Imaging of Abnormal Air in the Abdomen and Pelvis

Shobhit Sharma 1 Jonathan McDougal 2 Tarun Pandey 1 Kedar Jambhekar 1 Roopa Ram 1

1Department of Radiology, University of Arkansas for Medical Sciences, Little Rock, Arkansas, United States
2Department of Radiology, University of Kansas Medical Center, Kansas City, Missouri, United States

Address for correspondence Roopa Ram, MD, Department of Radiology, University of Arkansas for Medical Sciences, Slot 556, 4301, West Markham Street, Little Rock, AR 72205, United States (e-mail: rram@uams.edu).

Abstract

The presence of abnormal air collection on an imaging study is quite often the reason as well as the solution to a diagnostic dilemma. The purpose of this review article is to develop an understanding of anatomical localization and determine etiology of abnormal air collections in the abdomen and pelvis. Abnormal air collections are commonly encountered on imaging studies on a daily basis, and this article will help familiarize the interpreting radiologist with the pathophysiology of these collections and help solve various diagnostic challenges and avoid potential pitfalls.

Introduction

The presence of abnormal air collection on an imaging study is quite often the reason as well as the solution to a diagnostic dilemma. The purpose of this review article is to develop an understanding of anatomical localization and determine etiology of abnormal air collections in the abdominopelvic region. Abnormal air collections are commonly encountered on imaging studies on a daily basis and this case-based approach will help familiarize the interpreting radiologist with the pathophysiology of these collections and help solve various diagnostic challenges and avoid potential pitfalls.

Paranasal sinuses, mastoid antra and middle ear cavities, gastrointestinal, and respiratory tract are the normal air-containing structures in the body. Presence of abnormal air collections outside these expected locations in the absence of surgical intervention can often be pathological. Patterns of air collection and the proximity to the air-containing viscer a where they are located often helps in narrowing down the differential diagnosis. We present a diagnostic review of various causes of abnormal air in the abdomen.

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Pneumoperitoneum

Fascial planes allow movement of air between the various compartments of the thorax, abdomen, and pelvis, thus demonstrating the continuity of these spaces. Mediastinal air can have peritoneal extension across the diaphragm by dissecting along the vascular sheaths. 1 It can extend into the retroperitoneal space via postesophageal areolar tissue or aortic hiatus. 2 Retroperitoneal air under tension can breach parietal peritoneum and thus can present as intraperitoneal free air. 3 Similarly, intraperitoneal and retroperitoneal air can extend into the mediastinum. Air can also dissect into the extraperitoneal space from the mediastinum, peritoneal space, retroperitoneal space, or pelvic region. 4 Thin muscular/vascular septations within the air collection are the key to diagnosing extraperitoneal air (►Figs. 1 and 2). 5

The potential causes for pneumoperitoneum include perforated bowel, perforated tumor, 6 infection, diverticulitis, bowel obstruction, 7 bowel ischemia, 8 perforated appendicitis, volvulus, hernia, colonoscopy, esophagogastroduodenoscopy, endoscopic retrograde cholangiopancreatography (ERCP), peritoneal dialysis, 9 postsurgical, 10 penetrating trauma, and pneumomediastinal free air extension (►Table 1). 11

Pneumoretroperitoneum

Pneumoretroperitoneum (►Fig. 3) can be caused by a perforated retroperitoneal hollow viscus (duodenum, ascending/descending colon, rectum) (►Fig. 3A and B), blunt and penetrating abdominal trauma, foreign body insertion, diverticulitis, 12 and emphysematous cholecystitis. 13 It can be secondary to procedures such as ERCP (►Fig. 3C) with sphincterotomy, hemorrhoidectomy, 14 transanal excision of rectal carcinoma, 15 endoscopy, colonoscopy, or residual air from retroperitoneal surgery, urological/adenal, and spinal (anterolateral approach) procedures (►Table 2). 16
Pneumobilia

Pneumobilia is accumulation of air in the biliary tree. Common causes of pneumobilia include postinstrumentation (ERCP), sphincter of Oddi dysfunction (Fig. 4), which can be iatrogenic post sphincterotomy, and surgical or spontaneous biliary-enteric fistulas (commonly secondary to peptic ulcer disease). Passage of a gallstone, gallstone ileus (identifiable by the Rigler triad on plain abdominal films: pneumobilia, small bowel obstruction, and an ectopic gallstone), infection, and trauma are other conditions leading to pneumobilia.

