

## INTRODUCTION

Meckels diverticulum is the most common congenital anomaly of small intestine. It originates from failure of the vitelline duct to obliterate completely, which is usually located on the antimesenteric border of the ileum. It occurs in 2% of population; 2% are symptomatic, in children less than 2 years, affects males twice as often as females, is located 2 feet proximal to the ileocecal valve, is 2 inches long, and have 2 types of the mucosal lining. Most are discovered incidentally during a surgical procedure performed for other reasons. Complications include obstruction, hemorrhage, perforation, diverticulitis, and intussusception. Meckels scan is gold standard for diagnosis. Management includes resection of Meckels diverticulum. This rare case report presents diagnosis and management of injury to Meckels diverticulum during diagnostic laparoscopy for chronic pelvic pain.



## CASE REPORT

The patient is a 34-year-old female with history of chronic pelvic pain, menorrhagia with one previous Caesarean Section. Diagnostic hysteroscopy was normal. During laparoscopy on insertion of umbilical port, 'yellow extraperitoneal fat was noted, and there was suspicion of entry into bowel. Palmer's entry revealed bowel and omentum adherent to abdominal wall below the umbilicus, port appeared to be in extraperitoneal space with bowel pulled into it. Appearance was atypical of bowel loop, blind pouch with no identifiable descending part was noted. Advice was sought from General Surgeons, who extended the umbilical port entry to better visualise the bowel. There was an incidental finding of large MD adherent to the abdominal wall at site of entry. Adhesiolysis was performed and MD was visualised and inspected. This showed an injury to the top of diverticulum. The MD divided with Endo-Gia. The lumen checked and was widely patent. The pelvic organs showed no signs of endometriosis. Postoperative recovery was uncomplicated.



## DISCUSSION

There are various complications associated with different laparoscopic entry techniques. The effective way to reduce complications is to optimise insertion of primary trocar. Primary trocar site should be visualised from a secondary port. Other techniques like Hasson, Palmer's point can also be used. Secondary ports must be inserted under direct vision.

## IMPLICATIONS ON PRACTICE

There are various complications associated with different laparoscopic entry techniques. The most effective way to reduce complications is to optimize insertion of primary trocar and cannula. Veress should be inserted at right angle to skin, extensive lateral movement of needle should be avoided. Pressure should be 20-25 before trocar insertion, and then reduced to 12-15. Primary trocar should be inserted in a controlled manner at 90 degrees to skin. Once laparoscope has been introduced it should be rotated through 360 degree to check for adherent bowel. If there is concern that bowel may be adherent under umbilicus, primary trocar site should be visualised from a secondary port. Other techniques like Hasson, direct trocar insertion, Palmer's point entry can also be used. Secondary ports must be inserted under direct vision.



## CONCLUSION

This case report emphasizes the need for vigilance in diagnosis and management of suspected bowel injuries including the rare Meckels diverticulum during laparoscopy.

## REFERENCES

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