

Diverticulitis of the Transverse Colon

S. J. S. KENT

British Medical Journal, 1973, 2, 219

Diverticulitis of the transverse colon is rare. The first case was recorded in a man of 35 by Thompson and Fox (1944). Lockhart-Mummery (1949) described a case in a woman of 48 which was associated with diverticula of the caecum and duodenum. Rowlands (1951) described the second case in the United Kingdom in a woman of 54. This was a solitary diverticulum

Case Report

A woman aged 59 was admitted to hospital as an emergency. She complained of generalized abdominal pain for two days, most pronounced in the right iliac fossa. The pain was described as constant, and was not associated with nausea or vomiting. She had recently taken aperients for mild constipation and had not had her bowels open on the day of admission. There was no relevant past history.

On examination she was afebrile and her tongue was coated. Her pulse rate was 70/min and her blood pressure 130/80 mm Hg. Examination of her abdomen showed tenderness and guarding in the right iliac fossa, extending to the midline. Bowel sounds were normal and rectal examination showed nothing abnormal.

Investigations showed her haemoglobin to be 94% (13.4 g/100 ml). White cell count was 12,000/mm³.

A diagnosis of appendicitis was made and a laparotomy was performed on the evening of her admission using a right paramedian incision. There was no free fluid and the appendix was normal. There was a mass in the middle part of the transverse colon about 4 cm in diameter and hard, which was thought to be a carcinoma. No glands were palpable in the mesocolon and the liver was normal. As there was no evidence of perforation or obstruction of the bowel it was decided to close the abdomen and perform a transverse colectomy after adequate bowel preparation.

She was subsequently given bowel washouts and neomycin for 48 hours preoperatively. Five days after her first operation she was again taken to theatre. Preliminary sigmoidoscopy showed two large polyps of 21 and 23 cm. These were biopsied.

The previous incision was reopened. The mass in the colon was considerably smaller but there were now palpable glands in the mesocolon. It seemed likely that the mass was inflammatory, and

on careful palpation a shallow ulcer could be felt in the bowel wall in the middle of the mass. The glands were deemed to be enlarged secondary to inflammation. The lesion was thought to be diverticulitis but as the transverse colon was a rare site for diverticulitis and there were no other colonic diverticula the mass was resected locally. Continuity was restored by end to end anastomosis.

Microscopically there was an ulcerated and acutely inflamed mucosal diverticulum. An adjacent lymph node showed severe oedema and chronic inflammatory change. The polyps were reported as benign mucosal polyps.

Postoperatively she made an uneventful recovery. A subsequent barium enema examination showed no other diverticula.

Comment

Rowlands (1951) suggested that in the absence of other diverticula of the colon the pulsion theory was unlikely to apply, and that a localized ulceration may progress to form a diverticulum as suggested by Fairbank and Rob (1947).

Our case, like the others so far reported, presented as an emergency. None of the reported cases had any previous history of bowel symptoms.

The transverse colon is not a typical site for diverticulitis, and probably many surgeons, unaware of the condition because of its rarity, would diagnose a mass in the transverse colon as carcinoma rather than diverticulitis. The use of a diagnostic colotomy to solve the problem (Sanderson and Madigan, 1954) has been described with reference to sigmoid diverticulitis (Ellis, 1970).

Solitary diverticulitis of the transverse colon is extremely rare. It is likely to present as acute appendicitis and at laparotomy appear to be a carcinoma. Correct preoperative diagnosis has not been achieved in the cases so far reported, and differentiation from a carcinoma at operation was difficult. Awareness that the condition exists can avoid radical bowel resections being performed unnecessarily under unsuitable conditions.

I am grateful to Mr. A. G. Horsburgh for permission to report on one of his patients and for his help with the preparation of this report.

References

- Ellis, H. (1970). *British Medical Journal*, 3, 565.
 Fairbank, T. J., and Rob, C. G. (1947). *British Medical Journal*, 35, 105.
 Lockhart-Mummery, H. E. (1949). *British Journal of Surgery*, 36, 319.
 Rowlands, B. (1951). *British Medical Journal*, 2, 29.
 Sanderson, F. R., and Madigan, H. S. (1954). *Medical Annals of the District of Columbia*, 23(10), 563.
 Thompson, G. F., and Fox, P. R. (1944). *American Journal of Surgery*, 66, 280.

Watford General Hospital, Watford, Herts
 S. J. S. KENT, F.R.C.S., Surgical Registrar