

DRAINAGE OF SPLENIC ABSCESS: A CASE REPORT

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ABSTRACT

Background: Splenic abscesses are uncommon manifestation of an acute abdomen. We reported a case of splenic abscess managed by tube drainage.

Method: A case report using the case note records of the patient and review of the relevant literature on splenic abscess.

Result: A forty five year old Nigerian who presented with features of splenic abscess and was managed by tube drainage. His post operative recovery was uneventful.

Conclusion: Tube drainage of the splenic abscess is encouraged if there is easy access to the abscess and there is evidence of residual splenic tissue in the critically ill patient.

Key Word: Tube drainage, splenic abscess, splenectomy.



INTRODUCTION

Splenic abscesses are uncommon manifestation of an acute abdomen¹⁻⁶. They present with pyrexia and an enlarged tender spleen and are diagnosed by ultrasound scanning¹⁻⁶. Treatment is either by drainage or splenectomy.

CASE REPORT

Mr. A.O., a forty five year old Nigeria trader was referred to the University of Port Harcourt Teaching Hospital in 1999. He is married with a child; he did not smoke but took alcohol occasionally. He is not a sickle cell disease patient nor did he give a history of trauma and his retroviral status is negative. His complains on presentation were two weeks history of fever, abdominal pain and constipation alternating with diarrhoea.

On examination, he was febrile with temperature swinging between 38^oc and 39.5^oc, dehydrated and in shock. There was generalized abdominal distension with tenderness in the left hypochondrium. An ultrasound scan of the abdomen showed splenic abscess.

The dehydration was corrected and he was commenced on intravenous (IV) Rocephin 1 gram daily and IV Metronidazole 500mg eight hourly.

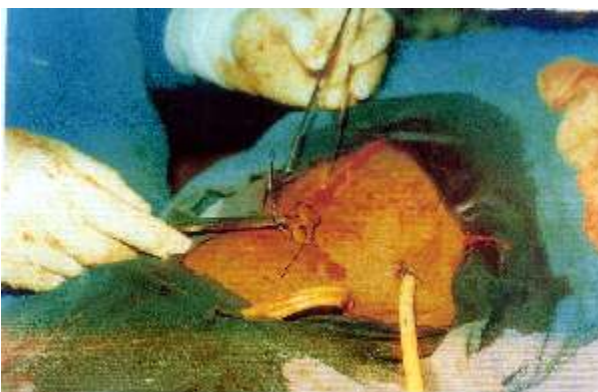
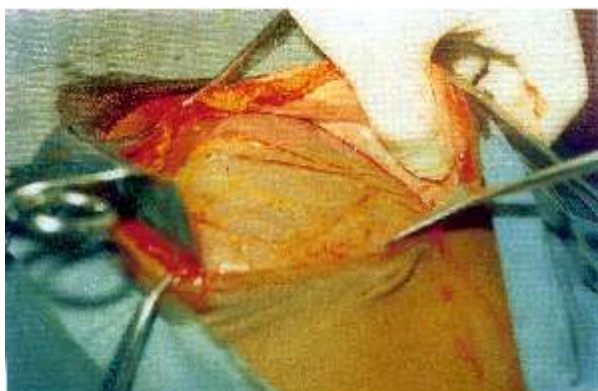
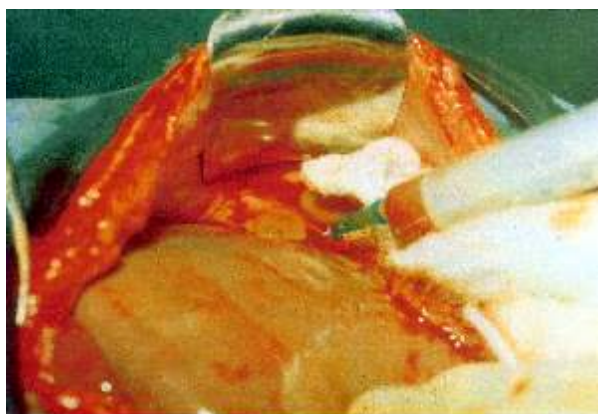
At surgery, a huge splenic abscess of dimensions 8cm by 10.5cm with thick capsule was found. The abscess was perforated at dependant point and a Foley's catheter size 28F was inserted for external drainage and connected to a uribag.

Culture of the aspirate yielded a heavy growth of coliforms sensitive to perflacine. He was then placed on perflacine 400mg twice daily for ten (10) days. Further investigation showed that his genotype was AA.

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The tube drain was removed on the seventeenth post operation day after it had stopped draining. He was thereafter discharged home with good wound healing.

He was followed up in the surgical outpatient clinic for four months and was subsequently discharged from the clinic with repeat ultrasound scan which showed no residual abscesses collection and the splenic mass had increased.



DISCUSSION

Because of the role of the spleen in immunological response in the body, splenic surgery is veering away from splenectomy towards splenic preservation.

In splenic injury, splenorrhaphy is now more often practiced than hitherto^{1,2}. Similarly, drainage of a splenic abscess is more commonly done than splenectomy¹⁻⁶. The drainage is usually by ultrasound guided needle aspiration. The drainage is usually repeated between three to five times³⁻⁶.

While ultrasound guided needle aspiration is only mildly invasive, we question its use in multi-locular abscesses of the spleen. Even some of its advocates like Chun⁷, Ooi and Leong⁸ and Scafani et al⁹ express caution because no randomized trial of percutaneous drainage versus splenectomy had been carried out.

Our patient had open tube drainage using a Foley's size 28F catheter and recovered completely after seventeen days of hospital stay. Our aim of splenic preservation was achieved and so he was not placed on the usual long term anti-malarial or anti-pneumococcal prophylaxis.

Furthermore, we had the opportunity at surgery of breaking down all septa to convert the multi locular abscesses into a single one for drainage.

We are therefore advocating tube drainage of splenic abscess in our environment for surgically fit patients with non-diseased spleens.

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