Table 1 Causes of pneumoperitoneum

| 1. Perforated hollow viscus—trauma, infection, tumor, ischemia, obstruction |
| 2. Volvulus |
| 3. Hernia |
| 4. Postprocedural—endoscopy, ERCP, surgery |
| 5. Extension from pneumomediastinum, pneumoretroperitoneum |

Abbreviation: ERCP, endoscopic retrograde cholangiopancreatography.
Fig. 3  Pneumoretroperitoneum. A 44-year-old man presented to the emergency room with acute abdominal pain. Axial computed tomography (CT) images in portal venous phase showing presence of retroperitoneal free air (arrow) anterior to the abdominal aorta (A). Inflammatory stranding with free air is seen around third part of duodenum (arrow) suggesting a perforation of a duodenal ulcer (B), which was confirmed per-operatively. (C) A 39-year-old woman with a history of sclerosing cholangitis, status post common biliary duct stent placement 2 days ago. Axial postcontrast CT abdomen in excretory phase demonstrates free air in the retroperitoneum adjacent to the 2nd and 3rd portions of the duodenum, surrounding the inferior vena cava, in the anterior and posterior pararenal spaces (arrows), and within the lateral abdominal wall.

Table 2  Causes of pneumoretroperitoneum

| 1. Perforated hollow viscus—trauma, infection, tumor |
| 2. Emphysematous cholecystitis |
| 3. Postsurgical—hemorrhoidectomy, transanal excision of tumor, spinal surgery |
| 4. Postprocedural—ERCP with sphincterotomy, colonoscopy |

Abbreviation: ERCP, endoscopic retrograde cholangiopancreatography.

Fig. 4  Pneumobilia. A 53-year-old female with choledochojejunostomy. Axial computed tomography in portal venous phase shows pneumobilia (arrows in A) which was secondary to reflux from air in the jejunum. Radio-opaque contrast is also seen in the biliary tree (arrow in B).

Gas in the gallbladder is seen in emphysematous cholecystitis (Fig. 5), a form of acute cholecystitis. It is a surgical emergency and must be distinguished from portal venous gas (which may also be an emergent finding depending on the underlying pathology). Seen on plain radiography, there is a relatively central location of linear air density in the liver in pneumobilia in comparison to peripheral linear air densities as seen with portal venous gas. Computed tomography (CT) is the definitive imaging modality and is the most sensitive and specific for detecting air in the gallbladder. Emphysematous cholecystitis must be promptly diagnosed by the radiologist as the air present can dissect into portal veins secondary to ischemia of gallbladder wall.

Portal Venous Air
Porto venous gas (Fig. 6) can arise from untreated cholecystitis as mentioned, or from a similar mechanism when gas producing organisms in the gastric wall (emphysematous gastritis) lead to intraluminal air dissection into the stomach wall and duodenum with absorption into the portal venous system. This can be secondary to bowel ischemia, inflammatory bowel disease, immunosuppression, or other causes. Emphysematous gastritis is shown in Fig. 6.

Intraparenchymal Air
Air visualized within hepatic parenchyma is commonly the result of liver abscesses caused by gas-forming bacteria. On CT, small pyogenic abscesses can demonstrate a “cluster sign” wherein the abscesses appear to cluster, or aggregate, in a pattern that suggests coalescence into a single, larger abscess cavity. This is a pattern which is not found in abscesses arising from mycobacterial or fungal etiologies. Parenchymal gas can also be seen following instrumentation or interventional procedures and is a common transient finding on US following orthotopic liver transplant. These patients must be evaluated carefully; however, as hepatic artery thrombosis is a potentially
severe complication of liver transplant which can lead to gas gangrene of the graft. 22

Emphysematous hepatitis is a rare and fatal condition distinguishable from typical pyogenic liver abscesses. This condition is characterized by widespread replacement of hepatic parenchyma with gas without the presence of discrete abscesses. The pathogenesis remains unclear, although there appears to be association with diabetes and other immunocompromised states. There are currently no treatment guidelines for this fulminant condition as adequate surgical debridement is generally unobtainable and attempts at percutaneous drainage and antibiotics have not been reported to be effective. 23,24

Emphysematous pancreatitis is a rare and life-threatening condition associated with acute pancreatitis. Plain radiography typically shows nonspecific findings, such as scattered gas in the mid abdomen. CT is the modality of choice for recognizing the presence of retroperitoneal free air within pancreatic parenchyma and/or the lesser sac (►Fig. 7). The infection is most commonly polymicrobial involving gas-forming organisms including anaerobes and gram-negative bacteria (e.g., *Escherichia coli*, *Clostridium*, *Staphylococcus*, *Streptococcus*, *Klebsiella*, *Candida*, and *Pseudomonas*). 25 Other common sources of pancreatic air include enteric fistulas, reflux from the small bowel following sphincterotomy or endoscopic instrumentation, and uncomplicated tissue infarction. 26

Air within the spleen is rare and has historically been visualized primarily in the setting of typical pyogenic abscesses or fistulous communication with adjacent gas-filled organs.
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Pulmonary (asthma, bronchitis, cystic fibrosis), gastric (enteritis, obstruction, inflammatory bowel disease), and iatrogenic (barium enema, endoscopy, surgical anastomosis) etiologies among others. Pneumatosis cystoides intestinalis is a benign variant that should be recognized. Importantly, findings on barium enema can resemble polyposis and it has been reported that removal of the “polyp” led to bowel perforation in some cases. Up to 15% of cases can be considered idiopathic and are usually located within the colon.

