

A CASE OF SPLENIC INFARCTION

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INTRODUCTION

Splenic infarct is a rare pathology of the spleen which is most commonly observed as a complication of another disease.^{1,2} More than one-third of splenic infarct cases are those with atrial fibrillation and atrial thrombus.¹ There are also hematologic, vascular, anatomical and other causes¹, which are present in the medical literature as case reports.²

A case of splenic infarct which is diagnosed after admission to the emergency room with symptoms mimicking renal colic and exacerbation of peptic ulcer is being presented in this case report.

CASE PRESENTATION

A 59-year-old male patient with unremarkable medical history was admitted to our Emergency Room (ER) with the complaint of pain in the epigastric area and left flank. He has recurrent ER admissions in the last ten days with the same complaints. During the physical examination, he was conscious, cooperative and oriented, his arterial pressure was 90/60 mmHg, heart rate was 110 beats per minute and he had moderate general condition. During the auscultation, there were no pathological breathing sounds at the lung, there was no murmur or pathological sound heard at the heart while S1 and S2 were present. There was pain with palpation on the abdomen especially on the upper left quadrant and epigastric areas. He had costovertebral angle tenderness on his left. Sinus tachycardia was present on the ECG. Renal colic and acute exacerbation of peptic ulcer were the early diagnoses. There was no alleviation of symptoms after symptomatic therapy. Blood analysis is as following: CRP; 247, WBC; 22000, Neutrophil; 19300, D-Dimer; 480 together with unremarkable urinalysis. There was no pathology detected on bedside ultrasound. In the IV contrast-enhanced Abdominal Tomography of the patient; there was an approximately 42x41x35 mm sized hypodense area in the upper pole of the spleen which was non-enhancing, peripheral wedge-shaped and significant in terms of infarction. (Figure 1).

The patient, who was hospitalized in the General Surgery Department with the diagnosis of splenic infarct, was taken to the emergency operation. The patient, who underwent total splenectomy, was discharged with recommendations after 4 days of service follow-up.

DISCUSSION AND CONCLUSION

The presence of well-circumscribed, non-enhancing, hypodense area on IV contrast-enhanced abdominal tomography is diagnostic at a rate of 75% for splenic infarct.^{1,2,3,4} Splenic infarct is a rare,

silent clinical condition that is difficult to diagnose and can be confused with other diagnoses unless there is clinical suspicion. It is most commonly caused by thromboembolism or other hematologic diseases.

In our case, the clinical presentation was resembling renal colic and acute exacerbation of peptic ulcer in a way to mislead the physician. However, the patient's complaints did not get any better despite the treatment and his general condition was not good, which warned the clinician to review the pre-diagnosis and led to further examination. The patient was diagnosed with splenic infarct after IV contrast-enhanced abdominal tomography, which is in accordance with the literature. While conservative treatment is sufficient in the early period, surgical intervention may be required in complicated cases such as ours.

Key-Words: splenic ischemia, epigastric pain, flank pain, infarct

REFERENCES

- 1-Jaroch TM, Broughan T, Hermann ER, The natural history of splenic infarction. *Surgery* 1986;27:100:743.
- 2- Maresca G, Mirk P, De Gaetona AM, et al: Sonographic patterns in splenic infarct. *Journal of Clinical Ultrasound* 1986;14: 23.
- 3- Dahlberg JP, Frecentese FD, Cogbill HT. Cholesterol embolism: Experience with 22 histologically proven cases. *Surgery* 1989;105:737.
- 4- Cohen BA, Mitty HA, Mendelson DS. 28 Computed tomography of splenic infarction. *Journal of CAT* 1984;8:167.

