Incidence of Meckel's diverticulum in 100 cadavers

M. S. ROJHAN M.D.  R. HEJAZI M.D.

Department of Anatomy, School of Medicine, Tehran University, Iran

Summary
The literature concerning the embryology, histology, clinical significance and preoperative diagnosis of Meckel's diverticulum has been reviewed.

Meckel's diverticulum was found in about 6% of subjects from the Tehran region, suggesting that it occurs more frequently in Iran than previously supposed.

Introduction
Meckel's diverticulum is the most significant diverticulum occurring in the jejunum or ileum. It is a remnant of an omphalomesenteric or vitelline duct which normally obliterates at about the seventh week of foetal life (Oppenheimer, 1962). For reasons unknown, a remnant of the duct may persist, more or less completely, as a tube or cord arising usually from the ileum 25–90 cm from the ileocaecal valve with or without a distal attachment to the umbilicus (Fig. 1) (Gurd, 1966; Oppenheimer, 1962). It may cause volvulus, strangulation or intussusception (Soderlund, 1959).

The incidence of Meckel's diverticulum has been reported as being 2%, occurring more frequently in men than in women (Martin, 1955; Oppenheimer, 1962; Soderlund, 1959). However, according to a recent study performed in the Departments of Anatomy and Pathology of Tehran University Medical School, the occurrence of Meckel's diverticulum seems to be three times greater than previously reported. The present paper reviews these findings.

Materials and methods
Eighty male cadavers were recently examined for presence of Meckel's diverticulum at Dissection Hall of Tehran University Medical School. The small intestine, from the ileocaecal valve to the ligament of Treitz was carefully examined and five cases of Meckel's diverticulum were discovered (the clinical history of these cadavers was not available).

Twenty autopsy cases (twelve male, eight female) were examined in the Autopsy Hall of Pahlavi Medical Centre, University of Tehran, and one case of Meckel's diverticulum was found.

Results
In 100 cadavers examined (ninety-two male, eight female) six cases of Meckel's diverticulum were observed. The conditions of the diverticula were as follows.

Case 1
This was the cadaver of a 50-year-old man. A Meckel's diverticulum was located on the antimesenteric border of the ileum 57 cm from the ileocaecal valve. The diverticulum measured 3 cm long x 1.5 cm wide and was connected to the intestine at the base (Fig. 2). The contents of the intestine could be seen in the diverticulum. Macroscopically signs of chronic inflammation and adhesiveness were
Meckel's diverticulum

FIG. 2. (Case 1). Meckel's diverticulum as seen in the cadaver.

FIG. 3. (Case 1). Medium-power photomicrograph of Meckel's diverticulum.

FIG. 4. (Case 2). Meckel's diverticulum on upper part of the intestine.

FIG. 5. (Case 2) Medium-power photomicrograph of Meckel's diverticulum resembling the small intestine (from top down: mucous membrane, submucous coat, muscular layers and serosa).

Meckel's diverticulum
seen. Microscopy revealed signs of subacute inflammation (Fig. 3).

Case 2

The cadaver was that of a 40-year-old man. The Meckel's diverticulum, 4 cm long and 2 cm in diameter, was located on the anterior surface of the ileum 85 cm from the ileocaecal valve (Fig. 4). The diverticulum was connected to the intestine by its base and the contents of the intestine could be seen in it. The wall of the diverticulum and its serous membrane were normal macroscopically. The mucous membrane, submucosa, muscular layer and serosa were normal on microscopy (Fig. 5). The stomach, Brunner and pancreatic glands were absent.

Case 3

The body was of a man aged 45 years. A cone diverticulum with thin wall was seen on the anterior surface of the ileum, 37 cm from the ileocaecal valve. The diverticulum was 5 cm in length. The width was 3 cm near the intestine but it decreased toward its free end. No sign of the diverticulum entrance was found inside the intestine. The Meckel's diverticulum was thus in the form of a cyst with a wall about 3 mm thick containing several millilitres of clear, yellowish liquid (enterocystoma) (Fig. 6). A dense lymph node 0.5 cm in diameter was found in the base wall of the cyst. The histological structure of the walls of the cyst included a mucous membrane lined with ciliated epithelium, a fibro-muscular layer in the middle, and a serosa outside (Fig. 7). A lymph node accompanied by several lymph nodules existed in the wall of the cyst (Fig. 8).

Case 4

The cadaver was that of a 55-year-old man. A Meckel's diverticulum, 3 cm long × 1 cm wide, was observed in the anterior surface of the ileum, 45 cm
Meckel's diverticulum

FIG. 9. (Case 4). Meckel's diverticulum resembling a glove finger after dissection of the intestine.

FIG. 10. (Case 4). Medium-power photomicrograph of Meckel's diverticulum with a Peyer's patch.

from the ileocaecal valve (Fig. 9). The diverticulum was connected to the intestine at the base and contained semi-fluid faeces. The serosa of the diverticulum was normal and its innermost coat resembled that of the small intestine. Its histological appearance was similar to the ileum but the crypts of Lieberkühn seemed relatively large (Figs. 10 and 11). No aberrant tissue was observed in serial sections.

Case 5

The cadaver was of a 60-year-old man. A Meckel's diverticulum, 2 x 2.5 cm, existed on the antimesenteric border of the small intestine at a distance of 79 cm from the ileocaecal valve (Fig. 12). Its entrance was connected to the intestine by a narrow opening of about 1 cm diameter. The valvulae connotentes, or Kerckring's folds, extended only to the entrance of the diverticulum and from there on the mucous surface of the diverticulum was smooth and without plicae circulares. In other words, the gross appearance of the diverticulum lacked Kerckring's folds as in the large intestine. The lack of plicae circulares in the diverticulum wall was confirmed on microscopy (Fig. 13). It would seem that this is the first reported case in which Meckel's diverticulum resembles the large intestine and lacks valvulae connotentes.

