Perforated Meckel's Diverticulum

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Abstract A 56-year-old male presented to the hospital with complaint of abdominal pain. On clinical evaluation, the patient had features suggestive of perforation peritonitis. Blood indices revealed leukocytosis, hemoconcentration, and pre-renal azotemia. Relevant CT scan images delineating the pathology have been uploaded. Surgical intervention with small-bowel resection was performed for perforated Meckel's diverticulitis. Post-operative course was uneventful.

Keywords Perforation · Meckel's · Diverticulitis · Peritonitis

A 56-year-old male presented to the hospital with complaint of severe, generalized abdominal pain associated with nausea and vomiting. On clinical evaluation, the patient had features suggestive of peritonitis evidenced by generalized tenderness, guarding, and rebound. Blood indices revealed leukocytosis, hemoconcentration, and pre-renal azotemia. Relevant CT scan images delineating the pathology have been uploaded (Fig. 1). The pictures reveal a diverticulum originating from the distal ileum (arrow) leading to an inflammatory phlegmon with extra-luminal air (arrow). Surgical intervention with small-bowel resection was performed for perforated Meckel's diverticulitis. Post-operative course was uneventful.

Meckel's diverticulum is a vestigial remnant of the vitellointestinal duct. It is present in 0.3–2 % of population, 45–90 cm proximal to the ileocecal junction and 1–12 cm in length. Up to 50 % of Meckel's diverticulum contains heterotopic tissue (gastric, pancreatic, biliary, colonic). Meckel's diverticulitis is often indistinguishable from acute appendicitis, and operative intervention is the mainstay of treatment.

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Fig. 1 Cross-sectional and coronal images of diverticular inflammation with extra-luminal air