Vipul D. Yagnik,* MS, FMAS, FIAGES, FAIS, FISCP
Bhargav Yagnik,† MBBS, DCP
*Nishtha Surgical Hospital and Research Centre, Patan, India and †Department of Pathology, Neuberg Supratech Laboratory, Mehsana, India

doi: 10.1111/ans.15527

Dear Editor,

Counter response to Response from Dr Yagnik and Dr Yagnik to Gangrenous giant Meckel's diverticulitis masquerading acute appendicitis: a surgical conundrum

We acknowledge the observations and comments by Yagnik and Yagnik[1] on the article by Teng *et al*.[2] with great interest. Authors had circumstantially described the 'Rule of 2' in relation to Meckel's diverticulitis (MD) namely the incidence of 2%, more commonly symptomatic under the age of 2 years, 2 inches in length, 2 cm in diameter, 2 ft proximal to the ileocaecal valve, presence of dual ectopic mucosal tissues, twice more common in males and more symptomatic in 2% of patients.[3,4] In addition to the extensive list, the authors had suggested the addition of another feature which is the position of MD, either at the anti-mesenteric (which is traditionally located) or mesenteric border.[4]

MD always happens on the anti-mesenteric side of the ileum due to its direct communication with the yolk sac during embryological life. However, the literature has suggested that MD can be originated from the mesenteric side as well because of various postulations.[4] We welcome another addition of unusual characteristic of MD to the current list of rule of 2 with an openhandedness. However, bear in mind that the list is just for academic purpose as majority of the cases even are not fulfilling the rule of 2. At the end of the day, when it comes to the management of MD, reality overrules the postulation.

We do agree that surgical treatment of MD is controversial. Yagnik *et al*. had extensively described the conclusion of a meta-analysis by Zani *et al*. on the resection of incidentally found MD.[5] However, we want to stress that our patient presented with gangrenous MD, which is deemed for resection. Failure to do so will lead to indisputable complications such as perforation, peritonitis, septic shock and even mortality.

References

1. Yagnik VD, Yagnik B. Response from Dr Yagnik and Dr Yagnik to Gangrenous giant Meckel's diverticulitis masquerading acute appendicitis: a surgical conundrum. *ANZ J. Surg.* 2020; **90**: 189–90.
2. Teng WW, Yeap BT, Azizan N, Hayati F, Chuah JA. Gangrenous giant Meckel's diverticulitis masquerading acute appendicitis: a surgical conundrum. *ANZ. J. Surg.* 2020; **90**: 189–90.
3. Affirul CA, Firdaus H, Hanizah N, Salleh S. Meckel's diverticulitis in adulthood: a revisit. *Surg. Chron.* 2018; **23**: 239–41.
4. Yagnik VD, Dawka S. Mesenteric Meckel's diverticulum: an intra-abdominal surprise. *ANZ. J. Surg.* 2019; **89**: 1516–8.
5. Zani A, Eaton S, Rees CM, Pierro A. Incidentally detected Meckel diverticulum: to resect or not to resect? *Ann. Surg.* 2008; **247**: 276–81.

Firdaus Hayati,* MD, DrGenSurg
Boon Tat Yeap,† MD, MMed
Nornazirah Azizan,‡ MD, DrPath (AnatPath)
*Department of Surgery, Faculty of Medicine and Health Sciences, Universiti Malaysia Sabah, Sabah, Malaysia, †Department of Medicine, Faculty of Medicine and Health Sciences, Universiti Malaysia Sabah, Sabah, Malaysia and ‡Department of Pathobiology and Medical Diagnostic, Faculty of Medicine and Health Sciences, Universiti Malaysia Sabah, Sabah, Malaysia

doi: 10.1111/ans.15571