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A RARE CASE OF OMENTAL NECROSIS MIMICKING ACUTE APPENDICITIS IN A PATIENT WITH CONGENITALLY ABSENT APPENDIX.

Surgery

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ABSTRACT

Omental necrosis is a rare cause of acute abdomen hence seldom diagnosed correctly1. It occurs due to vacular compromise of the greater omentum and usually mimics acute appendicitis. We present one such interesting case of omental necrosis mimicking acute appendicitis in a patient with congenitally absent appendix.

KEYWORDS

Omental necrosis, Absent appendix, Diagnostic laparoscopy.

INTRODUCTION

Omental necrosis is a rare cause of acute abdomen. It usually presents with right lower quadrant pain, hence is likely to be missed and frequently misdiagnosed as acute appendicitis.1 It may also be confused with other common causes of acute abdomen such as acute cholecystitis, acute diverticulitis, mesenteric thrombosis, ovarian cyst, and perforated peptic ulcer2.

CASE HISTORY

A 45 year old male came with complaints of right sided pain in abdomen associated with nausea since 2 days. Patient did not have any other co morbidities and no history of any surgical illnesses; however he had history of occasional alcohol consumption. Patient had no history of fever, burning micturition, diarrhea, constipation or vomiting.

Physical examination was unremarkable. On per abdomen examination it was soft and non tender. Ultrasonography of abdomen and pelvis was suggestive of a normal study. His total counts were 10,000/cubic mm. Rest other hematological and biochemical investigations were within normal limits. Patient was started on intravenous antibiotics, analgesics and anti emetics; however his pain did not subside.

He was subsequently posted for diagnostic laparoscopy. Operative findings included omental fat pad adhesion to right anterior abdominal wall overlying the distal ascending colon beneath the inferior border of liver. Also appendix was not visualized at the ileocolic junction. Adherent omental fat pad was excised and sent for histopathological examination. Histopathological examination was suggestive of Omental necrosis.

DISCUSSION

Omental necrosis arising due to omental infarction, is a rare cause of acute abdomen. Cases of omental infarction were first reported in the literature over 100 years ago3,4 . incidence of 0.0016-0.37%5 most common cause of omental infarction is omental torsion. Torsion is twisting of an organ along its long axis to an extent that its vascularity is compromised6. Torsion of omentum may be of two types 1) Primary 2) Secondary. Primary torsion occurs in the absence of any underlying intra abdominal cause for the same. Secondary torsion is due to underlying conditions such as cysts, tumors, adhesions, or hernia.

There is a higher incidence of torsion on the right side of the omentum. This may be attributed to the greater length and mobility on that side, which makes it more prone to twist upon itself along its long axis, thereby compromising the vascularity6. It often mimics more common surgical causes of acute abdominal pain and therefore it is. Although Ultrasonography findings are usually evaluated as normal7 and frequently diagnosed at laparoscopy8 Ultrasonography is considered a diagnostic procedure useful for ruling out other acute abdominal conditions. However, CT has been shown as having a high sensitivity and specificity for the diagnosis of intraperitoneal focal fat infarction[9].

A laparoscopic approach also helps in detection of other intra-abdominal masses and to identification of any associated pathology. Also, a thorough examination of the abdominal cavity to confirm the diagnosis, aspiration and washing of the peritoneum, and decreased postoperative pain and wound-related complications can be achieved with a laparoscopic approach. Although some cases require surgical intervention, nevertheless, surgical treatment of omental infarction seems to be limited to those with complications, such as failure of conservative management, omental abscess, bowel obstruction, and in cases of uncertain diagnosis.

In our case this was not applied as this has been associated with the development of omental abscesses in some patients 10. Considering of the severity of the presentation of our patient, surgical intervention was advised. Laparoscopic exploration should be considered as it can be both diagnostic and therapeutic and is associated with low morbidity . Laparoscopic resection of the involved omentum provides definitive treatment with a short hospitalization and rapid recovery.

CONCLUSION

Although rare, Omental infarction should be considered as a differential diagnosis in the presentation of acute abdominal pain.A bdominal ultrasonography and computed tomography should be used as initial diagnostic measures. If this fails, diagnosis and treatment of omental infarction can be achieved by laparoscopy with the advantage of determining the cause; decreased postoperative pain and wound-related complications; and short hospitalization and quick recovery.

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