pouch, formed by fusion of an abnormal fold, the plica inframesocolica transversa.

The fossa in the present case was an actual peritonealized pouch—the mesocolon forming its anterior wall extending upwards behind the stomach and lesser sac, the posterior parietal peritoneum overlying the third part of the duodenum and the pancreas forming the posterior wall. The relatively wide stoma, some $1\frac{1}{2}$ in. (3.9 cm.) in diameter, was directed downwards and somewhat to the right, with the middle colic artery lying to the left of the stoma. There was no fold suggestive of a plica inframesocolica transversa, and it is possible that the pouch was formed simply by the mesocolon being carried to a higher level at this point than normal before fusion with the parietal peritoneum.

The hernia was probably of the acquired variety into a preformed congenital pouch. It is difficult to see how the hernia could be a developmental anomaly either according to the theory of Treitz (1857), who considered that "the fossae are deepened and widened by the pressure and peristaltic movement of the intestines to produce a true hernial sac," or to that of Andrews (1923), who ascribed duodenal herniae as due to imprisonment beneath the mesentery of the developing small bowel. Such herniae, according to Andrews, contain only small bowel and usually at least half of the bowel, and the contents of the sac are adherent by thin adhesions of the retroperitoneal type. The hernia described in the present case fulfils none of these criteria. The complicated method of production of retromesocolic hernia described by Burnham (1953), really a combination of the theory of Treitz and that of Andrews, is also inapplicable in the present case. Tanner (1945) suggested that a posterior gastric ulcer may attach itself to the transverse mesocolon and pull out a pouch, thus forming a hernial sac, which may later rupture through into the lesser sac. He described a case of this nature, but the present case bears no such explanation.

Retromesocolic herniae almost invariably lie to the left of the middle colic artery; descriptions of herniae to the right of this artery are rare, and there appears to be no description of a hernia similar to the present case. It is possible that the case described by Smith (1945) of a hernia through a hole in the transverse mesocolon near the hepatic flexure might have resulted from the rupture of a sac similar to the one in this case. Hansmann and Morton described a sac extending behind the right side of the transverse mesocolon in much the same position, and containing terminal ileum and caecum, but the stoma lay in the right side of the ascending colon and the sac was retroperitoneal. They considered that a hernia may occur at any point where peritoneum is not defended by parietes or by vessels or nerves in the mesentery.

Summary

An unusual case of retromesocolic hernia to the right of the middle colic artery is described. It is thought to have been an acquired hernia into a congenital sac. Its stoma did not correspond to any of the described fossa, with the possible exception of the very rare right intermesocolic fossa of Brösike.

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Medical Memorandum

Diverticulum of a Meckel's Diverticulum

The pathology of Meckel's diverticulum is almost as varied as that of the rest of the gastro-intestinal tract, but, so far as is known, no case has been reported of diverticulosis of a Meckel's diverticulum.

The specimen was found incidentally in the course of laparotomy for abdominal pain in a 29-year-old man. The primary lesion was a torsion of the omentum which did not seem to bear any relation to the apparently normal Meckel's diverticulum.

Macroscopic Anatomy.—The Meckel's diverticulum, 2.5 cm. in length and 1 cm. in diameter at its base, was situated about 2 feet (60 cm.) from the ileocaecal junction. It arose near the attachment of the right leaf of the ileal mesentery, and had itself a small triangular mesentery, the base of which was attached to the mesentery of the ileum. Towards the free end of the antimesenteric border of the Meckel's diverticulum were two pedunculated tags of fat, and just proximal to these, on the same border, was a small hillock about 3 mm. in height (Fig. 1).

FIG. 1.—Meckel's diverticulum, showing the diverticulum (D) and two pedunculated tags of fat on its antimesenteric border and, opposite these, the remains of the mesentery of the diverticulum (M). The tip of the diverticulum is indicated by T.

FIG. 2.—Longitudinal section of the diverticulum arising from the Meckel's diverticulum.

Microscopic Anatomy.—The section shown in Fig. 2 is an approximately longitudinal section of the Meckel's diverticulum. The lumen is tortuous and has been sectioned in several planes. On the antimesenteric border there is a small true diverticulum with all the normal components of bowel wall, including one lymph follicle.

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A. O. WILSON, M.B., B.Sc., F.R.C.S.Ed.,
 Surgical Registrar, Dudley Road Hospital, Birmingham.