CASE REPORT

Idiopathic Segmental Infarction of The Greater Omentum

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ABSTRACT

Idiopathic segmental infarction of the greater omentum is a rare cause of acute abdomen. The diagnosis is based primarily on the abdominal CT scan. A 20 year old male presented with right lower abdominal pain. Initial examination unremarkable and patient was kept under observation. Symptoms did not abate and CT scan showed an ovoid fat density mass in abdomen. Laparoscopy showed partially twisted omentum which was resected at open surgery. Key words Infarction, Greater omentum, Acute abdomen.

INTRODUCTION:

Idiopathic segmental infarction of the greater omentum is a rare cause of acute abdomen. Most (90%) patients present with right-sided abdominal pain. It has been postulated that the right side of the omentum is more likely to undergo infarction due to its greater length and mobility. It often mimicking appendicitis, cholecystitis, or diverticulitis. Herein we report a case of omental infarction that was suspected on CT scan.

CASE REPORT:

A 20 year old male hospitalized for pain in the right flank. There was no significant antecedent history. Clinical examination showed overweight (body mass index 29kg/m²) male with body temperature of 37°C and tenderness in the right flank. The investigations showed leukocytosis 11500/mm³. The abdominopelvic scan showed a right intraperitoneal ovoid shaped mass with fatty density. The mass was with fine dense span in the center that discreetly heightened after contrast (Fig I & II).

The diagnosis of appendicitis was discussed and the patient was put under medical treatment with analgesics and anti-inflammatory drugs. The evolution was marked by the worsening of the pain and the onset of fever to 38 °C, hence the decision to perform a diagnostic laparoscopy.

Intraoperatively, it was an infarction of the greater omentum with an early abscess formation secondary to its twisting around its vascular axis (Fig III & IV).

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Fig-I & II: Abdominopelvic scan with contrast showing an intraperitoneal right ovoid fat density mass with fine and dense spans associated with heightened discreetly infiltration of the adjacent grease thickening and anterior parietal peritoneum.
The exploration of the abdominal cavity confirmed the primitive origin of this twist. A resection of the necrotic omentum was performed after conversion to open surgery. The postoperative course was uneventful.

**DISCUSSION:**
Infarction of the greater omentum is often not considered as first diagnosis in acute right flank pain. The condition generally occurs between 40 year and 50 year of age and is twice as common in men than in women.

The idiopathic segmental infarction of the greater omentum is an underestimated cause of acute abdominal pain. Primitive twists are the result of a rotation of greater omentum along its axis creating a blockage of the omental artery and as a result necrosis. Usually fever is missing or of low grade as well as nausea, vomiting, anorexia, and gastrointestinal complaints. Abdominal CT scan remains the most efficient examination and helps straighten the diagnosis.

Spontaneous untwisting is an expected possibility. Conservative management is recommended based on medical treatment with non-steroidal anti-inflammatory drugs and analgesics. Symptoms usually resolve gradually in a week or two. The rare surgical indications are failure of medical treatment and infectious complications like abscess formation. We elected laparoscopy in this case for diagnostic purpose and open surgery for segmental resection.

**REFERENCES:**


