OMENTAL INFARCTION FOLLOWING ROBOTIC ASSISTED LAPAROSCOPIC INGUINAL HERNIA REPAIR

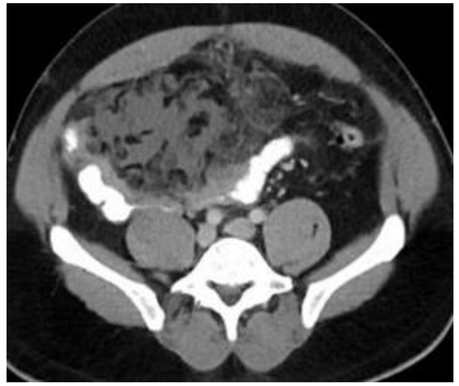
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INTRODUCTION

The omentum is a two-layered folding of the parietal peritoneum hung from the greater curvature of the stomach down to the pelvis. It contains fat, lymphatic tissue, and vessels. Omenal Infarction (OI) is a rare condition with an incidence of 0.001-0.3%.1

CASE PRESENTATION

A 44-year-old male who underwent an uneventful robotic-assisted laparoscopic left inguinal hernia repair, presented on postoperative day 16 with right lower quadrant pain, fever, and chills. He had a distended tender abdomen with guarding, WBC was 8000, and lactic acid was 1.27. CT scan revealed localized focal omental edema versus inflammation suggesting OI (Figure 1). After the failure of conservative management, he underwent a diagnostic laparoscopy converted to laparotomy with findings of necrotic omentum overlying matted lops of the bowel. The omentum and bowel were resected. The pathology confirmed OI and ruled out any bowel perforation.



CONCLUSION

OI is a rare condition and was previously a diagnosis of exclusion. This is the first reported case of OI following robotic-assisted inguinal hernia repair. Treatment should be started with conservative management if the patient is stable; in cases of failure to improve or when the diagnosis is in doubt, surgery via laparoscopy or laparotomy is warranted.

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DISCUSSION

OI can occur spontaneously with increased risk in children and morbidly obese adults due to the heavy burden of fat tissue and omental redundancy. OI can be secondary to trauma, surgery, inflammation, hernia, adhesions, or any other possible lead point. Although spontaneous OI in children and in non-surgical contexts have been reported many times, relatively few case reports and series have included patients with OI following surgeries. Since 1946 when OI was first described, there have been less than 50 cases reported of OI following surgery, but all following pancreatic, gastric, colonic, or cesarean section surgery.2,3 Regardless of the etiology, the pathophysiology consists of blood flow interruption leading to venous stasis and edema. The average time for presentation varies from weeks to months after the primary surgery. Clinically, the presentation of OI is often difficult to distinguish from other causes of acute abdominal pain, prompting potentially unnecessary surgical exploration. However, due to developments in imaging technology, CT findings can now identify OI accurately with the presence of heterogeneous fatty attenuation is highly suggestive of OI.4 Treatment options range from conservative to interventional radiology or surgical resection of the infarcted omentum.3