Annals of Clinical Case Reports

Clinical Image
Published: 17 Jun, 2019

Omental Torsion

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Clinical Image

A 50 year-old male with past history of obesity hypertension diabetes, presented for one week of right-sided chest and abdominal pain following a forceful hug. There was associated dyspnea, cough and fatigue. Initial vitals heart rate 113 bpm, temperature 100.4°F, blood pressure 130/76 mmHg, SpO2 95% on room air [1]. Exam benign other tenderness to the right flank and right upper abdomen with mild voluntary guarding EKG and labs only notable for anion gap 14, glucose 300, and WBC 14.5. CTA PE did not show cause. CT abdomen and pelvis revealed a likely hemangioma in right hepatic lobe and inflammatory changes in right anterior lateral abdomen believed to be fat necrosis or contusion (Figure 1). The patient was diagnosed with omental torsion. He was initially treated with pain control and antibiotics; two weeks later, was readmitted for a two-week ICU stay including exploratory laparotomy for associated perihepatic abscess drainage and small bowel resection due to infarcted omentum [2-4].

Separate from epiploic appendages which are largely pieces of fat lining the colon (and associated epiploic appendagitis), omental torsion occurs when the omentum supplying blood to the intestine torses. It can happen primarily or secondarily from a hernia or tumor. Risk factors include abdominal trauma, obesity and abdominal surgery. It more often occurs on the right side. Imaging can reveal a swirling omentum but is not sensitive as the axis of the omentum is not in transverse plane [5]. Best management remains controversial in terms of conservative versus surgery, as sometimes the condition is self-limiting in stable patients.

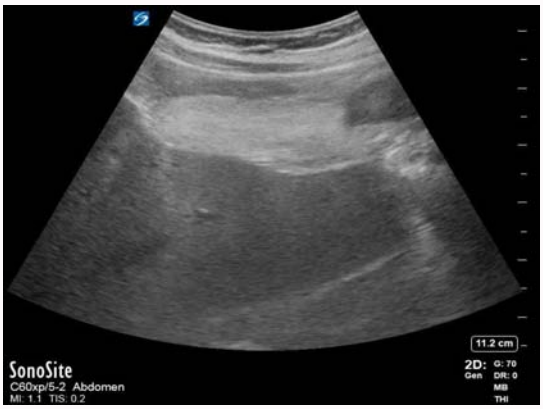

Figure 1: CT abdomen and pelvis.

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Received Date: *30 Apr 2019*
Accepted Date: *11 Jun 2019*
Published Date: *17 Jun 2019*

Citation:
Stenberg R. Omental Torsion. Ann Clin Case Rep. 2019; 4: 1669.

ISSN: 2474-1655