Mesenteric Neoplasms: CT Appearances of Primary and Secondary Tumors and Differential Diagnosis

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Computed tomography (CT) remains the optimal imaging modality for diagnosing tumors in the mesentery. Although primary neoplasms arising from the mesenchymal tissues of the mesentery are rare, the small bowel mesentery is a major avenue for the dissemination of tumor within the peritoneal cavity. Tumors spread to the mesentery by four major routes: (a) direct extension, commonly seen with carcinoid tumor of the small intestine as well as intraabdominal cancers such as pancreatic and colon cancer; (b) lymphatic dissemination of lymphoma and some epithelial malignancies; (c) hematogenic spread resulting in embolic metastases to the small intestinal wall, usually seen in melanoma and breast cancer; and (d) seeding through the peritoneum from ovarian and gastrointestinal malignancies as well as some lymphomas.

Although percutaneous imaging-guided or surgical biopsy is often necessary to guide management, analysis of CT features along with the clinical history may be useful in differentiating mesenteric tumors from infectious, inflammatory, or vascular processes affecting the mesentery. The article presents the characteristic appearances of primary and secondary mesenteric neoplasms at CT and offers a rational approach to the differential diagnosis of mesenteric masses depicted at CT.

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Introduction
The small bowel mesentery is a broad, fan-shaped fold of peritoneum that suspends the loops of the small intestine from the posterior abdominal wall. The two layers of peritoneal reflection forming the mesentery contain a variable amount of fat through which run the major arteries, veins, and lymphatics of the small intestine (Fig 1). Its root, a bare area that is contiguous with the pararenal spaces, extends diagonally from its origin at the ligament of Treitz inferiorly and to the right toward the ileocecal valve.

Primary tumors arising in the mesentery are relatively rare (1–3). On the other hand, the mesentery is a frequent avenue of spread for malignant neoplasms through the peritoneal cavity and between the peritoneal spaces and the retroperitoneum (2,3). Patients with mesenteric neoplasms usually present with nonspecific symptoms of abdominal pain, weight loss, a palpable abdominal mass, or diarrhea. CT plays a critical role in achieving an accurate diagnosis of these neoplasms to guide patient management.

The objectives of this article are to illustrate the appearances of primary and secondary mesenteric neoplasms as depicted at CT, including the patterns of tumor spread to the mesentery, and to discuss important aspects of the differential diagnosis of these tumors as well as potential pitfalls.

Primary Mesenteric Neoplasms
Primary tumors arising from the mesentery are rare. In their review of a large series of patients with mesenteric abnormalities seen at CT, Whitley et al (3) found 101 cases of mesenteric neoplasms, and all but one were metastatic lesions. Most primary lesions are mesenchymal in origin, and the majority are histologically benign (1).

Desmoid Tumor
Desmoid tumors are rare, locally aggressive, nonencapsulated masses resulting from a benign proliferation of fibrous tissue. Abdominal desmoids can occur sporadically and develop anywhere in the abdomen, including the musculature of the abdominal wall, the retroperitoneum, and the pelvis. However, desmoids forming in the mesentery are especially common in patients with familial adenomatous polyposis (Gardner syndrome), occurring in 9%–18% of cases (4–6). In fact, abdominal desmoids are responsible for a considerable number of life-threatening complications in these patients. Almost 75% of these tumors develop in patients who have undergone previous abdominal surgery (7).

Abdominal desmoids can be solitary or multiple. Their CT manifestations are variable. Intra-muscular desmoids tend to have well-defined or partially well-defined borders (7). Mesenteric tumors appear as soft-tissue masses with well-demarcated or poorly defined borders, strands radiating into the adjacent mesenteric fat (8), or a “whorled appearance” of fibrosis growing into the mesenteric fat (7). Infiltration into adjacent organs or growth into the abdominal wall musculature of the psoas muscle is not uncommon. Most mesenteric desmoids are isoattenuating relative to muscle (Fig 2), although large lesions may display areas of low attenuation caused by necrosis (Fig 3).

