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Images in vascular medicine

Ormond's disease: an unusual cause of abdominal pain

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Panel A



Panel B

A 47-year-old male smoker with hyperlipidemia reported suffering from dull, aching, mid-abdominal pain with right groin pain for 4 months. The pain was associated with nausea, diminished appetite and a weight loss of 10 pounds (4.5 kg). He reported back pain radiating to the buttocks with bilateral calf claudication that was not relieved completely with rest. He also described significant nocturnal sweats and fever of 99–100.5°F (37.2–38.1°C). Pertinent laboratory evaluation revealed an erythrocyte sedimentation rate of 87 mm/hour and a C-reactive protein of 77.4 mg/l. Antineutrophil cytoplasmic antibodies, rheumatoid factor, and antinuclear antibody were negative. Antiphospholipid IgG antibodies were borderline elevated. The urinalysis demonstrated microscopic hematuria.

Computed tomographic angiography of the abdomen revealed periaortic soft tissue thickening and enhance-

ment of 4.5–5.0 cm, while the opacified lumen measured 1.6 cm (Panel A, arrow). Severe atheromatous disease involved the distal aorta extending into the iliac vessels. The celiac, superior mesenteric artery (SMA), and renal arteries were patent.

An indium white blood cell scan revealed normal tracer uptake. The clinical findings and laboratory evaluation led to a low suspicion for malignancy or infection. Prednisone was started and 2 months later the groin pain, fever and chills were resolved with improvement of the back and abdominal pain. The inflammatory markers returned to normal.

Computed tomographic angiography of the abdomen after 2 months of treatment revealed a marked reduction in the infrarenal periaortic soft tissue thickening with no aneurysmal disease (Panel B, arrow).

The clinical manifestations of idiopathic retroperitoneal fibrosis or Ormond's disease include inflammatory abdominal aortic aneurysm as well as chronic periaortitis.¹ Periaortic fibrous tissue may encase adjacent structures causing obstructive complications such as deep venous thrombosis and ureteral obstruction. In the case presented, the inflammatory component predominated with rapid response to steroid therapy. Advanced atherosclerotic disease is also associated with retroperitoneal fibrosis, which was apparent in this case.^{2,3}

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