

Giant Splenic Artery Aneurysm

Sir,

Splenic artery aneurysm is a rare disease. Its prevalence varies from 0.02 - 0.1% in general autopsies.¹ Giant splenic artery aneurysm of 10 cm in size has been rarely reported in geriatric patients.² As compared to vascular aneurysm in other sites, atherosclerosis is rarely a cause of splenic artery aneurysm. These occur four times more commonly in females. Multiple pregnancies, medial hyperplasia, splenomegaly, portal hypertension and liver transplantation are thought to be the possible causative factors although inflammation or calcification may be rarely seen in the histology specimens. Commonly these are secular and occur in the middle or distal part of the artery.³ Presentation varies from asymptomatic patient diagnosed on routine imaging to massive bleeding and shock. Treatment is recommended for all symptomatic aneurysms, aneurysm of 02 cm or more in size, growing aneurysm, women of child bearing age or who may become pregnant as chances of rupture increases in pregnancy.⁴

A 58 years old man presented with one episode of upper GI bleed and passage of black tarry stools. There was no history suggestive of any systemic infections, trauma, peptic ulcer disease, previous surgery, family history of aneurysm or connective tissue disorders. The patient had an anxious look, pale, pulse 120/minute and BP of 90/70 mmHg. He was resuscitated with I/V Ringer's lactate and blood transfusion. An emergency upper gastrointestinal endoscopy revealed small para esophageal hernia but no varices or peptic ulceration. Abdominal examination showed splenomegaly, pulsatile mass in the epigastrium and left hypochondrium, a thrill and bruit over it. Hemoglobin was 9 gm/dL and liver function tests were normal. Ultrasonography of abdomen with color doppler showed massive splenomegaly and a

splenic artery aneurysm. CT scan abdomen with intravenous contrast and CT angiogram confirmed splenic artery aneurysm arising from its origin from the celiac axis. Laparotomy was planned after pre-anesthesia assessment and consent. Abdomen was opened by roof top incision. Lesser sac was opened to reveal the aneurysm. Celiac axis was exposed and control of origin of splenic artery was taken with vascular clamp resulting in disappearance of pulsations over the aneurysm. Distal control of the aneurysm was also taken and aneurysmectomy with splenectomy was done. Histopathology of the specimens showed true aneurysm of splenic artery and congestion of spleen with small areas of infarction. Patient had an uneventful post-operative period and was discharged on the 6th post-operative day.

The significance of splenic artery aneurysm lies in its life threatening complication of rupture. Most of the aneurysms are detected incidentally, others present with vague upper abdominal pain and discomfort or pulsatile mass.³ Very few patients present with hematemesis, hematochezia or malena.⁵ Treatment options are open surgical, laparoscopic or endovascular means. Open surgical options depend upon the location of the aneurysm. Middle and distal aneurysms are treated by aneurysmectomy and splenectomy. Proximally located aneurysms are treated by ligation of splenic artery origin with or without splenectomy.⁴ Splenic artery aneurysm, although rare, should be considered in patients presenting with upper GI bleeding and malena.

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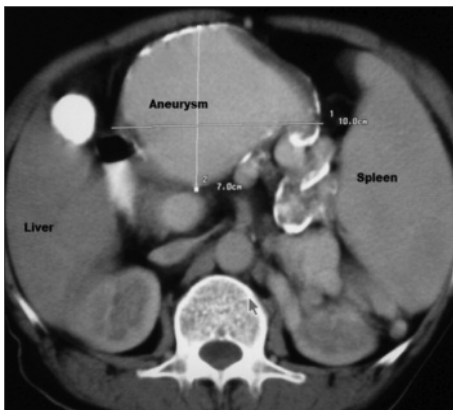


Figure 1: CT scan with contrast showing giant splenic artery aneurysm.

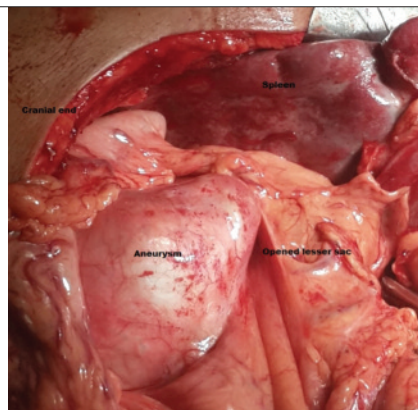


Figure 2: Per operative splenic artery aneurysm.

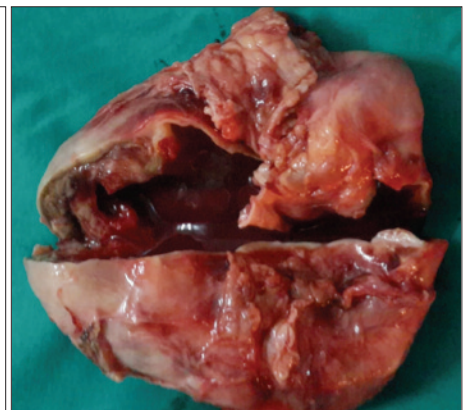


Figure 3: Excised splenic artery aneurysm.

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