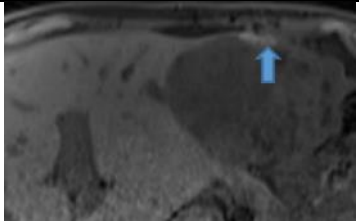
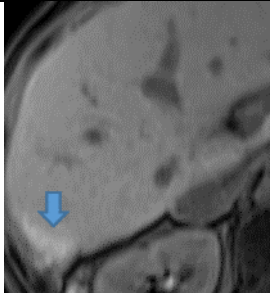

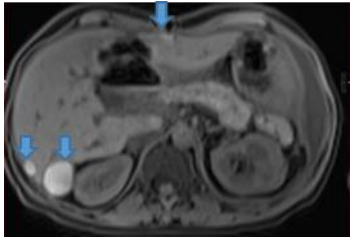


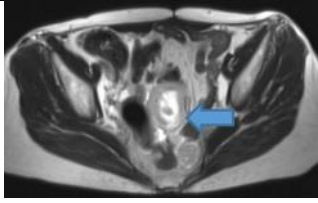
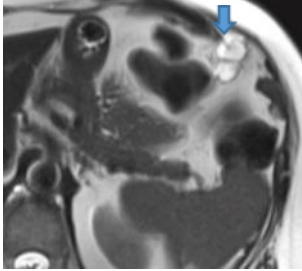
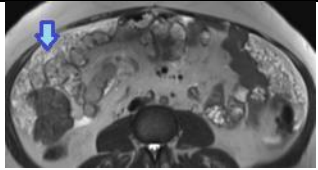
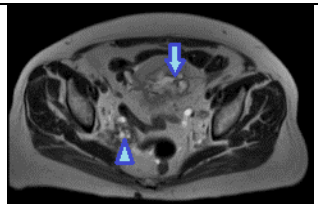
**Table 1.** Favoured PC sites and underlying reasons.

Favoured PC sites	Underlying Reason
Ileocecal region	Anchor of the small bowel mesentery
Sigmoid mesocolon	Area of arrested flow
Right paracolic gutter	Major gravity dependent pathway
Subhepatic space	Gravity dependence
Right subphrenic space and omentum	Resorption sites

Table 2. Behaviour of peritoneal deposits according to their appearance on MR and CT, their content and the corresponding primary tumour, regardless of the cell line.					
Content	T1	T2	CT	Primary tumour	Figures
Melanin	↑	↓	↓	Melanoma	 <p><b>Figure 41.</b> Axial NE FST1WI. PC from melanoma: Note the hyperintense melanin-containing perihepatic deposits (arrow).</p>
Calcium	↑=	↓=	↑	<p>Mucinous tumors (ovary, stomach, colon, pancreas, appendix, gallbladder, urachus)</p> <p>Serous papillary ovarian tumour</p>	 <p><b>Figure 42.</b> Axial NE FST1WI. PC from serous ovarian adenocarcinoma: Hyperintense perihepatic deposits (due to calcified content).</p>  <p><b>Figure 48.</b> Axial CE CT. PC from colloid adenocarcinoma of the caecum: Observe the specks of calcification (arrows) scattered throughout the deposits (*).</p>
Blood (*)	↑ ↑	↓ ↑	↑	<p>Hypervascular tumours. High-grade ovarian tumours (serous and endometrioid adenocarcinoma). Clear cell ovarian carcinoma Granulosa cell tumour.</p> <p>(*) In the subacute stage of a haematoma, the methemoglobin causes a high SI on T1WI, and a variable SI on T2WI (low in early subacute stage, high in late subacute stage).</p>	 <p><b>Figure 43.</b> Axial NE FST1WI PC from serous ovarian adenocarcinoma: Blood-containing peri and subhepatic deposits (arrows).</p>

Continues

**Table 2. Behaviour of peritoneal deposits..... (continuation)**

Content	T1	T2	CT	Primary tumour	Figures
Myxoid	↓	↑	↓	Myxoid tumours	 <p><b>Figure 44.</b> Axial T2WI. Myxoid leiomyosarcoma of the uterus: patient with pelvic deposits in the setting of a relapse. Observe the deposit central high SI on T2WI due to the myxoid content.</p>
Non mineralized cartilage	↓	↑	↓	Condrosarcoma	 <p><b>Figure 45.</b> Axial T2WI. Peritoneal deposit from rib condrosarcoma: Omental deposit showing high SI on T2WI, due to the non-mineralized cartilage content.</p>
Mucin	↓	↑	↓	Mucinous tumours (ovary, stomach, colon, pancreas, appendix, gallbladder, urachus)	 <p><b>Figure 46.</b> Axial T2WI. PC from mucinous adenocarcinoma of the urachus: Hyperintense omental-cake due to mucinous content.</p>
Keratin	↓	↑	↓	Squamous differentiation	 <p><b>Figure 47.</b> Axial T2WI. Bladder adenocarcinoma with a squamous differentiation. Observe the locally advanced vesical tumor (arrow). Note the right pelvic peritoneal deposit (arrowhead), showing the same imaging features as the tumour. The high signal on T2WI may be due to the keratin formed by the squamous differentiation.</p>

