and vaginal canal by counter pressure. Massive uncontrolled bleeding is an indication for immediate surgical intervention since it may be rapidly fatal. Ligation of the anterior division of the internal iliac artery on one or both sides may control haemorrhage. Total abdominal hysterectomy is indicated if tissue damage or necrosis occur or bleeding remain uncontrolled.

A high index of suspicion is needed to make a diagnosis of this rapidly fatal condition.

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REFERENCE

1 Orasaye AU, Odiase GI. 1981. Incidence of ectopic pregnancy in Benin City, Nigeria. *Trop Doct* 1981;**11**:160–3

Meckel's diverticulum in pregnancy: difficult differential diagnosis

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INTRODUCTION

Ectopic pregnancy is certainly the most common cause of acute abdomen in early pregnancy. Although appendicitis is the most common non-obstetric surgical disease of the abdomen during pregnancy[1], pregnant women can develop other rare conditions that lead to an acute abdomen. We describe a case of a perforated Meckel's diverticulum in a woman in early pregnancy.

CASE HISTORY

RM, a 26-year-old woman, was admitted in the evening to our hospital with a history of 3 days' left iliac fossa pain with radiation to the whole abdomen. She complained of mild fever, abdominal distension, constipation for one day and 7 weeks' amenorrhoea.

On physical examination the patient appeared hypotensive, dehydrated and pale; the abdomen was distended with diffuse rebound tenderness at palpation; pelvic tenderness was elicited by vaginal and rectal examination.

Haematological investigations showed haemoglobin concentration of 8.8 g/l and white cell count of 10.2×10^9/L[3]. A pregnancy test detecting the presence of β-subunit of human chorionic gonadotrophin in the urine was positive. Ultrasound examination was not available.

The patient was brought to theatre with diagnosis of left ectopic pregnancy. At laparatomy pus in the peritoneal cavity, omentum adherent to the loops of small intestine and uterus of 7–8 weeks were found. After adhesiolysis, a perforated Meckel's diverticulum was found, about 50 cm toward the oral side from the ileocaecal valve, penetrating the left Fallopian tube. Part of the ileum, including the diverticulum, and the left Fallopian tube were resected *en bloc*. Histological report indicated that the diverticulum had normal ileal layer with ectopic gastric mucosa.

The post-operative recovery was uneventful and the patient was discharged on seventh day from surgery. The anaemia was treated during the admission with iron dextran 200 mg, daily intramuscular for 4 days, followed by iron sulphate 200 mg twice a day and folic acid 0.5 mg by mouth for the rest of the pregnancy.

Twenty-nine weeks after the discharge, she was readmitted in labour and delivered without complications a baby boy of 3.220 kg.

DISCUSSION

The Meckel's diverticulum is a congenital abnormality of the small intestine present in 2% of the population; in nearly 90% of cases it is situated on the antimesenteric border within 150 cm (commonly 60 cm) from the ileocaecal valve. Although in the Meckel's diverticulum are present all three coats of the ileum, in 20% of cases the mucosa contains heterotopic epithelium, more commonly gastric tissue. Males possessing a Meckel's diverticulum outnumber females in the ratio of 3:1. Complications that can arise in connection with this anomalous structure are: severe haemorrhage (caused by peptic ulceration), intussusception, intestinal obstruction and diverticulitis, with or without perforation[2,3].

As the association between a symptomatic Meckel's diverticulum and pregnancy is very rarely reported[4], our case shows that acute abdomen in pregnancy can be often a difficult differential diagnosis, mostly in hospitals with few diagnostic facilities, and surgeons must be ready to face various and even rare pathologies.

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REFERENCES

1 Gomez A, Wood MD. Acute appendicitis during pregnancy. *Am J Surg* 1979;**137**:180–4
2 Man CV, Russell RCG, Williams NS. *Bailey and Love's Short Practice of Surgery*. London: Chapman & Hall, 1995
3 Ellis BW. *Hamilton Bailey's Emergency Surgery*. Oxford: Butterworth-Heinemann, 1995
4 Clark KH, Lawson EA. Meckel's diverticulum in pregnancy. *J Tenn Med Assoc* 1992;**85**:367–8