



## **Omental Infarction: A Case Series**

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### **Abstract**

#### **Background & objectives**

Omental infarction (OI) is rare cause of the acute abdomen. Usually presents sudden onset right side pain abdomen, and sometimes pain may be in any other quadrants. It is more common in male than in females with middle age people. The difficulty is in the initial diagnosis where it can present in a number of

different ways and may mask an underlying surgical condition

#### **Methods**

Observational study from 01/02/2020 to 01/09/2021

#### **Results**

Right sided abdomen pain which were diagnosed as omental infarction in 3 cases.

## **Interpretation & conclusions**

All of them were managed by laparoscopic approach. Computed tomography(CT) abdomen would be gold standard choice of investigation.

## **Keywords**

Pain Abdomen, Computed tomography of abdomen, Laparoscopy.

## **Introduction**

The acute abdomen is most common presentation of surgical emergency around the world. Most common presentation would be non-specific pain abdomen, renal colic, biliary colic, appendicitis etc. because of common presentation of acute abdomen, the rarity of this has to be kept in back of mind. Early and correct diagnosis is the key. Omental infarction can be either primary or secondary. Primary infarction can be of unknown origin and omentum twisting on itself has been found out. Affecting men more than women, with majority being overweight. It is challenging to diagnose the case clinically, on account of advancing imaging techniques and improved recognition of its radiographic presentation<sup>2,3</sup>.

## **Material & Methods**

Observational study from 01/02/2020 to 01/10/2021

## **Study Design**

Case series type of study

## **Results**

### **Case 1**

A 20yr female, presented to ER with complaints of pain abdomen pointing towards RIF. Pt had h/o pain abdomen since 2 days associated with nausea. Pt consulted local doctor and was given medication to relieve pain. Routine blood investigation was done and WBC count was 18,000 cells/ml and erect abdomen and USG was done, probe tenderness in

RIF present but appendix was not visualised, Pt complained of increasing pain and was planned for explorative laparoscopy and intra op findings were appendix was elongated and then we noticed greater omentum was adherent to abdominal wall strongly and small amount of collection was observed and adhesions released and omentectomy was done and also appendicectomy was performed. Pt was discharged @ POD-5 without any complications.

### **Case 2**

A 50 yr old man with no previous positive medical history presented to OPD with chief complaints of pain abdomen. On palpation there was no organomegaly but mild tenderness was present's abdomen and erect abdomen X-ray was requested. Erect abdomen X-ray showed no significant thing and usg showed all solid organs to be normal. In blood investigation WBC was 9,000 cells/ml. He was prescribed analgesics and asked to come for review. He again presented to ER with pain abdomen of increased intensity. Guarding was present in Rt upper quadrant, in CBC the count was 12,000cells/ml. Erect abdomen X-ray showed no significant changes. CECT scan was requested and CECT revealed high density fat in the Rt upper quadrant with hypovascularity suggestive of omental infarction with ascites. Pt was taken for explorative laparoscopy and omentectomy was performed. Pt was discharged @ POD-4 without any complications.

