Idiopathic Omental Bleeding: Report of a Case

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Abstract

We report a case of idiopathic omental bleeding in a 27-year-old man who was brought to our hospital after the sudden development of intermittent abdominal pain, nausea, and fainting. Computed tomography showed intra-abdominal fluid and emergency laparotomy revealed a hemorrhagic mass in the omental bursa, which was excised. The patient was successfully treated and a diagnosis of idiopathic omental bleeding was made.

Key words Omental bleeding · Diagnosis · Computed tomography

Introduction

Omental bleeding is most often caused by injury. Other causes, such as omental torsion, are rare and usually indistinguishable from acute appendicitis preoperatively, being diagnosed only at the time of laparotomy. Very few cases of idiopathic omental bleeding have ever been reported. We recently treated a 27-year-old man with idiopathic omental bleeding, which necessitated excision of the affected omentum.

Case Report

A 27-year-old man was brought to our hospital after the sudden development of intermittent abdominal pain, nausea, and fainting. He had never experienced this type of abdominal pain before and had not recently ingested a heavy meal, or suffered coughing, straining, or a blow to the abdomen. The patient had undergone surgery for cryptorchidism at the age of 7 years, and there was an operation scar on his left lower abdomen.

The patient was 165 cm tall and weighted 52 kg. His body temperature was 37.1°C and physical examination revealed rebound tenderness in the entire abdomen without muscular guarding. No mass or groin hernia was identified. His hemoglobin level was 12.1 g/dl, with a white blood cell count of 18.1 × 10³/mm³ and a platelet count of 17.8 × 10⁴/mm³. Liver function test results were within normal limits and a roentgenologic examination of the abdomen showed no remarkable findings.

Computed tomography (CT) showed intra-abdominal fluid, which was considered to be ascites (Fig. 1a). However, retrospectively, contrast medium was seen to exude from the omentum (Fig. 1b) and intra-abdominal bleeding was suspected.

Under the provisional diagnosis of possible perforating peritonitis, we performed an emergency laparotomy, which revealed a hemoperitoneum and adhesion between the omentum and the operation scar. We also found a hemorrhagic mass around the adhesive part of the omentum and in the omental bursa (Figs. 2 and 3). There was no evidence of perforation or any other abnormal findings in the abdominal cavity. The hemorrhagic part of the omentum was excised with a margin of normal tissue. Histological examination of the excised omentum revealed hemorrhage with venous dilatation but no evidence of thrombosis, vasculitis, or infarction.

The patient had an uneventful postoperative course and was discharged 9 days after the operation. He returned to unrestricted activity and has remained well.

Discussion

Omental bleeding is usually caused by injury, but it has also been reported to occur in association with neo-
plasms, varix, or torsion of the omentum, none of which were found in our patient. Histological examination of the excised omentum revealed hemorrhage with venous dilatation, but there was no evidence of thrombosis, vasculitis, or infarction.

Omental bleeding of indeterminate cause, or so-called idiopathic omental bleeding, is a rare surgical condition, and we were able to find only ten other cases reported in Japan in the last 10 years (Table 1). Moreover, we found no such reports in any English-language journals.

The symptoms include acute intense pain, abdominal distension, signs of an abdominal mass, and a sudden fall in blood pressure. Some patients had rebound tenderness in the right lower quadrant of the abdomen or muscular guarding, and were diagnosed preoperatively as having acute appendicitis.

Abdominocentesis, ultrasonography, and CT are reported to be valuable diagnostic modalities; however, because omental bleeding is rare and the patient’s condition is invariably unstable, emergency laparotomy is usually required. Therefore, it is very difficult to diagnose this condition preoperatively, and only two of the ten patients reported previously were diagnosed correctly before surgery. The other preoperative diagnoses