A CASE OF
TRAUMATIC RUPTURE OF AN ACCESSORY SPLEEN

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Traumatic rupture of the spleen is well documented in medical literature. We present here a case with some unusual features.

Case Report

T.M., an 8-year-old boy, was admitted to Alder Hey Children’s Hospital on July 17, 1961, with a three-day history of central abdominal pain, accompanied by some nausea and vomiting. On the night before admission he slipped in the bathroom and hurt the lower part of his left chest. This injury did not seem to disturb him much, though, in reply to leading questions, he did say that the abdominal pain had slightly increased during the night. There was no history of pain referred to the left shoulder.

On examination he did not look ill or exsanguinated. His temperature was 99°F. (37.2°C.); pulse 135 per minute, but of good volume; blood pressure 110/80 mm. Hg. There was no bruising or tenderness over the site of trauma, and examination of the heart and lungs did not reveal any abnormality. The abdomen looked slightly distended, and there was localized tenderness in the right iliac fossa. Bowel sounds were present, though infrequent. Rectal examination revealed no tenderness, though there was suggestion of slight fullness in the pouch of Douglas. A diagnosis of appendicitis with peritonitis was made and laparotomy was carried out on the day of admission.

Operation. A right-sided grid-iron incision was made, and on opening the peritoneum, free blood was found in the peritoneal cavity. A large amount of fluid and clotted blood was sucked out, but the source of bleeding could not be located from this incision. The history of trauma to the left lower chest suggested that a ruptured spleen was the most probable cause of the haemoperitoneum. A second incision was, therefore, made in the left sub-costal region. Careful examination of the spleen did not show any laceration on its surface, though there was a large blood clot overlying the left colic flexure. After removal of the blood clot, an accessory spleen, about 3 x 2 cm., was found near the lower pole of the spleen with a laceration on its surface, which was bleeding profusely (see Fig.). The pedicle of the accessory spleen had partly torn off the main splenic pedicle near the hilum where there was a large haematoma. It was, therefore, found necessary to remove the main spleen as well as the spleniculus to gain complete control of bleeding. A careful search did not reveal any further splenuli. The appendix was mildly inflamed and was removed through the original grid-iron incision. Blood loss was replaced by blood transfusion which was instituted urgently after the real nature of the abdominal condition was recognized.

The patient recovered satisfactorily after the operation and was discharged on the twelfth postoperative day.

Discussion

There are two interesting features about this case. First, the history of abdominal pain, suggestive of appendicitis and preceding the injury to the left lower chest, influenced the clinical assessment of the case and prejudiced due significance being accorded to the history of trauma. Moreover, except for a rather rapid pulse rate, there was no definite evidence of internal haemorrhage. Secondly, the trauma spared the spleen and damaged a splenulus only. The accessory spleens, when present, are usually multiple and very small in size; whereas, in this case there was an unusually large solitary splenulus.

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