Abstract:
Wandering spleen is a rare clinical entity caused by absence or weakness of splenic ligaments due to acquired or developmental causes. It is usually seen in pediatric age group, rarely seen in multiparous females. Unusually long suspensory ligaments of spleen leads to torsion of splenic pedicle. It usually presents as acute or chronic intermittent abdominal pain. Pseudocyst formation is one of the rare complication. Here we present a case of Wandering spleen in a young female presented with complication of pseudocyst.

Keyword: Wandering spleen, pseudocyst spleen

INTRODUCTION
Wandering spleen is by absence or weakness of normal suspensory ligaments. Suspended with a long vascular pedicle, the spleen often has an axial rotation and tendency to migrate (1). The mobility of the spleen due to its abnormally long vascular pedicle predisposes it to various complications such as torsion, infarction, gangrene, abscess formation, variceal haemorrhage, pancreatic necrosis and pseudocyst formation [4–7].

A CASE REPORT
A 33-year-old, multiparous gravid female presented with complaints of intermittent abdominal pain 15 days and vomiting 2 days. Delivered dead fetus 2 days after admission. On examination, a large partly mobile lump of size 15x10 cm was palpated in the abdomen. Routine laboratory tests were unremarkable. Plain X-ray abdomen revealed bowel loops occupying the left upper quadrant with a large soft tissue shadow in the hypogastrium. Basic blood investigations revealed hypochromic microcytic anemia (Hb 5.6gms%). USG abdomen showed spleen not visualised in left hypochondrium. Splenic area is occupied by colon. Heterogenous echotexture similar to that of spleen seen in right iliac fossa of size 20x15 cm extending superiorly up to right hypochondrium with multiple areas of anechogeneity suggesting wandering spleen with splenic vein thrombosis.
Contrast-enhanced CT revealed spleen not visualised in left hypochondrium. Evidence of ill defined poorly enhancing mass lesion of size 12x15 cm in right iliac fossa within peritoneal cavity suggesting torsion and infarction of wandering spleen with reactionary haemorrhagic ascites. This prompted a diagnosis of wandering spleen containing a benign cystic lesion. On exploratory laparotomy, huge cyst arising from spleen extending from left/right hypochondrium up to pelvis. Around 4.5 liters of haemorrhagic fluid drained. we observed the spleen twisted at 180° along its long pedicle. A decision was made to perform splenectomy as it was not possible to rule out an infected parasitic cyst intraoperatively. On histopathology, section showed a structure of spleen with areas of infarction and haemorrhagic necrosis was reported.

Post operative specimen showing large spleen with ruptured cyst.

DISCUSSION

Wandering spleen is a rare clinical entity with an incidence of less than 1 in 2000 & accounts for only 2 per 1000 splenectomies(less than 0.5%). It can be asymptomatic, present as acute abdomen, or as intermittent abdominal pain. Incomplete fusion of dorsal mesogastrium to the posterior abdominal wall during second month of development result in an unusually long splenic pedicle leading to wandering spleen. An acquired mechanism thought to exist in multiparous female secondary to hormonal changes during pregnancy & associated abdominal laxity [2].

Acute torsion presents as acute abdomen and causes vascular congestion, infarction, and even gangrene. Chronic intermittent torsion causes venous congestion and splenomegaly with intermittent abdominal pain. Other complications are acute pancreatic necrosis due to the incorporation of the tail of the pancreas in the spleen's vascular pedicle, splenic abscess formation, gastric distention and variceal haemorrhage [4–6]. Pseudocysts usually are the result of prior trauma, with organization and liquefaction of the resultant hematoma, surrounded by a fibrous pseudocapsule(7). Small, asymptomatic pseudocysts (<4cm) usually regress with time, whereas larger splenic cysts (>5 cm) require treatment because the risk of rupture can be as high as 25%. . . In our patient, a large pseudocyst was present in the spleen. In our review of literature, we could find only very few cases including a traumatic pseudocyst in a wandering spleen [7]. Our patient complained of intermittent abdominal pain, but denied any history of trauma. However, an enlarged ectopic spleen could be vulnerable to injury due to trivial unnoticed trauma. Another possible aetiology could be intermittent episodes of torsion, resulting in embolic/thrombotic episodes, leading to infarction and subsequent pseudocyst formation.
Splenopexy has now been established as the treatment of choice in patients with wandering spleen to prevent any future complications [3,8]. In the absence of infarction it has replaced splenectomy, particularly in children. In our patient, although the splenic tissue was viable, the presence of a large cyst, which possibly could have been a parasitic cyst, prompted splenectomy.

REFERENCES


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