INTRODUCTION
Although first described almost a hundred years ago, the exact etiology of primary segmental omental infarction is still not clear. Clinical features most often simulate common surgical emergency of acute appendicitis. Due to rarity of disease and non-specific clinical features, pre-operative diagnosis is very rare. This report describes a case of young adult male who presented with pain right lower abdomen in which omental infarction was found at laparoscopy which is a rare cause of acute abdomen.

CASE REPORT
A 22 years male patient presented with history of right lower abdominal pain and vomiting for the last 2 days. Pain started in the peri-umbilical region and then shifted to the right iliac fossa. He had vomited twice during this period. There was no past history of surgical intervention. On examination, the abdomen was tender in the right iliac fossa with positive rebound tenderness. He was afebrile with pulse of 68 bpm. TLC was 9.2 x 10^9/L with 82% neutrophils. Ultrasound abdomen revealed minimal amount of free fluid in the pelvic cavity. Keeping in view the history, clinical features and investigations, a diagnosis of acute appendicitis was made.

Patient was kept nil per mouth, Cefuroxime 1.5 gm intravenously was given and he was shifted to operation theatre with a plan of laparoscopic appendicectomy. Pneumoperitoneum was established and general inspection of the abdominal cavity was done by using 30 telescope. A piece of dusky colored greater omentum was found lying close to the appendix. On further exploration, it was found infarcted but no element of torsion could be found. Appendix was normal without any evidence of inflammation. Terminal ileum and caecum was also normal. Omentectomy of the infarcted portion of greater omentum was done laparoscopically with suction of small amount of free fluid in the pelvis. The patient was briefed about the pathology and procedure in the postoperative period to prevent future confusion if an attack of acute appendicitis occurs. He had smooth postoperative recovery and was discharged in stable state.

DISCUSSION
Omental infarction occurs when there is interruption of blood supply to the omentum which may be due to thrombosis or torsion of blood vessels. Thrombosis may be due to vascular abnormality, trauma, and hypercoagulable state or very rarely idiopathic. Torsion may be primary (idiopathic) or secondary to hernia, adhesion or tumour. Primary omental infarction should not be confused with primary omental torsion which is a well known entity.

Clinical signs and symptoms may be non-specific abdominal pain to acute abdomen. It may present like acute appendicitis as was in this case. Pain is due to irritation of parietal peritoneal from infarcted omentum and as it is more mobile in the right side, right sided peritoneal irritation and pain may mimic more common condition of acute appendicitis. Ultrasound and CT scan aid in the diagnosis of omental infarction. Ultrasound generally shows a moderately echogenic, solid, non-compressible, ovoid lesion in the region of maximum tenderness but it is operator
dependant. CT scan features are well circumscribed mass with fat interspersed having hyper attenuating streaks in it. CT scan was not done in this case because of strong suspicion of acute appendicitis and it is not the authors routine to subject every case of acute appendicitis to CT scan of abdomen.

There is no clinical trial comparing conservative versus surgical management of omental infarction. In a rare instance when diagnosis can be made confidently pre-operatively, conservative management can be done but it may be complicated with abscess formation, adhesions or sepsis. Operative management includes excision of the involved part of greater omentum either by laparotomy or laparoscopy. Laparoscopy has the advantage that it can visualize other intra abdominal organs, minimally invasive and the chances of missing the pathology are less.

The aim to highlight this case is that omental infarction should be kept in the differential diagnosis of acute abdomen especially acute appendicitis and a search should be made to see the lower part of greater omentum in the right iliac fossa should a patient be operated for acute appendicitis and appendix, caecum, terminal ileum and right ovary in a female appears normal. Laparoscopic appendicectomy is superior to open procedure as it can detect other intraabdominal pathologies that may be missed in open appendicectomy.

REFERENCES