Multiple splenic abscesses

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ABSTRACT

Splenic abscess is a rare clinical entity with poor prognosis. But owing to imaging technique, diagnosis and prognosis have improved nowadays. Most patients who are presented with splenic abscess are immunocompromised due to predisposing risk factors like diabetes mellitus, intravenous drug abuse, trauma, bacterial endocarditis, human immunodeficiency virus (HIV), chemotherapy, or steroids. Here, we are presenting a rarer case of multiple splenic abscesses with its complication in an immunocompetent healthy adult male without any risk factor.

Key words: Immunocompetent, multiple, splenectomy, splenic abscess

INTRODUCTION

Splenic abscess is a rare clinical problem with 800 reported cases in the international literature with high mortality if left untreated.[1-2] In an autopsy series, its incidence was 0.14-0.7%.[3] The incidence of splenic abscess increased owing to the advanced imaging technique.[4] Most patients were presented with compromised immune system. The clinical manifestations of splenic abscess are left upper quadrant pain, fever, nausea, and vomiting. Fever is the most prominent symptom (present in up to 95% of cases) in splenic abscess. But in our case, the patient had only nonspecific complaints of abdominal pain with ascites, melena without fever, nausea, and vomiting for 7 days. Surgery is the gold standard treatment for multiple abscesses.

CASE REPORT

A 25-year-old male without any past medical history was admitted to the department of medicine with the chief complaint of left upper quadrant pain for 7 days without any additional symptoms. His past medical history was free of any chronic illness and risk factor. Clinical examination revealed localized point tenderness and pain in the left hypochondria. His abdomen was soft and distended. His pulse rate was 90 beats per minute, respiration rate was 16 regular breaths per minute, and blood pressure was 110/80 mmHg. Chest and cardiac auscultations were normal. Laboratory study revealed polymorphous leukocytosis while the other tests were within normal limits. In erect posture, the chest and abdomen x-ray were normal. Echocardiography was normal. Abdominopelvic ultrason soundography (USG) showed multiple hypoechoic heterogenous spaces occupying the cystic lesions, among which the largest was 3.5 cm × 3.0 cm with minimal intestinal free fluid. Contrast-enhanced computed tomography (CECT) of the abdomen showed a mildly enlarged spleen and a large peripherally enhancing cystic lesion of approximate size 107 mm × 71 mm × 91 mm in the mid and the lower pole of the spleen with internal air loculi communicating to the perisplenic collection [Figure 1a and b]. The liver, the pancreas, and the kidney were normal in both computed tomography (CT) and USG.

Broad spectrum antibiotics were started with aerobic and anaerobic coverages. Splenectomy was done after being vaccinated with pneumococcal vaccine; meanwhile, the antibiotics were continued. There were two large abscesses with multiple small abscesses pointing to...
We could not find out the etiology and pathophysiologic mechanism of splenic abscess in our patient. Our patient had multiple splenic abscesses and so hematogenous spread may have caused them, although both blood and abscess fluid cultures were negative. Most probably, it is the secondary complication with obscure primary etiology.

CONCLUSION

Splenic abscess is an uncommon problem in clinical practice with high mortality in spite of early diagnosis. So, splenic abscess should be suspected in a patient with left upper quadrant pain and tenderness. Multiple splenic abscesses with high mortality rate are very rare in clinical practice. So, early suspicion and diagnosis and the prompt use of antibiotics improve the prognosis. Splenectomy is safe and the gold standard treatment for multiple splenic abscesses.

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