P-009 Antenatal Perforation of Meckel’s Diverticulum Presenting as Meconium Peritonitis: Case Report and Literature Review
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Aim: To report a case of antenatal perforation of Meckel’s diverticulum (MD) presenting as meconium peritonitis and review the literature. Case Report: A pregnant woman was referred to our institute at 36 weeks gestation for intrauterine growth retardation and fetal bradycardia. Antenatal ultrasonography showed dilated bowel with massive ascites and meconium peritonitis was suspected. A male infant, 1776 grams, was born by cesarean section. Laparotomy revealed a perforated MD with meconium peritonitis. The MD was excised and an ileostomy was created. Histology showed no ectopic gastric mucosa in the MD. The postoperative course was uneventful. Rectal suction biopsy was performed to rule out Hirschsprung’s disease. Contrast bowel enema showed no evidence of distal bowel obstruction. Literature Review: Spontaneous perforation of MD resulting in meconium peritonitis is extremely rare. A search of the English literature revealed there are only two cases where meconium peritonitis was caused by perforation of MD without any complications such as intussusception, bowel atresia or Hirschsprung’s disease. Conclusion: Perforation of Meckel’s diverticulum can be a cause of meconium peritonitis and should be included in its etiology.

P-010 Biliary reconstruction in choledochal cyst associated with accessory hepatic duct. A case report and literature review
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Purpose: We report a case of choledochal cyst (CC) associated with accessory hepatic duct (AHD) and review the literature, focusing on biliary reconstruction. Case report: During routine intraoperative endoscopy to the proximal bile duct at CC excision in a 17-month-old girl, AHD originating from the posterior segment of the right hepatic lobe was identified. Preoperatively, there was no suspicion of AHD on any conventional radiological investigations. The AHD was 7 mm in diameter, the same size as the common hepatic duct (CHD). The distance between the AHD and CHD was 15 mm. The AHD and CHD were each anastomosed end-to-side to the Roux-en-Y jejunal limb by initially suturing their posterior walls to the jejunal limb and then their anterior walls. The postoperative course was uneventful and she is doing well at follow-up of 10 months. Literature review: There are only 5 reported cases of CC associated with AHD in the literature. Anastomotic technique was similar to ours in 2 cases. In 2 other cases, the AHD and CHD were made into a common channel which was then anastomosed to the jejunal limb as a single duct, and in the remaining case, the AHD was overlooked during CC excision and was only identified after radiological investigations for persistent abdominal pain. Conclusions: CC is only rarely associated with AHD. Intraoperative endoscopy is invaluable for confirming anatomical relations and highly recommended for routine use. Reconstructive surgery is feasible for AHD in CC cases.