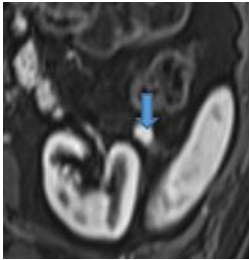
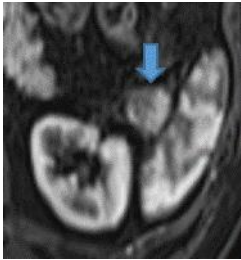
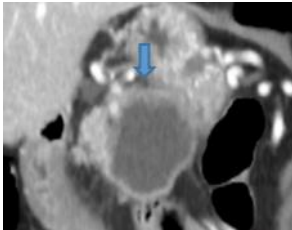
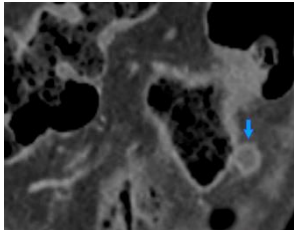

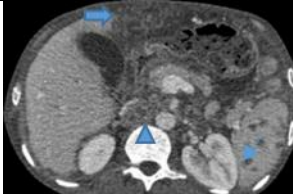
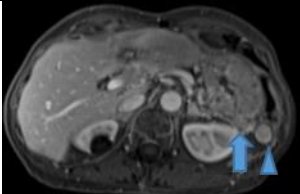