CT is useful in planning surgical resection and predicting prognosis. Large size (>10 cm); multiplicity; and extensive infiltration, tethering, and encasement of small bowel loops and entrapment of the ureters are poor prognostic signs (7).
Figure 2. Desmoid tumor in a 42-year-old man with abdominal pain. (a) Axial contrast-enhanced CT image of the lower abdomen shows a 5-cm soft-tissue mass in the mesentery (arrow). The attenuation of the mass is similar to that of the psoas muscles. (b) Coronal reformatted image demonstrates that the mesenteric vessels are displaced but not encased by the mass. Histologic analysis of the surgical specimen yielded the diagnosis of desmoid tumor.

Figure 3. Desmoid tumor in a 29-year-old woman with Gardner syndrome and recent onset of abdominal pain. (a) Axial contrast-enhanced CT image shows a 4 × 7-cm soft-tissue mass involving the left rectus abdominis muscle (arrow). The mass is nearly isoattenuating relative to muscle. (b) Contrast-enhanced axial CT image obtained 11 cm higher shows an intraabdominal soft-tissue mass with a central area of lower attenuation (arrow). Histologic findings confirmed the diagnosis of desmoid tumors.
Other Primary Mesenteric Tumors
These neoplasms are quite uncommon. Case reports of a variety of mesenchymal tumors of the mesentery including lipomas, schwannomas, smooth muscle tumors (Fig 4), and sarcomas are scattered through the literature (9–12).

Differential Diagnosis
Carcinoid tumor metastatic to the mesentery and sclerosing mesenteritis can mimic primary mesenteric neoplasm at CT.

Carcinoid Tumor.—Carcinoid tumors originate in the intestines with secondary spread to the mesentery by direct extension or lymphatic spread and will be discussed later. However, as the primary intestinal mass is often small and difficult to detect at CT, the mesenteric tumor is usually the dominant imaging finding.

Sclerosing Mesenteritis.—Sclerosing mesenteritis is a rare inflammatory condition of unknown cause that affects the root of the mesentery. The mesenteric fat is involved with a variable amount of inflammation, fatty necrosis, and fibrosis.

When the inflammation predominates (so-called mesenteric panniculitis), patients generally present with acute pain. On CT images, mesenteric panniculitis appears as a focal area of increased attenuation within the mesenteric fat surrounded by a pseudocapsule (Fig 5), an appearance that has been described as “the misty mesentery” (13). Areas of fibrosis within the inflamed fat appear as linear bands of soft-tissue attenuation (14).

In the chronic form or retractile mesenteritis, the fibrosis predominates and the disease manifests itself as large masses of soft-tissue attenuation that may contain calcifications (Fig 6). Some masses are poorly defined, with whiskers of soft-tissue thickening extending into the adjacent fat (14). Involvement of parenchymal organs such as the pancreas has been described (15).
Retractile mesenteritis cannot be distinguished from a carcinoid tumor or lymphoma without extensive histologic sampling, which often requires open surgical biopsy. Although the disease process is usually indolent and follows a benign course, in some cases the infiltrative nature of the fibrosis may result in serious complications, including thrombosis of the mesenteric vessels with secondary variceal bleeding (Fig 6). Scarring with retraction of the mesentery and encasement of small bowel loops can lead to ischemia or obstruction. Retractile mesenteritis has been associated with other conditions such as retroperitoneal fibrosis, lymphoma, and Gardner syndrome.

Figure 6. Sclerosing mesenteritis in a 70-year-old man with recurrent rectal bleeding. (a) Axial contrast-enhanced CT image of the midabdomen shows an 8.5 × 3-cm soft-tissue mass at the root of the mesentery (solid arrows). The lesion contains coarse calcifications (open arrow). Mesenteric varices are present (arrowheads). (b) Axial contrast-enhanced CT image obtained 3 cm above a shows encasement of the superior mesenteric artery (open arrow) and near occlusion of the superior mesenteric vein (solid arrow). Note the mesenteric varices (arrowheads). (c) Coronal oblique reformatted image displays the full extent of the lesion encasing the superior mesenteric artery. Open surgical biopsy of the mass revealed sclerosing mesenteritis.
Figure 7. Dissemination of tumor through the mesentery. Drawings illustrate the four major patterns of mesenteric tumor spread: direct spread along the mesenteric vessels and surrounding fat (a), extension through the mesenteric lymphatics (b), embolic hematogenous spread (c), and intraperitoneal seeding (d).
Secondary Mesenteric Tumors

