Splenic trauma usually presents acutely with a distinct mechanism of injury. But in settings of polytrauma with other major injuries, it can be missed or the occurrence may be delayed[1]. We are presenting here an interesting case with academic and clinical significance.

The Case:

A 21 years old young man was presented to ER at 4 AM with an alleged history of RTA (Road Traffic Accident) , following which he had been in altered sensorium. On evaluation by ER physician and neurosurgeon, he was found to have a large left sided acute SDH (Subdural Hematoma) with midline shift and brainstem distortion. His BP was 130/90 mmhg, Pulse 88/min and Hb 10 gm%. He had also fracture left radius. Other systemic examinations were found to be satisfactory. He underwent emergency craniotomy at 8 AM. At the leg end of the surgery he suffered a cardiac arrest. Patient was revived, ROSC achieved after CPRand shifted to ICU after surgical closure of the craniotomy site. ABG revealed respiratory alkalosis with low haematocrit (Hb was 3 gm%). Immediate bedside USG revealed hemoperitonium with multiple splenic lacerations. Urgent laparotomy was done and splenectomy performed. Massive blood transfusion was given according to protocol. After shifting back to ICU patient became hemodynamically stableand vasopressins were gradually tapered off. On Post-operative day 1 his sensorium improved satisfactorily. He was shifted from ICU on post-operative day2. Post-operative day 3 he underwent ORIF (open reduction and internal fixation) with plating for fracture left radius. He recovered well and discharged on post-operative day 10. Later on he underwent elective cranioplasty.

Discussion:

Left upper quadrant pain, Kehr’s sign (shoulder pain due diaphragmatic irritation by hemoperitonium) , guarding and rebound tenderness are usually classical presentation of splenic trauma[2,3]. But in some situations especially in case of polytrauma or when patient is in altered sensorium these classical findings may be totally absent as in our case. So in trauma cases there should be a high degree of suspicion of injury to other organ system as well. Meticulous hemodynamic monitoring remains the cornerstone in these cases. A low threshold for imaging modalities and multidisciplinary team approach is very much essential in dealing with such disasters.

Downloaded from ccemjournal.com

References:

1. McIndoe, Archibald H. “Delayed haemorrhage following traumatic rupture of the spleen.” *British Journal of Surgery*78 (1932): 249-268.
2. Farhat GA, Abdu RA, Vanek VW: Delayed splenic rupture: real or imaginary?.Am Surg. 1992, 58: 340-345.
3. Kodikara S: Death due to hemorrhagic shock after delayed rupture of spleen: a rare phenomenon. Am J Forensic Med Pathol. 2009, 30: 382-383. 10.1097/PAF.0b013e3181c03caf.

Author:

1. Dr.Saikat Mallik (Consultant, Laparoscopic & Transplant Surgery Narayana Superspeciality Hospital, Guwahati)
2. Dr. Apurba Kumar Borah (Consultant & HOD, CCEM, Narayana Superspeciality Hospital, Guwahati)

Author



- CCEM Journal
  View all posts

Downloaded from ccemjournal.com