e.g. stomach, small bowel, cecum, sigmoid and gallbladder), solid organs, (e.g. spleen, ovaries), or even extraperitoneal (extraabdominal) organs such as the testicles, leading to the pathologic entity of volvulus or torsion of the corresponding viscous with its associated (different) imaging findings, prognosis and treatment. Moreover, twisting of the mesentery and volvulus can occur secondary to a variety of conditions including congenital anomalies of intestinal rotation with variable prognosis. Finally, torsion of the omentum can be either

primary or secondary, also associated with different pathology, imaging findings and treatment. Consequently, a broad spectrum of abnormalities ensues related to the pathophysiology of torsion which requires a detailed classification, an accurate description and the use of correct terminology making it impossible to be covered within the time limits of a presentation. Therefore, focusing the discussion on to abnormal twist of small bowel mesentery and omentum will simplify the approach to avoid overlaps and confusion.

**A-456** 09:30

**C. Acute stages in neoplastic diseases**

*J.A. Guthrie; Leeds/UK*

After the initial presentation, a patient with cancer enters a phase of active treatment (surgery, chemotherapy or radiotherapy), and then remission/cure or palliative phases. An "acute abdomen" may complicate any phase. The principle causes are obstruction, perforation, haemorrhage, ischaemia and sepsis. Tumours arising from the GI tract are leading causes but any tumour involving the abdominal cavity or haematological malignancy may be implicated. During treatment with chemotherapy or radiotherapy acute abdominal symptoms are common as a consequence of direct toxicity. Imaging must be used as an adjunct to clinical assessment. Patterns of abdominal involvement are often modified in the later phases of disease. GI tract obstruction may be due to progression or the mechanical consequences of prior surgery and is more commonly at multiple levels. Perforation or fistulation may occur with either progressive disease or tumour lysis in response to therapy. Cancer does not protect against the common inflammatory conditions but poor host response and the use of steroids may mask signs leading to extensive abnormality at diagnosis. Bone marrow suppression increases susceptibility to infection including neutropenic enterocolitis and haemorrhage. Bone marrow transplantation and consequent graft versus host disease is a potent cause of acute abdominal symptoms. CT is the major imaging technique although MR has an increasing role particularly in the assessment of the female pelvis. Major determinants when considering the differential diagnosis include; the nature and initial stage of the primary, any prior anatomical modification (surgery), the nature and relationship to current treatment and the bone marrow status.