Major Pathways for the Spread of Tumor to the Mesentery

Tumors originating in the abdomen or elsewhere in the body can disseminate to the mesentery in four major ways (16) (Fig 7): (a) direct spread along the mesenteric vessels and surrounding fat, (b) extension via the mesenteric lymphatics, (c) embolic hematogenous spread, and (d) intra-peritoneal seeding. Although convenient, this classification is somewhat arbitrary, since many neoplasms spread by more than one route.

Direct Spread to the Mesentery

Gastrointestinal Carcinoid Tumor.—Gastrointestinal carcinoid tumors arise from neuroendocrine cells in the intestinal mucosa or submucosa. Although these slow-growing tumors are rare (representing only 2% of tumors of the gastrointestinal tract), they are the most common malignant neoplasm of the small intestine (17). Approximately 40%–80% of gastrointestinal carcinoids spread to the mesentery, either by direct extension or through the local lymphatics (18, 19). The distal ileum is the most frequent location of the primary lesion (20). The mesenteric mass is usually discovered first, when patients present with nonspecific abdominal pain. Alternatively, patients with hepatic metastases may present with the carcinoid syndrome caused by the release of vasoactive substances such as serotonin and 5-hydroxytryptophan into the systemic circulation. These patients experience paroxysmal flushing, diarrhea, episodes of wheezing, and right-sided heart failure caused by stenoses of the tricuspid and pulmonary valves.

At CT, the most common manifestation of mesenteric carcinoid tumors is that of an enhancing soft-tissue mass with linear bands radiating in the mesenteric fat (Fig 8). Radiologic-pathologic
correlation has shown that these radiating strands of soft tissue do not generally represent tumor infiltration along neurovascular bundles but rather result from the intense fibrotic proliferation and desmoplastic reaction in the mesenteric fat and the adjacent mesenteric vessels caused by the release of serotonin and other hormones from the primary tumor (18). Calcifications are visible in up to 70% of lesions at CT (Fig 9) (18). Thickening of adjacent small bowel loops caused by tumor infiltration or by ischemia owing to sclerosis of mesenteric vessels as well as angulation can be present (Fig 9) (21). The primary tumor is often small, sometimes occult, and only occasionally diagnosed at CT (Fig 10) (22). Morphologic appearances include a well-defined, hypervascular enhancing mass (Figs 9, 10) or regional intestinal wall thickening (23). Administration of water as an oral contrast agent (Fig 10) may help enhance detection of the primary focus.

**Other Neoplasms.**—Several intraabdominal malignancies, including gastric, pancreatic, biliary, and colon cancer, may extend directly into the leaves of the mesentery or spread along the mesenteric vessels (24). About 40% of patients with newly diagnosed adenocarcinoma of the pancreas have unresectable, locally advanced disease with tumor extension along the root of the mesentery and encasement of the major mesenteric vessels (Fig 11) (25).
Figure 10. Carcinoid tumor in a 65-year-old man with an incidentally found mesenteric mass. (a) Axial CT image obtained in the arterial phase of enhancement shows a 4-cm enhancing mass at the root of the mesentery (arrow). There is a 1.5-cm enhancing mass in the wall of the proximal small intestine near the ligament of Treitz (arrowhead). (b) Coronal reformatted image shows that the mesenteric mass is contiguous with the primary tumor. At pathologic analysis, a jejunal carcinoid tumor was found to be extending through the intestinal wall to invade an adjacent lymph node.