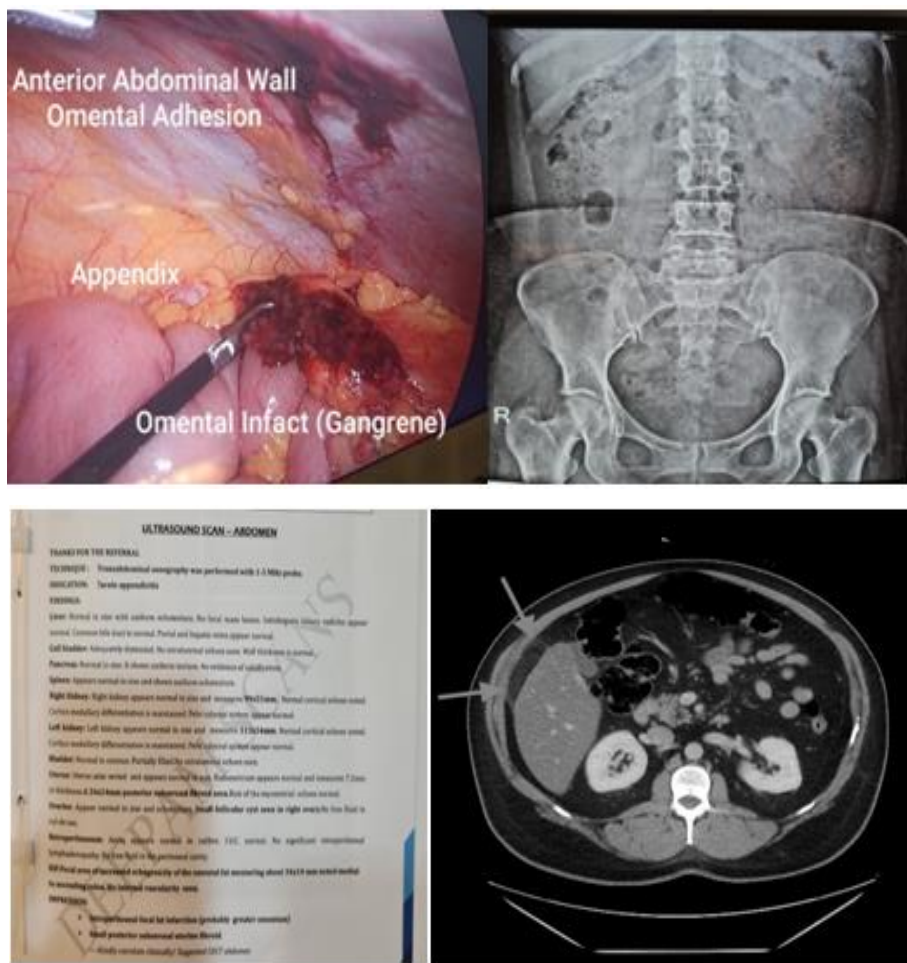
### **Case 3**

A 32 yr male presented to OPD with complaints of pain in Rt lower quadrant since 3 days associated with 2 episodes of vomiting. No h/o comorbidities. No h/o abdominal trauma. Pt was admitted and body temperature was 38\*c and lab examination revealed a WBC count of 14,000 cells/ml

and a CRP of 1.80 mg/dl. Erect abdomen X-ray was unremarkable. USG revealed hyperechoic mass of oval shape at lower border of liver. CECT of abdomen revealed elevated fat density confined to lower end of inferior aspect of liver and below the abdominal wall with ascites. Diagnosis of omental infarction was made

based on emergency laparoscopy where greater omentum was seen strongly adherent to anterior abdominal wall with small amount of ascitic fluid. Careful dissection was done to relieve adherence and omentectomy was performed. Pt was discharged POD-4 without any complications.

1. Out of 3 cases which we discussed above, 2 patients presented with right hypochondriac region and 1 patient complained of right iliac fossa pain. One pt was evaluated with CECT abdomen, and rest two were taken for diagnostic laparoscopy.



### Discussion

Omental infarction is a rare cause of acute abdomen, with an incident equivalent to less than four cases per 1000 cases of appendicitis<sup>4</sup>. Because of its low incidence and nonspecific clinical presentations mislead to diagnosis like appendicitis, cholecystitis,

pancreatitis among other pathology<sup>3-7</sup>. infarction can be separate event or in continuous process of omental torsion. OI can be divided into two groups, Primary and Secondary. In primary OI there is no specific aetiology found, whereas aetiologies for secondary OI include

hypercoagulability, polycythaemia, omental torsion, cysts, tumours and adhesions. Based on our observation it is very much recommended to identify the cause of pain abdomen with radiological imaging and proceed with diagnostic laparoscopic approach for further management.

### **Conclusion**

From our study we conclude that, it is very important to diagnose a case of pain abdomen with warrant of radiological studies. CT abdomen can be considered as gold standard investigation for diagnosing omental infarction. All treating doctors must consider omental infarction as one of the differential diagnosis in patients with right sided pain abdomen. Laparoscopic approach for treatment would be considered for decreased hospital stay and early discharge.

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