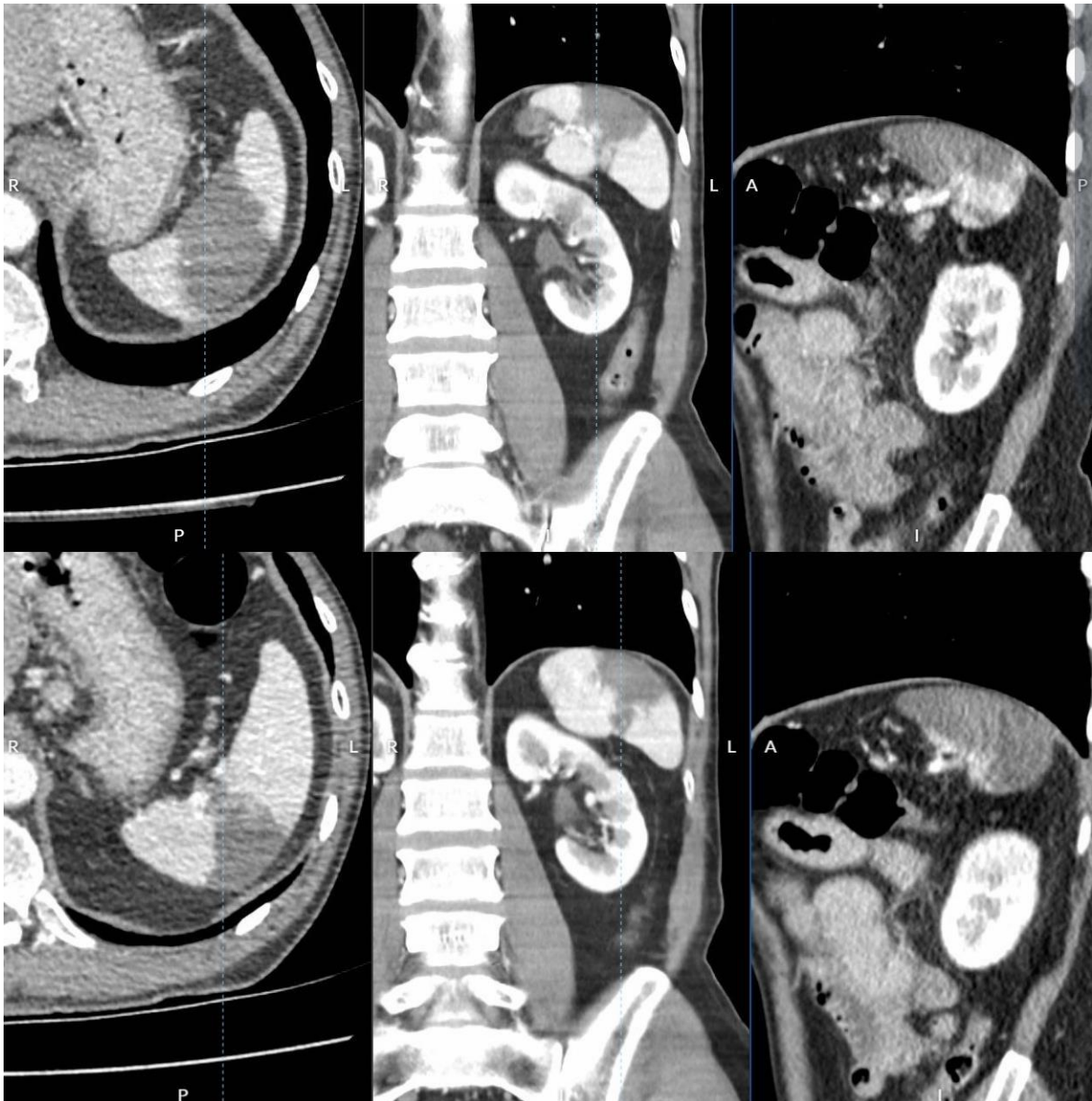


Figure 1. IV Contrast-Enhanced Abdominal Tomography of the patient. In the upper pole of the spleen, an approximately 42x41x35 mm sized non-enhancing hypodense area wedge-fit to the periphery which is significant in terms of infarction.