Figure CT 1. Enhanced parietal peritoneal deposits attached to the abdominal wall, and in block with small bowels loop, and nodular spread of deposits in pelvis, large bowel cancer origin.

Figure CT 2. Deposits close to urinary bladder wall, bladder cancer origin
Figure CT 3. Parietal peritoneal pelvic carcinomatosis, large bowel malignancy origin

Figure CT 4. Nodular pattern of large bowel cancer deposits
Figure CT 5. The thickened pelvic peritoneum with small nodular pattern

Figure CT 6. Surrounding the urinary bladder wall and close to pelvic anterior wall nodular deposits pattern is shown
Figure CT 7a and 7b. Retro and sub hepatic space filled with solid deposit mass and periportal and hilar space with solid conglomerate mass (ovarian cancer)
Figure CT 8. Omental sac with great solid conglomerate deposit

Figure CT 9. Conglomerate pelvic mass consist unidentify uterus, left ovarian tumor mass and attached pelvic deposits in surroundings
Figure CT 10 (a and b). Small nodular deposit pattern near the abdominal wall
Figure CT 11 Omental cake with the infiltration of small bowel loops and anterior abdominal wall
Figure CT 12 (a and b). Nodular peritoneal pattern of endometrial cancer spread

Figure CT 13. Great omental mass with irregularly shape and nodular deposits near abdominal wall, large bowel cancer origin
Figure CT 14. Omental small nodular deposits, stomach cancer origin
Figure CT 15 (a and b). Abdominal peritoneal solitary nodular deposits in melanoma

Figure CT 16. Abdominal peritoneal solitary nodular deposits in large bowel disease
Figure CT 17. Omental cake in pancreatic cancer, after resection

Figure CT 18. Small nodular parietal deposit attached to anterior abdominal wall
Figure CT 19. Pelvic peritoneal deposits with rectal infiltration
Figure CT 20 (a and b). Peritoneal nodular deposits, variable size, sometimes easy to recognize, but sometimes should be searched
Figure CT 21 (a and b). Peritoneal fan-shaped pattern with ascit and thickened border direct to dissemination of small nodular deposits (not easy to recognize)

Figure CT 22. Subphrenic nodular deposits easily can be recognized with ascit
Figure CT 23. Pelvic deposits should be searched systematically (ovarian cancer origin)

Figure CT 24. Who should know without systematical approach is there or how many deposits are here?
Figure CT 25 (a and b). Attention on postoperative scans! Deposits are in front of our view!
Figure CT 26 (a, b and c). Misty mesentery with acit, unclear borders, lymph nodes and deposits. Who is who?
Figure CT 27 (a, b, c and d). Sagittal and coronal reconstruction sometimes should add to diagnosis, but sometimes is not easy to recognize target tissue (spread of omental cake or other pelvis or abdominal masses is easy to identify, but solitary peritoneal nodular deposits is not easy to differentiate from guts or lymph nodes).