

A case of secondary omental pregnancy presenting as right iliac fossa pain

S Sanjai Venkatesh^{1*}, S Sindhuja², PB Sudarshan³, Karthikeyan⁴

^{1,2}PG Resident, ³Associate Professor, ⁴Assistant Professor, Department of General Surgery, Saveetha Medical College Hospital, Saveetha Nagar, Thandalam, Kanchipuram District 602105.

Email: venkateshsomasukumar@gmail.com

Abstract

We report a case of 27 yr old female who presented to the emergency department with complaints of right lower abdominal pain. Clinical examination revealed tenderness in right iliac fossa. Her vital signs and laboratory values were within normal limits. Ultrasound of the abdomen was indicative of probe tenderness in the right iliac fossa ??? appendicitis. She was discharged from the hospital in two days following conservative management. She was again admitted with similar complaints after 10 days. Abdominal examination revealed right iliac fossa pain and computer tomography imaging showed an infarcted omental mass with minimal haemoperitonuem in the pelvis. Diagnostic laparoscopy was performed and omental mass excision done and pathologic examination confirmed an omental pregnancy.


Keywords: Diagnostic laparoscopy, Omental infarction, Omental mass excision, RIF pain, RIF mass, Secondary omental pregnancy.

*Address for Correspondence:

Dr. S Sanjai Venkatesh, PG Resident, Department of General Surgery, Saveetha Medical College Hospital, Saveetha Nagar, Thandalam, Kanchipuram District 602105.

Email: venkateshsomasukumar@gmail.com

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INTRODUCTION

A mass in the right iliac fossa is a common diagnostic problem experienced in clinical practice. A mass in the right iliac fossa commonly appear from the structures normally present in that region or from the structures which are abnormally located in that region. Most of these cases require surgical intervention and are curable¹. Omental pregnancy is a rare and uncommon form of ectopic pregnancy, and can be seen primarily or secondary to a tubal pregnancy. Nearly 95% of ectopic pregnancies are implanted in one of the segments of the fallopian tubes. The remaining 5% implant in the ovary, peritoneal cavity, within the cervix. The omental

pregnancy is the least common form of abdominal pregnancies². A review of the literature has showed that only very few cases of omental pregnancies have been reported so far, and most of them were secondary omental pregnancies. The diagnosis of omental pregnancy is usually made at laparotomy. Here we report a case of secondary omental pregnancy which is diagnosed by histopathological examination after a diagnostic laparoscopy.

CASE REPORT

A 27 year old female patient (P2 L2 A0) completed the family presented to the emergency department with the history of abdominal pain for a period of two weeks. The pain was more localised to the right iliac fossa. The pain increased in intensity and analgesics had minimal effect. She had no other associated symptoms such as change in the bowel habits or urinary symptoms and was otherwise well. There was no history of trauma or surgery. Patient revealed a normal menstrual cycle.

At the time of presentation her pulse was 88/min, blood pressure was 110/70 mmHg and temperature was 98.2 F. On examination, her abdomen was soft with tenderness in the right iliac fossa. Her pervaginal examination and peranal examination were normal. Heamatological

investigations were within normal limits. Urine analysis was normal, urine pregnancy test was negative and beta-HCG levels were within normal range.

Ultrasound abdomen was done and it was indicative of probe tenderness in right iliac fossa and appendix could not be visualized. So patient was treated conservatively with anti-inflammatory drugs, analgesics and antibiotics. The pain gradually settled and the patient was discharged after two days.

The patient was readmitted after 10 days with the similar complaints. On clinical examination she was hemodynamically stable and there was tenderness present in the right iliac fossa. All the hematological investigations were within normal limits except for mildly raised C-reactive protein (22 mg/L) and the pregnancy tests proved negative. CT abdomen was taken and it was suggestive of omental infarction with normal uterus and ovaries with no free fluid in the intraperitoneal cavity. It revealed increased density and stranding in omental fat in the right lower quadrant, suggestive of segmental infarction of omentum with central necrosis. She was started on IV antibiotics, anti-inflammatory, and

analgesics again for two days and because of continuing abdominal pain, an elective diagnostic laparoscopy was performed.

