Omental infarct mimicking acute pancreatitis

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Abstract Omental infarction is a rare condition which is being increasingly reported in the literature due to the advancement in imaging techniques and its typical computed tomography appearance. Accurate diagnosis of omental infarct can be made on computed tomography, thereby avoiding exploratory surgery. We report a case of conservatively managed primary omental infarct which was clinically thought to be acute pancreatitis.

Keywords Omental infarct · Computed tomography (CT) · Pancreatitis · Acute abdomen

Case Summary

A 30-year-old male came with history of acute epigastric pain. Physical examination showed tenderness over the epigastric region. Pulse and blood pressure were normal. The patient was an occasional alcoholic and not a smoker. There was no pyrexia, and routine blood investigations were normal. Clinically acute pancreatitis was suspected. Abdominal ultrasound did not show any specific findings with part of the pancreas being obscured by bowel gases. Contrast computed tomography (CT) was done which showed presence of focal fatty encapsulated lesion measuring 7 cm craniocaudally with hyperattenuating streaks and surrounding soft tissue

stranding anterior to transverse colon abutting anterior abdominal wall in epigastric location which was classical for omental infarct (Fig. 1a, b). No hyperattenuating ring or central hyperdensity noted to suggest epiploic appendagitis. Pancreas was normal on CT. The serum amylase and lipase levels were within normal limits. The patient was not obese, and he did not have any history of local trauma or surgery. The blood investigations did not suggest any evidence of hypercoagulable states or vasculitis. The cause for omental infarct could not be found out; hence, the omental infarct was considered primary or idiopathic. Patient was managed conservatively with analgesics, anti-inflammatory medications, and intravenous fluids and he improved symptomatically. Repeat CT scan done after 6 weeks showed considerable shrinkage in the size of omental infarct with no fat stranding.

Discussion

Omental infarction is a rare cause of acute or subacute abdominal pain in children and adults. It is usually common on right side but can occur at any site including the epigastric area and the lower abdomen [1, 2]. The incidence of omental infarction is equal to less than four cases per 1,000 cases of acute appendicitis [1]. Omental infarction is categorized classically into primary and secondary cases. Primary or idiopathic omental infarction is made when no other discernable etiology could be made out [1]. Secondary cases are related to surgery, hypercoagulopathy, and vasculitis [1, 3, 4]. Omental infarct should be included in the list of causes for acute abdominal pain. This condition runs a self-limited course; hence, conservative management is recommended [1, 2]. Surgical intervention is required in

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Fig. 1 Axial (a) and coronal (b) contrast-enhanced CT scan showing presence of well-defined encapsulated fatty density lesion with surrounding fat stranding and intermingled hyperattenuating streaks in epigastric region anterior to transverse colon (*white arrows*) suggestive of acute omental infarct. The pancreas appears normal (*black arrow*)

patients with unclear radiological findings or if the clinical condition of the patient deteriorates [5, 6]. The diagnosis of omental infarct is most commonly made on computed tomography [3, 4]. Accurate radiological diagnosis can avoid surgical intervention in most of these patients [1, 2].

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