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General Surgery

SPLENIC PSEUDOCYST – A CASE REPORT

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ABSTRACT Pseudocysts of spleen occur very rarely which usually develop secondary to trauma. In most cases, they remain asymptomatic. Here, we present a case of pseudocyst developed secondary to abdominal trauma, presented with heaviness and lump in the left hypochondrium. After relevant investigations, laparotomy and splenectomy was done. Histopathological examination confirmed the diagnosis, by the absence of lining epithelium of the splenic cyst.

KEYWORDS : Pseudocyst of Spleen

INTRODUCTION:

Splenic cysts are very rare entities. Only around 800 cases are reported so far in the world literature.[1] Splenic cysts can be classified as parasitic and non-parasitic. Non-parasitic cysts are again classified as true cysts and pseudocysts. True cysts have an epithelial lining and include epidermoid cysts, epithelial or congenital cysts. A pseudocyst does not have an epithelial lining. They are usually post-traumatic, inflammatory or degenerative.[2]Splenicpseudocysts are usually asymptomatic and require treatment only when they become symptomatic. Only large cysts produce symptoms and require Splenectomy.

It is mandatory to distinguish pseudocyst of spleen from other benign, malignant and hydatid cysts for the right treatment and management.

Case Report:

A 20-year old male presented with complaints of heaviness and swelling in the left upper abdomen. The swelling was enlarging in size gradually. Patient did not have pain, fever, dyspnea or vomiting. There was a history of injury while practicing karate 10 months ago.

On examination, there was a non-tender, well demarcated mass with sharp borders in the left hypochondrium extending to the umbilical and epigastric regions which seemed to originate from the spleen.

CT scan of the abdomen (plain and contrast) taken 9 months ago showed a fluid attenuating lesion measuring 13 x 15 x16.9cm arising from lower pole of spleen, from its medial aspect, displacing stomach medially. All other viscera were normal. Laparotomy was planned considering the diagnosis of splenic cyst and splenectomy was done. Spleen weighed 2.85 Kg and showed a huge cystic mass measuring 21 x 15 x 11cm (Fig.1)

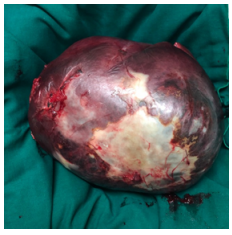

Fig.1 Spleen with pseudocyst

Cut section left out blackish brown fluid (Fig.2). The cyst wall was thickened. Normal splenic tissue was seen in the periphery. No solid area or papillary projections were seen inside the cyst.

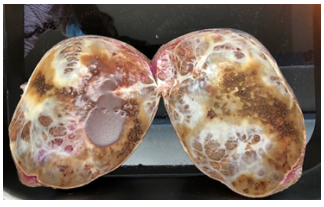

Fig. 2 Spleen cut open

Microscopic Features:

Sections from spleen showed red pulp, white pulp and hyalinised cyst wall.

Sections from cyst wall showed a lining of dense fibrous tissue. No epithelial lining was seen. Wall of the cyst showed haemorrhage and scattered hemosiderinladen macrophages.

These findings confirmed the diagnosis of pseudocyst.

DISCUSSION:

A pseudocyst of spleen is frequently caused by trauma which might have occurred several months ago. Most of the splenic cysts are asymptomatic. Symptoms will appear when they enlarge and compress adjacent viscera. Large cysts may cause dull ache and heaviness in the left hypochondrium. They may present as a palpable mass.[3] Pressure on adjacent organs may cause nausea, vomiting, flatulence and diarrhea. Pressure in the cardio-respiratory system may lead to dyspnea and pleuritic pain. Irritation of left dome of diaphragm may cause persistent cough. Complications of splenic cysts are rupture of spleen, intracapsular hemorrhage and infection.

Small cystic lesions of the spleen are usually asymptomatic. They are detected incidentally while imaging abdomen for other purposes. In small, benign cysts, preservation of spleen is the aim of treatment which can prevent complications like post splenectomy sepsis, especially in young patients.

Total splenectomy is indicated when the cysts are huge. Spleen preserving techniques like periodic check up, percutaneous drainage, marsupialization, complete cystectomy with partial splenectomy are also tried. Percutaneous drainage may give a temporary relief of symptoms, but the rate of recurrence is high.[4]The gold standard of treatment remains splenectomy.[5]

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