ORIGINAL RESEARCH PAPER

General Medicine

# SPLENIC ABSCESS

**KEY WORDS:** Splenic abscess, Loculated, Tappable

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**ABSTRACT**

Splenic abscess is rare but has mortality rates as high as 14% even with recent improvements in management. Early and appropriate intervention may improve patient outcomes, yet at present there is no identified method that can predict mortality risk rapidly and accurately for emergency physicians, surgeons, and intensivists to decide on the ideal course of action. Splenic abscess is septic collection which occurs after hematogenous spread or local dissemination. It is an uncommon and rare condition, more frequently affecting male and immunocompromised patients. There are no guidelines regarding its diagnosis and management. Computed tomography (CT) scan is highly sensitive and specific (95% and 92%, respectively) in the diagnosis of splenic abscess. Diagnosis is based on blood cultures which are positive in 24 to 80% of cases. Bacterial growth culture of abscess after drainage is more efficient (50-80%) and can be performed after surgery or percutaneous drainage under imaging, including CT scan. Microorganisms involved are frequently Enterobacteriaceae, gram-positive cocci and anaerobes. This particular ecology leads to an empiric broad-spectrum antibiotic therapy, with a variable duration, from 10 days to more than one month. Management remains very close to the one applied in case of liver abscesses. The role of splenectomy in the prevention of recurrence remains controversial. The most frequently seen symptoms and signs are fever, abdominal pain and tenderness over left upper quadrant, splenomegaly, leukocytosis, and left lower chest abnormalities.Here I Discuss about a 63 years old Patient who presented with Left Lumbar Pain and Abdominal Distension.

**Case**:
63year old Female came with complaints of
Distention of Abdomen since 18 days.
Pain in Left Lumbar Region since 10 days.

**Distention of Abdomen :**
- Gradually Progressive.
- Associated with Pain.
- No Vomiting, Nausea, Decrease Urine Output, Breathlessness or Palpitations.

**Pain in Left Lumbar region:**
- Dull Aching type of Pain.
- Continuous, Non Radiating.
- Not Relieved on Medications.
- No Fever, Burning Micturition, Constipation or Diarrhea.

Patient is K/C/O Diabetes Mellitus Type 2 , Hypothyroidism on
Tab. Thyronorm 100mcg 1-0-0.
Tab. Glimipride + Metformin (1/500) 1-0-0.

No Past Medical or Surgical History.

Family History: Elder Sister Diabetic Passed away of Chronic Kidney Disease.

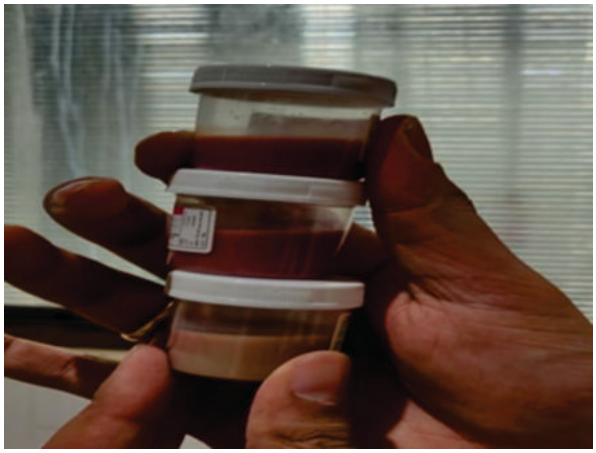
**CT Scan** :
Altered echotexture of liver with surface nodularity S/O Cirrhosis.

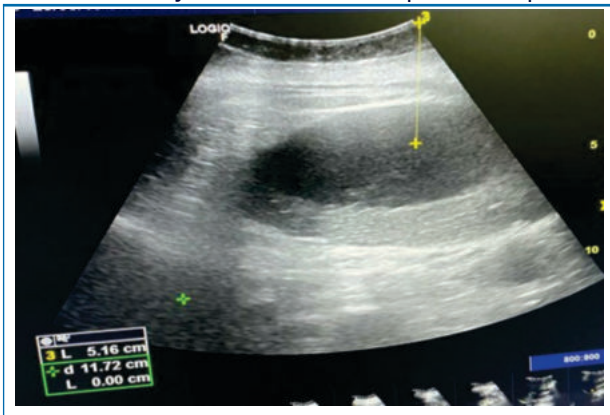
Splenomegaly.

Splenic Abscess measuring 192cc Noted within Splenic parenchyma not Loculated.

**USG Scan**:
Splenomegaly.

- Altered Echotexture of Liver with Surface nodularity
- Splenic Abscess measuring 192cc noted within Splenic parenchyma ( Semi Liquified and non loculated)
- Repeat USG scans were done until Loculated and Tappable Splenic Abscess is seen. ( measuring 135cc)
- Under USG guidance Spinal Needle is inserted and Tapped 55cc Abscess of Dark Brown (Chocolate color).



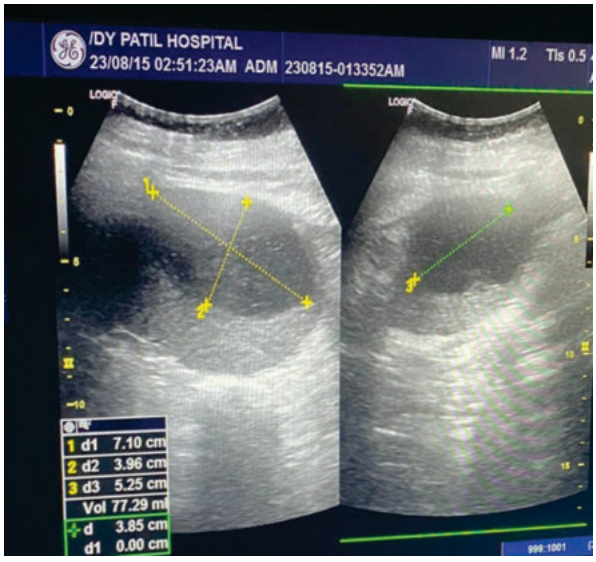



**Post Tap USG**:

- Splenomegaly with Splenic Abscess measuring 77cc.
- Altered Echotexture of Liver with Surface nodularity.
- -> On Due Course Patient was given with
- Inj Metrogyl 100cc 1-1-1 IV
- Inj Monocef 1g 1-1-1 IV
- Inj Vancomycin 1g 1-1-1 IV

**Reports** :

Fluid for AFB: Negative, No Growth.
Cytology: Plenty of Pus Cells.
ZN Stain : No Organism seen.
Gene Xpert : Negative.
Serum. IgG Amoebic antibody: Positive

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