Intraoperative findings

1. A mass is seen in the right iliac fossa measuring 6*5 cms formed by omentum, also right fallopian tube and the fimbrial end was pulled up into the RIF adherent to the mass.
2. The mass as a en bloc found attached to anterior abdominal wall in the right illaic fossa.
3. Uterus, fallopian tube and ovaries on both sides visualized normal expect for right fimbrial end congested.
4. Appendix visualized normal and found to be not a part of the mass.
5. Adhesion to the tube and anterior abdominal wall separated. Omental mass excised in toto and sent for histopathological study.
6. Histopathological examination revealed trophoblastic tissue and chorionic villi with the infarcted omentum.

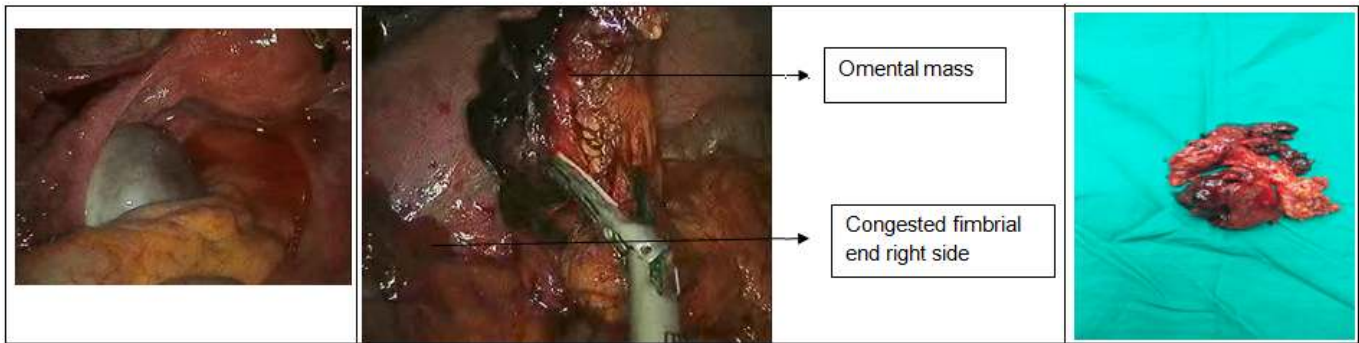


Figure 1

Figure 2

Figure 3

Legend

Figure 1: Left side ovary visualised intraoperatively; Figure 2: Intraoperative view of omental mass; Figure 3: Excised omentum mass

DISCUSSION

Omental pregnancy

Abdominal pregnancy occurs in 1.4% of all ectopic pregnancy cases, and omental pregnancy is the least common form of abdominal pregnancies. The mortality rate for abdominal pregnancy is seven times higher than non-abdominal cases^{3,4}. A review of the literature on Medline for the period 1958-2012 reported only 16 cases of omental pregnancy².

Abdominal pregnancy can be classified as primary or secondary. The latter is more common due to re-implantation of a ruptured tubal ectopic pregnancy. Our case was diagnosed to be a secondary omental pregnancy as the fimbrial end was congested on right side.

Diagnosis of omental ectopic pregnancy could be missed out without extensive surgical evaluation. Laparoscopic surgery for omental pregnancies had been reported especially in early presentation when the sac is not yet ruptured[5,6]. In our case, laparoscopic management could be performed, because the patient was haemodynamically stable. And in our pathological sections, extensive villus formation and dense trophoblastic invasion deep into the omental tissues including blood vessels were seen. These histopathological findings proved our case to be an omental pregnancy.

CONCLUSION

RIF pain is a common clinical presentation in a surgical ER. Common differential diagnosis usually includes pathology pertaining to anatomical structures in RIF.

But we should be aware of such rare conditions like omental pregnancy which can also present as RIF pain.

So our article can be an eye opener for surgeons while dealing RIF pain

Omental ectopic pregnancy is a rare form of ectopic pregnancy. Early diagnosis of omental pregnancy is difficult but it is important to reduce the high mortality risk for the mother. Our case successfully illustrates the importance of having high index of suspicion in managing patients presented with atypical clinical features of ectopic pregnancy. A primary omental pregnancy should be considered in patients presenting with acute abdomen, severe haemoperitoneum and with intact adnexes on surgical exploration.

Treatment includes excision of the mass and educating the patient to undergo sterilization if they have completed the family.

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