Figure 11. Adenocarcinoma of the pancreas in a 57-year-old woman with abdominal pain. (a) Axial CT image obtained in the arterial phase of enhancement shows a subtle soft-tissue mass abutting the superior mesenteric artery (arrow). The mass has lower attenuation than that of normal pancreatic parenchyma. (b) Coronal reformatted image from the arterial phase of enhancement allows better appreciation of the tumor growing along the superior mesenteric artery and encasing the vessel (arrow). (c) Coronal reformatted image from the venous phase of enhancement shows marked narrowing of the superior mesenteric vein (arrow). Coronal reformatted images allow a more confident diagnosis of unresectability. The diagnosis of adenocarcinoma of the pancreas was confirmed by means of percutaneous biopsy.
Extension via the Mesenteric Lymphatics

Lymphoma.—Lymphoma is the most common malignant neoplasm affecting the mesentery (3). Approximately 30%–50% of patients with non-Hodgkin lymphoma harbor disease in the mesenteric lymph nodes. Markedly mesenteric adenopathy can also be present in chronic lymphocytic leukemia. Patterns of mesenteric lymphoma at CT include multiple, rounded, mildly enhancing, homogeneous masses that often encase the mesenteric vessels (Fig 12) and produce the “sandwich sign” (26); a large, lobulated, “cake-like,” heterogeneous mass with low-attenuation areas of necrosis displacing small bowel loops (Fig 13); or an ill-defined infiltration of the

Figure 12. Follicular mixed lymphoma in a 68-year-old woman. (a) Axial contrast-enhanced CT image of the lower abdomen shows a 5.5-cm soft-tissue mass in the mesentery (arrow). (b) Axial contrast-enhanced CT image obtained at the level of the superior mesenteric artery demonstrates an ill-defined, infiltrating retroperitoneal mass (arrows) encasing the superior mesenteric artery, aorta, inferior vena cava, and right renal artery.

Figure 13. Mesenteric lymphoma in a 77-year-old man who presented with a palpable abdominal mass. (a) Axial contrast-enhanced CT image of the lower abdomen shows a large soft-tissue mass in the mesentery (arrows) that displaces the small intestine. The mass has low attenuation, indicating extensive necrosis. (b) Axial contrast-enhanced CT image of the midabdomen shows the mass is encasing the superior mesenteric vein (arrowhead). Large retroperitoneal nodes are also present (open arrow). Percutaneous biopsy of the mass yielded B-cell lymphoma.
mesenteric fat, particularly after successful chemotheraphy (Fig 14) (3,13). Bulky retroperitoneal adenopathy commonly accompanies the mesenteric disease and should be a clue to the diagnosis (Fig 12) (2).

Other Malignancies.—Metastases from colon cancer, ovarian carcinoma, breast cancer, lung cancer, carcinoid, and melanoma can spread to mesenteric lymph nodes. However, the degree of nodal enlargement seen in mesenteric metastatic disease is less pronounced than that seen in mesenteric lymphoma, and the distribution of involved nodes is comparatively more localized in metastatic disease (Fig 15) (3).

Differential Diagnosis.—Several infectious and inflammatory conditions, such as atypical mycobacterial infection and tuberculosis, other inflammatory conditions, and vascular abnormalities, produce mesenteric nodal enlargement that mimics lymphoma or metastatic disease. However, in the majority of cases, inflammatory adenopathy remains discrete, whereas lymphomatous nodes tend to coalesce, a helpful distinguishing feature.

The rising prevalence of abdominal atypical mycobacterial infection and the reemergence of tuberculosis can be attributed to the increasing number of immunocompromised hosts, particularly patients infected with human immunodeficiency virus (HIV), those who undergo chronic steroid therapy, and intravenous drug users. Abdominal tuberculosis is transmitted by three major routes: (a) ingestion of infected milk or sputum, which carries the infection through the intestine to local lymph nodes; (b) hematogenous spread from the lungs to abdominal and paraaortic lymph nodes; and (c) direct spread from the serosal surface of infected organs such as the fallopian tubes. Intraabdominal lymphadenopathy is the most common manifestation of abdominal tuberculosis and infection with Mycobacterium avium–intracellulare complex. Affected nodes often demonstrate rim enhancement in the peripheral
inflammatory reaction and a low-attenuation center in the central caseous necrosis (Fig 16) or a multilocular appearance (27,28).

Whipple disease, a very rare condition predominantly affecting young white men and caused by the Gram-positive bacillus *Tropherymamyia whipplei*, should be included in the differential diagnosis of low-attenuation nodes in the mesentery (Fig 17).

