CLINICAL SNAPSHOT

Acute Infarction of the Spleen

A 32-year-old man presented with acute abdominal pain. The physical examination revealed guarding in the left upper quadrant and worsening of the pain on deep inspiration. Positive laboratory findings included leukocytosis, an elevated C-reactive protein concentration, and an elevated lactate dehydrogenase concentration. Ultrasonography revealed an inhomogeneous splenic parenchyma with no detectable blood flow (a) and an accompanying left-sided pleural effusion (*). On contrast ultrasonography, there was rapid filling of the splenic artery (b, arrow) but hardly any contrast medium in the parenchyma, with residual perfusion only in the hilar area. These findings established the diagnosis of a subtotal infarction of the spleen. Splenic infarction can be caused by bacterial infection, coagulopathies, and hematologic/oncologic or cardiovascular disease, but are usually restricted to subcapsular portions of the parenchyma. Symptomatic treatment generally suffices; surgery is indicated only in unusual, complicated situations (e.g., infection within large areas of necrosis). In the present case, further tests did not reveal the cause of the splenic infarction, which was therefore designated as idiopathic. The patient was treated with antibiotics and analgesic drugs, and his symptoms regressed.

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Conflict of interest statement

The authors state that they have no conflict of interest.

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