Case 6

The patient was a 30-year-old woman who had complained of abdominal pain, fever, rigors and vomiting. She had been treated with antibiotics and vitamins but died 40 days after being admitted to hospital with symptoms of intestinal occlusion. At autopsy a Meckel's diverticulum, 6 cm long, was found on the ileum about 20 cm from the ileocaecal valve which was inflamed and attached to the mesentery (Fig. 14). The inflammation extended to the tunica serosa of the bladder, and a vesico-ileal fistula was found (Fig. 15). Microscopically, diverticulitis accompanied by inflammatory reaction in the serous membrane was observed (Figs. 16 and 17).

Discussion

Persistence of a vestigial remnant of the omphalomesenteric, or vitelline, duct may give rise to a diverticulum in the ileum. This anomaly was first described and correctly interpreted in 1812 by Johann Friedrich Meckel, anatomist in Halle from 1781 to 1833 (Gurd, 1966; Martin, 1955). Meckel's diverticulum occurs on the antimesenteric border, like a glove finger, at a distance of 25-90 cm from the ileocaecal valve (Fig. 1). The length of the Meckel's diverticulum is usually 1-10 cm and its diameter 1-4 cm. The nutrient arteries and veins originate from the primitive omphalomesenteric or vitelline vessels. These vessels cross over the ileal wall and course...
FIG. 12. (Case 5). Meckel's diverticulum is shown on the uplifted small intestine.

FIG. 13. (Case 5). Medium-power photomicrograph of Meckel's diverticulum with absence of the plicae circulares.

FIG. 14. (Case 6). Meckel's diverticulum causing a vesico-ileal fistula in a 30-year-old woman (arrow).
subserously, or are confined in an accompanying mesentriolum, along the diverticulum to its tip (Fig. 1A) (Oppenheimer, 1962). The histological structure of the diverticulum is the same as that of the small intestine, namely, it is composed of mucous membrane, submucosa, muscular layers and tunica serosa from the inside out (Fig. 5) (Gurd, 1966; Soderlund, 1959). In a large proportion of cases aberrant tissue is present. Ectopic gastric tissue has been found in 16% of all Meckel’s diverticula, often accounting for haemorrhage (Hallendorf and Lovelace, 1947). Aberrant pancreatic tissue occurs in 3–4%. Less commonly, duodenal or bile duct tissue is encountered (Gurd, 1966; Hallendorf and Lovelace, 1947).

Sometimes, the whole vitelline duct remains between the umbilicus and intestine as a tube-like structure, which causes an umbilical faecal fistula (Fig. 1b) (Oppenheimer, 1962). In some cases, the remnant of vitelline duct remains between the umbilicus and intestine in the form of a fibrous cord (Fig. 1c). This cord may cause strangulation of the intestinal loop (Hallbrook, 1970). The middle section may remain as a cyst, and the two ends form a fibrous cord (Fig. 1d). Such a case may subsequently cause enterocystoma as in Case 3 (Oppenheimer, 1962).

Most diverticula are asymptomatic and are incidental findings to abdominal exploration for other lesions, or at autopsy (Soderlund, 1959). The usual complications bringing the patient with Meckel’s diverticulum to surgical attention are (a) inflammation, (b) haemorrhage,* (c) small bowel volvulus, strangulation or occlusion and (d) perforation (Altemeier and Bravant, 1963); Bacon and McGregor, 1961; Hallbrook, 1970). In all these situations the symptoms may appear in the right lower quadrant of the abdomen, in which case the signs are often indistinguishable from appendicitis or other cases of acute abdomen (Bacon and McGregor,
Haemorrhage occurs more commonly in childhood and is usually brisk resulting from peptic ulceration secondary to heterotopic acid-secreting gastric mucosa in the diverticulum (Grossman, 1950; Kelley and Falk, 1960). This mucosa is nowadays easily diagnosed by means of a technetium 99m scan (Harper, 1965; Lathrop, 1964). Meckel’s diverticulum may be incarcerated in a hernia (Oppenheimer, 1962). Calculi (see footnote*) and foreign bodies such as fish bones sometimes become lodged within the diverticulum and lead to perforation (Kavlie and Marchioro, 1972). Polyps, leiomas, sarcomas, carcinomas and carcinoids have been reported as originating in Meckel’s diverticulum (Jones, 1972).

Preoperative diagnosis of Meckel’s diverticulum is seldom made. It would seem advisable, therefore, to pay attention to radiological studies (Kanter, 1968; Lerner, 1953).

(a) Barium meal followed by serial films of the abdomen is the most successful method of examination (James, 1952);

(b) useful radiological signs are the barium-filled diverticulum, the gas-filled diverticulum, and an opaque calculus lying within a bubble of gas;

(c) a ribbon-like opacity, representing the calculus within the gas bubble, may be characteristic (James, 1952; Martin, 1955).

Preoperative diagnosis of Meckel’s diverticulum is more important when haemorrhage occurs. The management of these patients is outlined as follows.

(a) Angiography for those with continued or recurrent bleeding (Kittredge, 1969; Reuter and Bookstein, 1968);

(b) arrest of bleeding by adrenalin perfusion through an arterial catheter (Rosch, 1971).

References


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doi: 10.1136/pgmj.50.589.694

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