**Figures 16, 17.** (16) *M avium–intracellulare* infection in a 37-year-old man infected with HIV (human immunodeficiency virus). Axial contrast-enhanced CT image of the midabdomen shows multiple enlarged nodes (arrows) surrounding the mesenteric vessels. Some of the nodes contain low-attenuation areas and demonstrate rim enhancement (arrowhead). *M avium–intracellulare* was cultured from the patient’s stool. (17) Known Whipple disease in a 43-year-old woman. Axial contrast-enhanced CT image of the lower abdomen shows a conglomerate of low-attenuation nodes with rim enhancement in the mesentery (arrow).

**Figure 18.** Mesenteric varices in a 55-year-old man with hepatocellular carcinoma and portal vein thrombosis. (a) Axial CT image of the midabdomen obtained in the arterial phase of enhancement shows multiple round soft masses in the mesentery (arrow). (b) On an axial CT image obtained in the venous phase of enhancement, these “masses” (arrow) are enhancing to the same degree as the superior mesenteric vein and are shown to represent mesenteric varices.
Enlarged mesenteric nodes can also be seen in some noninfectious inflammatory conditions, such as celiac sprue, Crohn disease, systemic mastocytosis, and sarcoidosis (29,30). Rare cases of mesenteric Castleman disease manifesting as intensely enhancing mesenteric adenopathy have been reported (31).

Patients with portal hypertension or portal or mesenteric vein thrombosis may develop porto-systemic collateral varices in the mesentery. Care should be taken to avoid confusing them with adenopathy on unenhanced CT images (Fig 18).

**Embolic Hematogenous Spread**

Embolic metastases from melanoma, breast cancer, and lung cancer can reach the antimesenteric border of the small intestine through small mesenteric arterial branches. These tumor deposits can act as a lead point for intussusception. The small intestine and its mesentery are the most common site of gastrointestinal metastases from melanoma (32). In a series of 230 patients with melanoma reviewed by Kawashima et al (33), 7.4% had evidence of small bowel involvement at CT. Metastases from melanoma classically manifest as enhancing mural nodules protruding into the intestinal lumen or as focal thickening of the intestinal wall (Fig 19). Metastases are even more commonly described in autopsy series, as they have been found in up to 35%–58% of cases (33).

**Intraperitoneal Seeding**

Because of the natural flow of fluid in the peritoneal cavity, the portion of mesentery close to the terminal ileum in the right lower quadrant is a common site of intraperitoneal tumor seeding. Tumor deposits within the leaves of the mesentery can appear as focal masses (Figs 20, 21) or can produce a diffuse infiltration of the mesenteric fat, the so-called stellate appearance of the mesentery.
**Carcinomatosis.**—The stellate appearance of the mesentery is more commonly seen in association with peritoneal carcinomatosis, particularly if caused by breast, gastric, pancreatic, or ovarian cancer (Fig 22) (30). Lobular breast carcinoma metastasizes to the mesentery and gastrointestinal tract more frequently than infiltrating ductal carcinoma (34).

Peritoneal lymphomatosis (Fig 23) results from peritoneal seeding of primary gastrointestinal lymphomas and cannot be distinguished from carcinomatosis on the basis of CT appearance (35).

**Malignant Peritoneal Mesothelioma.**—Malignant peritoneal mesothelioma is a rare, usually lethal neoplasm arising from the mesothelial cells lining the serosal surface of the peritoneal cavity. The majority of patients have a history of asbestos exposure (36). CT manifestations include ascites in variable amounts, enhancement of the peritoneum after intravenous administration of contrast material, focal peritoneal soft-tissue masses, and infiltration of the omentum (Fig 24). Spread to the mesentery is common and appears as increased attenuation in the mesenteric fat, perivas-

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**Figure 21.** Metastatic ovarian carcinoma in a 73-year-old woman with a pelvic mass. (a) Axial contrast-enhanced CT image of the lower abdomen shows several calcified masses in the mesentery and omentum (arrows). (b) Coronal reformatted image depicts the extent of the intraperitoneal spread of this ovarian cancer. The primary tumor appears as a large calcified pelvic mass (arrows). Surgical resection revealed a high-grade serous carcinoma of the ovary with extensive psammoma bodies.