Pneumatosis intestinalis can also be the hallmark potentially fatal conditions such as intestinal ischemia (Fig 9), toxic megacolon, necrotizing enterocolitis in neonates, or trauma. The patterns of the radiolucencies are seen as linear, circular, or as small bubbles. Pneumatosis cystoides (►Fig. 9) is the most common presentation of pneumatosis. A subtle but highly specific finding of bowel ischemia is nonenhancement of the bowel wall on contrast-enhanced CT. Ideally, such studies should be performed without oral contrast to appreciate this finding. (Fig 7)

Air in the kidneys and upper urinary tract is most commonly due to infection. Other causes can be iatrogenic, fistulas, reflux from the bladder, or the result of trauma. Emphysematous pyelonephritis (►Fig. 10) is a rare but severe infection primarily found in diabetics with poor glucose control but has also been described in cases of nephrolithiasis and tumors. It is characterized by presence of intraparenchymal, intracalyceal, and intrapelvic gas and extension into the perinephric space. The most common causative organism is Escherichia coli, followed by Klebsiella and Proteus. On CT, emphysematous pyelonephritis is classified into two types: type 1 is more aggressive and shows streaky or mottled areas of gas representing parenchymal destruction seen extending radially along the pyramids, with no fluid collections. Type 2 shows bubbly or loculated areas of gas associated with renal and perirenal fluid collections, and/or demonstrates gas into the pelvicalyceal system or ureter.

Emphysematous pyelitis is the presence of air only in the renal collecting system and/or ureter. Radiography shows gas outlining the ureter and dilated calices, with air-fluid levels which can sometimes be seen in the ureter. It is caused by the same organisms as emphysematous pyelonephritis but is more strongly associated with urolithiasis. Distinction between these two entities is important as emphysematous pyelitis carries a better prognosis and will respond to medical management, while emphysematous pyelonephritis requires intervention and drainage, if not complete nephrectomy.

Frequently, the cause for an abnormal air collection in the abdomen or pelvis may lie in the chest which extends along fascial and subcutaneous planes and manifests itself in the abdomen. The most common cause is pneumomediastinum which is discussed below.

Pneumomediastinum

Fig. 8 Splenic abscess. A 38-year-old immunocompromised man with fever, chills, and rigors and left upper quadrant pain. Axial computed tomography in portal-venous phase demonstrates a large rim-enhancing fluid collection within the spleen with large amount of air within the collection (arrow). Image courtesy Dr. Rochita V. Ramanan.
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In hospitalized patients, tracheoesophageal fistula due to overinflated endotracheal tube cuff (►Fig. 12), leading to pressure necrosis of tracheal and esophageal wall, can eventually be associated with pneumomediastinum. As with pneumothorax, pneumomediastinum can also occur spontaneously in patients with asthma or croup. The pathophysiology of pneumomediastinum in these cases is the emergence of a pressure gradient between the alveoli and the surrounding structures that, upon reaching a critical level, causes alveolar rupture with air leak into the interstitium, causing interstitial emphysema. The air dissects along the bronchovascular bundle towards the mediastinum which is the path of least resistance owing to lower pressure. Due to contiguity of fascial planes, it can reach the subcutaneous tissue and the peritoneum. Increased pressure within the mediastinum leads to rupture of mediastinal pleura, causing pneumothorax.

Increased intrathoracic pressure such as from vigorous exercise, child birth, violent retching, mechanical ventilation, thoracic trauma including rib fracture, bronchotracheal laceration are other causes of pneumomediastinum (►Fig. 13). Rarely, extension of mediastinal air may be seen into the spinal epidural space producing pneumorrhachis (►Fig. 13C). Esophageal injury from instrumentation and vomiting (►Fig. 14) and airway injury from difficult intubation have also been reported to be associated with pneumomediastinum.