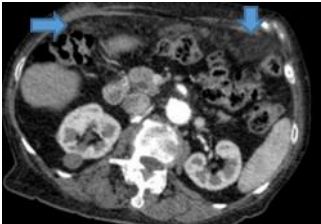
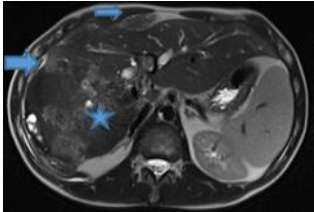
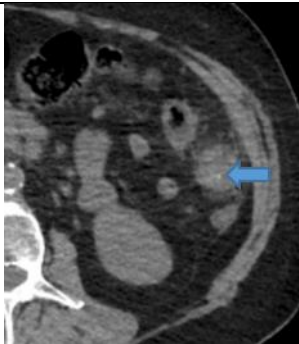
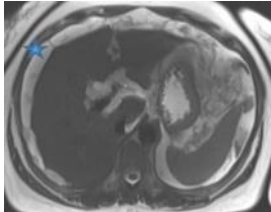
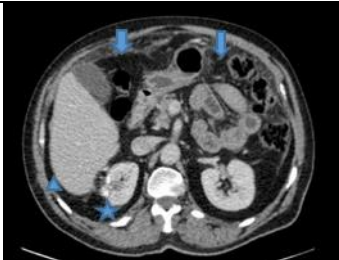
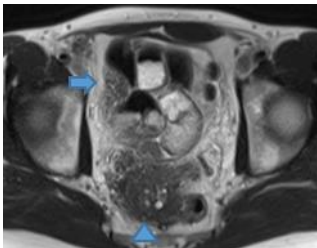
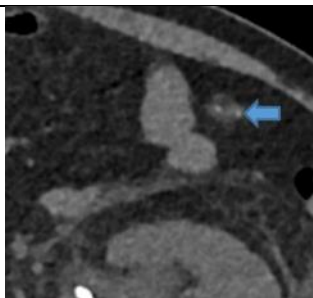
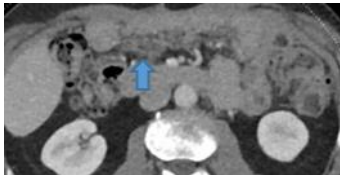
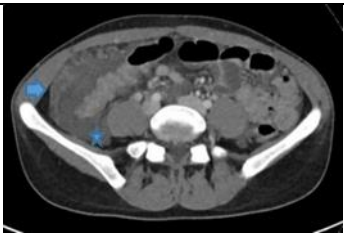
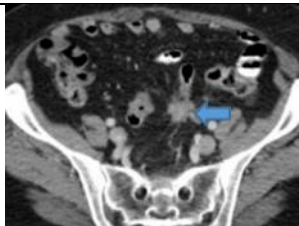
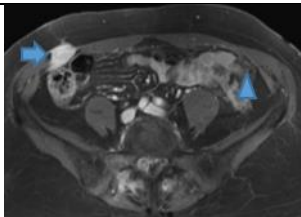
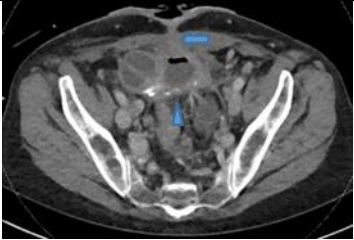
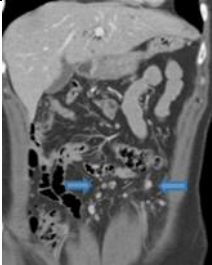
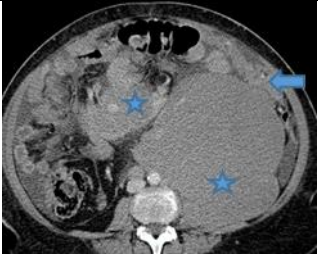
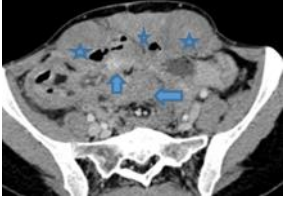
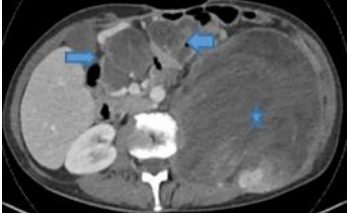
<b>Table 3.</b> Relation between vascular pattern of the deposits and differential diagnosis of possible primary tumours.	
<b>Hypervascular deposits</b>	<b>Hypovascular deposits</b>
Ovarian (clear cell, granulosa)	Mucinous tumours (ovary, stomach, colon, pancreas, appendix, gallbladder, urachus)
Breast carcinoma	Pancreas adenocarcinoma
Lung carcinoma	Liposarcoma (myxoid or undifferentiated)
Melanoma	
Sarcoma: - GIST -Leiomyosarcoma -Fibrous solitary tumour	
Renal cell carcinoma	
Neuroendocrine tumours	
Hepatocellular carcinoma	
Thyroid carcinoma	
Paraganglioma	
Choriocarcinoma	
<div> <div><b>A</b></div>  <div><b>B</b></div>  </div> <p><b>Figure 49.</b> Axial CE portal phase FST1WI. PC from clear cell renal carcinoma: Note the hypervascular deposit adjacent to the spleen that was mistaken for an accessory spleen (A). Observe the growth on the follow-up CT (B).</p>	<div> <div><b>A</b></div>  <div><b>B</b></div>  </div> <p><b>Figure 50.</b> Coronal MPR CE CT PC from pancreatic cystadenocarcinoma: Observe the primary tumour (A) and its deposit within the sigmoid mesocolon (B). Notice the hypovascular resemblance between them.</p>

Table 4. Differential diagnosis			
Inflammatory	Infectious	Benign non-inflammatory non-infectious	Malignant
Omental infarction	Peritoneal tuberculosis	Splenosis Accessory spleen	Primary peritoneal serous carcinoma
 Figure 51	 Figure 56	 Figure 59	 Figure 65
Peritoneal amyloidosis	Peritoneal echinococcosis	Bowel perforation	Pseudomyxoma peritoneal
 Figure 52	 Figure 57	 Figure 60	 Figure 66
Peritoneal sarcoidosis		Encapsulated omental fat necrosis	Peritoneal malignant mesothelioma
 Figure 53	 Figure 58	 Figure 61	 Figure 67
Familial Mediterranean fever		Endometriosis	Desmoplastic small round cell tumour
 Figure 54		 Figure 62	 Figure 68

Continues

**Table 4.** Differential diagnosis (continuation)

Inflammatory	Infectious	Benign non-inflammatory non-infectious	Malignant
Encapsulated sclerosing peritonitis		Leiomyomatosis peritonealis	Peritoneal lymphomatosis
 Figure 55		 Figure 63	 Figure 69
		Desmoid tumours	Peritoneal sarcomatosis
		 Figure 64	 Figure 70

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