A 70-YEAR-OLD MAN WITH NO SURGICAL history presented to the emergency department with right lower quadrant pain that began acutely 1 day prior. The pain was described as colicky and progressive in nature and radiated to the midabdomen and back. The patient denied any accompanying subjective fever, nausea, or vomiting.

Physical examination demonstrated moderate tenderness over the right lumbar region. The abdomen was soft and not tender, with minimal distension. The remainder of the physical examination and results of basic laboratory tests were unremarkable. A computed tomographic scan of the abdomen and pelvis with oral and intravenous contrast demonstrated dilated loops of small bowel indicative of small-bowel obstruction, with no contrast seen passing through to the colon (Figure 1). Following computed tomography, fluid resuscitation and supportive care were initiated in preparation for surgery. However, the patient then began to report intensifying pain, and the decision was made to take the patient immediately to the operating room for a diagnostic laparoscopy. On entering the peritoneum, a small amount of serous ascites were noted as well as moderate small-bowel distension. The bowel was run from the ligament of Treitz distally. On reaching the region of the terminal ileum, we encountered the source of the site of the obstruction (Figure 2).

What Is the Diagnosis?

A. Small-bowel obstruction due to adhesion  
B. Incarcerated paracecal hernia  
C. Small-bowel volvulus  
D. Cecal diverticulitis

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Figure 1. Computed tomographic image of the abdomen demonstrating dilated loops of small bowel with no contrast passing through to the colon, consistent with small-bowel obstruction. No clear transition point was visualized.

Figure 2. Intraperitoneal view of the right lower quadrant of the abdomen through a midline subumbilical port demonstrating a loop of ileum incarcerated in the cecal mesentery.