

Letters to the Editor

Infarction of the greater omentum. Case report

Key words: Omentum. Omental torsion. Necrosis.

Dear Editor,

A 65-year-old female attended at Emergency Department complaining of abdominal pain in the upper right quadrant and a fever of 38 °C. Upon examination a painful mass of approximately 10 cm was detected below the right costal margin. Under analysis, leucocytosis and a slight left deviation was specified, with increased acute phase reactants. A right colon tumour was initially suspected. An X-ray was taken of the abdomen, with no findings, and a colonoscopy, which proved normal. In the computed tomography (CT), a thickening of fat was observed in the greater omentum with a mass effect, compatible with torsion of the greater omentum (Fig. 1). There were no alterations in other abdominal structures.

It was decided to provide conservative treatment with the fever disappearing and the symptoms reducing, with the patient being discharged on the seventh day. CT control was carried out 15 days after admission, with good clinical and radiological evolution. Three months later, the patient was asymptomatic and abdominal examination was normal.

Discussion

The infarction occurred due to its rotation on the transverse plane, which may cause vascular compromise with

strangulation, necrosis and/or infarction. This occurs more frequently in paediatric age. There is no known aetiology. Predisposing factors include changes to omentum consistency, anatomical malformations or vascular abnormalities associated to triggers such as obesity or exercise. The secondary torsion is more frequent and it is associated to hernia injury, intra-abdominal inflammation, prior laparotomy or tumours, which give rise to a fixed point around which a segment of the omentum rotates.

The most frequent symptom is localised abdominal pain in the right hemiabdomen. For this reason, the differential diagnosis includes appendicitis, cholangitis, diverticulitis, etc. A mass is frequently associated to this area. Other symptoms and less specific signs are fever, nausea, vomiting, diarrhoea, or increased leukocyte count. The chosen technique for diagnosis is CT (1), which shows, as in this case, well-defined abdominal mass composed of interspersed fatty and fibrous folds, which are distributed concentrically or in a spiral, and the centre of which may contain a hyperdense vascular structure that descends perpendicularly to the transverse plane.

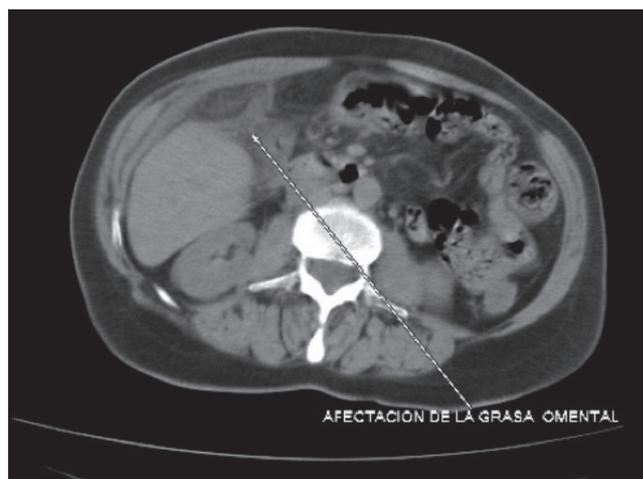


Fig. 1.

Surgical treatment was traditionally opted for, although good evolution has been observed in patients treated conservatively, especially in the case of segmentary infarctions (2) that do not present immediate complications. The CT (3) provides preoperative diagnosis in order to avoid emergency surgery and maintain an expectant attitude (4), and therefore act according to the patient's evolution, without considerable increase in complications being reported. There is a review of 43 cases in which conservative treatment is recommended, therefore preoperative image diagnosis is essential (4). However, some patients treated this way present complications such as sepsis or the formation of abscesses and adhesions. Surgical intervention must be considered where conservative treatment is not effective (5,6).

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