Narrow base and lumen generally predisposes Meckel’s diverticulum to obstruction, inflammation, edema, ischemia, necrosis and perforation. On the other hand, various foreign bodies, ingested accidentally, have been implicated as causes of perforation.

An 11-month-old girl child presented with vomiting, constipation, fever and abdominal distension of 3 days’ duration. On examination the patient appeared to be restless, irritable and dehydrated; she had tachycardia, tachypnea, and temperature of 40°C. The abdomen was distended, tense and tender. Liver dullness was not obliterated and bowel sounds were absent. Per rectal digital examination revealed the rectum to be empty. Blood tests revealed leukocytosis. X-ray of the abdomen showed ground-glass opacity in the lower abdomen with multiple air-fluid levels in the upper part.

Exploratory laparotomy revealed distended small gut with feculent fluid compartmentalized to the lower part of the abdomen. A live roundworm was found lying free in the peritoneal cavity. Many roundworms could be felt along almost the entire length of the gut. The distal ileum was kinked around a band running from the tip of a congested Meckel’s diverticulum to the lateral pelvic wall. On separating the band, the diverticulum with a wide base (Fig) revealed a tiny perforation at its tip, by the side of the band, through which gut contents could be extruded out on pressure. The diverticulum along with a segment of the adjoining bowel was resected and end-to-end anastomosis done. No heterotopic tissue could be detected on subsequent examination of the specimen. The patient had an uneventful postoperative recovery.

Meckel’s diverticuli usually produce no symptoms, and are discovered incidentally. Two-thirds of symptomatic patients present before 2 years of age; 8%-22% of patients present with complications.1 Diverticular perforation from acute inflammation or foreign body is present in less than 5% of the complicated cases.1 Inflamed Meckel’s diverticulum may present with features like that of acute appendicitis.

Perforation and peritonitis commonly result because a narrow base and lumen of the diverticulum causes stagnation and infection of the contents and subsequent inflammation,2 or from peptic ulcer on the heterotopic gastric tissue.3 It has also been reported to occur due to a variety of materials like piece of sharp plastic,3 fishbone,4 and toothpick,5 but there is no report of perforation caused by a roundworm.

Our patient had a diverticulum with a wide base without any heterotopic tissue. The perforation was very small and at the tip of the congested diverticulum, proximal to the site of intestinal kinking. In all probability the roundworm found free in the peritoneal cavity had penetrated through the congested tip and caused fecal peritonitis.

References

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Gigantic post-traumatic pseudocyst of sigmoid mesentery

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A 29-year-old man presented with dull abdominal pain and a lump occupying almost the entire abdomen, 4 months after a fall from a height. Ultrasonography revealed a cystic lesion with debris occupying almost the entire abdomen. Diagnostic tap revealed brownish fluid. Exploration revealed a huge thick-walled cyst of the sigmoid mesocolon, which could be enucleated out entirely. Histology suggested it to be a false cyst. [Indian J Gastroenterol 2005;24:26-27]

Traumatic cysts, also called serosanguinous cysts of the mesentery, are not mesenteric cysts in the true meaning of the term. These acquired cysts are very rare
and result from earlier hemorrhage within the leaves of the mesentery; a definite history of trauma is seldom obtained.

A 29-year-old man was admitted with history of abdominal distension of 4 months’ duration and dull abdominal pain for 4 days. He also complained of weakness and frequency of urination for 4 months. His bowel habits were normal and there was no history of fever. Approximately 4 months ago he had a fall from a height, followed by low back pain. Clinical and radiological examination at that time had shown no abnormality. He apparently improved with conservative management but was not totally symptom-free. About a month later, he noticed progressively increasing distension of abdomen, accompanied by vague abdominal discomfort and gradually increasing malaise.

On examination the patient appeared pale. There was a smooth, spherical mass measuring approximately 55 cm in transverse axis, occupying almost the entire abdomen, simulating ascites. It was immobile, slightly tender, tense cystic in feel, with definite fluid thrill. The lower margin of the mass was not palpable as it extended into the pelvis. On per rectal digital examination an extraluminal tense cystic mass was palpable through the anterior rectal wall.

Hematological and biochemical investigations were normal except for hemoglobin of 6.9 g/dL. Ultrasonography revealed a huge multiloculated, cystic lesion with thin septations and internal echoes due to debris, extending from the epigastrium to the pelvis and occupying both flanks. The site of origin of the lesion could not be defined. Diagnostic tapping showed free-flowing brownish fluid. The patient could not afford CT scan.

Exploration revealed a huge thick-walled cyst, located within the leaves of the sigmoid mesocolon, which extended from the upper abdomen to deep within the pelvis. On aspiration approximately 5 liters of brownish fluid was evacuated. Careful dissection enabled us to shell out the entire cyst, from between the leaves of the mesentery, without injuring any mesocolic vessel. On opening the cyst it was found to contain plenty of brownish debris.

Postoperative recovery was uneventful. Histology of the cyst wall showed fibrocollagenous tissue without epithelial lining and plenty of hemosiderin-laden macrophages on one side, suggesting a pseudocyst, probably of traumatic origin.

There are varieties of mesenteric cysts, including chylolymphatic, enterogenous, urogenital, teratomatous, traumatic, gas, mycotic, parasitic, tubercular, and cysts following malignant degeneration.1 Traumatic cysts are basically pseudocysts that are lined by fibrous tissue elements instead of epithelium. They are acquired following trauma and rupture of lymphatic or blood vessels. Traumatic cysts are rare entities and only a few cases have been reported;2,3,4 there is only one previously reported huge post-traumatic cyst of the sigmoid mesentery.2 Surgical excision, preferably enucleation, as was done in this case, is the preferred treatment. Mar- supialization, internal drainage or aspiration may be followed by recurrence.

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Bifid liver in a patient with diaphragmatic hernia

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Liver malformations including lobe and segmental abnormalities are rare. We report a 65-year-old lady with complaints of breathlessness and fullness after meals for two months. Investigations revealed a diaphragmatic hernia on the right side with a bifid liver; the right lobe of the liver was among the hernia contents. The lady is asymptomatic after surgical repair. [Indian J Gastroenterol/2005;24:27-28]

Congenital abnormalities of the liver include agenesis of its lobes, absence of segments, deformed lobes, decrease in size of lobes, lobar atrophy, and hypoplastic lobes. Right-sided diaphragmatic hernias are rare because of presence of liver. However, congenital anomalies of the liver may be associated with right-sided diaphragmatic hernia, which presents in childhood.

A 65-year-old woman presented with history of breathlessness, sensation of fullness after meals, and vomiting for two months. She had a history of bronchial asthma since many years, but had no similar complaints or trauma or surgery in the past. Clinical examination revealed decreased respiratory excursions on the right hemithorax, with decreased breath sounds on the right side. The abdomen was scaphoid in shape with no organomegaly.

X-ray chest and abdomen in the standing position revealed a fundic air shadow and air shadows suggestive of bowel loops under the right hemidiaphragm, which was riding high. Ultrasonography revealed a bifid liver with the right liver lobe in the right thorax along with stomach and bowel loops. CT scan of the abdomen confirmed the findings of a bifid liver (Fig), with the stomach and few bowel loops lying high up in the right thorax.

The patient was explored through a upper midline incision and was found to have a large right-sided diaphragmatic hernia with the shrunken finely nodular right liver lobe, stom-