Invasive procedures such as thoracotomy or mediastinoscopy can also have postprocedure pneumomediastinum.
Fig. 11  Pneumomediastinum. A 62-year-old man with multiple myeloma expectorated fungal ball from tracheal diverticulum leading to subcutaneous emphysema and pneumomediastinum. Lateral plain radiograph of the neck (A) shows presence of free air in anterior soft tissues of the neck (arrows). Axial postcontrast computed tomography (CT) (B) images through the upper chest in lung windows reveal tracheal diverticulum (arrow) arising from posterolateral tracheal wall with associated subcutaneous emphysema and pneumomediastinum. Patchy areas of fibrosis are noted in bilateral lungs. Axial postcontrast CT images (C) obtained few days earlier revealed unruptured tracheal diverticulum (arrow). Another axial noncontrast CT (D) image obtained at a different time shows abnormal density occupying the tracheal diverticulum, confirmed to be an aspergillus fungal ball (asterisk).

Fig. 12  Pneumomediastinum. A 43-year-old man developed tracheoesophageal fistula as a complication of overinflated endotracheal tube cuff. Frontal plain radiograph of the chest (A) shows overinflated cuff of the endotracheal tube (arrows). Gastrografin esophagogram revealed leakage of contrast (arrow) into the tracheal lumen (B) and lining of bronchial tree (C) by contrast media (arrows).

Mediastinal air can dissect into the pleural space to produce pneumothorax. It can also can track into the neck, and lead to pneumopericardium through air tracking along the pulmonary veins. Various radiological signs for pneumomediastinum have been described in literature. These are based on outlining of anatomical structures by air that has escaped from the mediastinum. Elevation of thymus by air produces the
“thymic sail” sign. Air surrounding the pulmonary artery or its main branches can produce the “ring around the artery” sign. Air surrounding the major branches of aorta will cause both sides of the vessel to be depicted which is known as the “tubular artery” sign. Here, mediastinal air outlines the medial side and the aerated lung margins the lateral side. Air residing next to the major bronchus can allow clear depiction of the bronchial wall and producing the “double bronchial wall” sign. Air trapping posterior to the pericardium can give the appearance of a continuous collection of air on frontal view, known as the “continuous diaphragm” sign. Air from the mediastinum can extend laterally between the parietal pleura and the diaphragm to produce the extrapleural sign. Air can also migrate from the mediastinum into the pulmonary ligament secondary to rupture of the distal esophagus. \(^2\)
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benign etiologies of uterine air that must be excluded include non-neoplastic fistula formation with the bowel, recent instrumentation, and sexual intercourse. 42

Pneumoscrotum
Pneumoscrotum is subcutaneous collection of air in the scrotum. It can be seen secondary to infection related to Fournier’s gangrene (∼Fig. 16), 43 urethral injury, extension of pneumoperitoneum, 44 scrotal trauma, and visceral perforations. It may also occur from a variety of iatrogenic causes such as colonoscopy and surgical procedures of the abdomen. 45

Necrotizing Fasciitis
Necrotizing fasciitis is characterized by gas dissecting through fascial planes in the absence of history of penetrating trauma (∼Fig. 17). While the presence of gas in soft tissues is specific for necrotizing fasciitis, it is not a sensitive finding. Absence of significant vascular occlusion and absence of Clostridia from tissue culture both of which are findings associated with gas gangrene are not usually associated with necrotizing fasciitis. Gas in muscles is nonspecific and can be seen with many soft tissue infections and is not characteristic of gas gangrene. Since rapid destruction of tissues is expected in Fournier’s gangrene, early surgical debridement is always performed. Staphylococcus aureus and methicillin-resistant Staphylococcus aureus are the most commonly isolated organisms isolated from abscesses. 46
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Septic Arthritis

Septic arthritis resulting from gas-forming organisms is uncommon. It can be caused by direct inoculation of the joint from surgery, percutaneous procedure, or trauma. A native joint may develop septic arthritis (Fig. 18) secondary to hematogenous spread in patients with bacteremia or infectious endocarditis. Immunosuppression and dialysis are additional predisposing factors for developing septic arthritis. *Clostridium* species is the commonest anaerobic organism associated with septic arthritis. The infection may frequently be polymicrobial. Septic arthritis from gas-forming organisms (*Clostridium*) can manifest as air seen within the joint capsule on plain films or CT. Associated abscesses may also be seen.47

Conclusion

Presence of air is an important diagnostic clue to various disease pathologies. When a collection of air is encountered, one should aim at localizing the abnormal air as to determine the source and obtain detailed clinical information, both of which are equally crucial for radiological assessment. In many clinical scenarios, presence of air in an abnormal location is iatrogenic or expected after trauma, and follow-up imaging may demonstrate resolution or significant interval improvement. However, in certain situations it may be an ominous sign of a serious infection or hollow viscus injury and warrants immediate attention and intervention. This is particularly true for air collections encountered in the abdominal and pelvic organs. Interpretation of imaging characteristics and underlying pathological mechanisms of abnormal air collections is the key to developing and narrowing the differential diagnosis.

Conflict of Interest

None declared.

References

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