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**Figure 22.** Metastatic breast cancer in a 57-year-old woman with a palpable abdominal mass and a history of breast cancer. Axial contrast-enhanced CT image of the midabdomen shows an ill-defined soft-tissue mass infiltrating the root of the mesentery and encasing the mesenteric vessels (arrows). Surgical biopsy revealed metastatic lobular breast carcinoma.

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cular soft-tissue thickening, and rigidity of the vascular bundles (36). This so-called stellate appearance is caused by microscopic infiltration of tumor within the fat along the mesenteric blood vessels (37). Associated pleural calcifications, thickening, or effusions are common.
Differential Diagnosis.—Involvement of the peritoneum and mesentry with tuberculosis generally occurs secondary to infection in the gastrointestinal tract. Differentiating tuberculous peritonitis from carcinomatosis at CT can be quite challenging. In addition to diffuse thickening and fine nodularity of the mesentery and infiltration of the mesenteric fat, CT features that suggest the diagnosis of tuberculous peritonitis include enhancement and smooth thickening of the peritoneum, high-attenuation ascites, thickening of the intestinal wall (particularly the terminal ileum and cecum), and low-attenuation mesenteric nodes (Fig 25) (13,27,38).
## Differential Diagnosis of Mesenteric Masses at CT

<table>
<thead>
<tr>
<th>CT Appearance</th>
<th>Pathologic Conditions</th>
<th>Associated Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round well-defined mass(es)</td>
<td>Non-Hodgkin lymphoma</td>
<td>Retropertioneal adenopathy</td>
</tr>
<tr>
<td></td>
<td>Metastases</td>
<td>Small bowel nodules (melanoma, lung, etc)</td>
</tr>
<tr>
<td></td>
<td><em>M. avium-intracellulare</em> tuberculosis</td>
<td>Low-attenuation adenopathy, predominantly in mesentry; liver and spleen lesions</td>
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<td></td>
<td>Whipple disease</td>
<td>Low-attenuation adenopathy, thickened small bowel folds</td>
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<tr>
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<td>Mesenteric cyst</td>
<td>Well-defined, low attenuation, thin wall</td>
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<tr>
<td></td>
<td>Mesenteric lipoma</td>
<td>Well-defined, fat attenuation</td>
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<td></td>
<td>Castleman disease</td>
<td>Hypervascular mass</td>
</tr>
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<td>Ill-defined, irregular mass(es)</td>
<td>Small bowel carcinoid</td>
<td>Calcifications; thickening, tethering of small bowel loops; enhancing small bowel mass (primary)</td>
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<td>Mesenteric desmoid</td>
<td>Subcutaneous nodules (Gardner syndrome); musculoskeletal masses; infiltration of abdominal wall, bowel, psoas muscle, ureters</td>
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<td>Tumor infiltration from pancreatic, gastric, or colon cancer</td>
<td>Primary tumor</td>
</tr>
<tr>
<td></td>
<td>Lymphoma</td>
<td>Active disease or after chemotherapy</td>
</tr>
<tr>
<td></td>
<td>Sclerosing mesenteritis</td>
<td>Calcifications</td>
</tr>
<tr>
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<td>Ascites, enhancing omental masses, calcified implants (ovarian, mucinous colon, or gastric cancer)</td>
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<tr>
<td></td>
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<td>Small bowel or colonic mass, adenopathy</td>
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<tr>
<td></td>
<td>Malignant peritoneal mesothelioma</td>
<td>Ascites; ill-defined peritoneal and omental masses; pleural, peritoneal calcified plaques</td>
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<tr>
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<td>Systemic amyloidosis</td>
<td>Focal mesenteric thickening due to edema, clot in superior mesenteric vein or artery</td>
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<td>Vascular thrombosis</td>
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## Conclusion

CT remains the dominant imaging modality for the diagnosis of mesenteric neoplasms. The Table presents a systematic approach to the differential diagnosis of mesenteric lesions detected at CT.

## References