GIANT PSEUDOCYST OF SPLEEN- A RARE CASE REPORT.
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ABSTRACT: False cysts of spleen or the pseudocysts accounts for about 75% of the non-parasitic splenic cysts and are usually traumatic in origin. These cysts are differentiated from the true cysts of the spleen by absence of an epithelial layer on histology. Primary cysts have a cellular lining that can be caused by congenital events or parasitic infection (Echinococcus). Secondary cysts have no cellular lining and may be of hemorrhagic, serous, inflammatory, or degenerative origin. Without a recent trauma history, there is no clinical or radiological feature which distinguishes them from epidermoid cyst. Distinction may be made at histology. Surgical management of these symptomatic pseudocysts promotes spleen parenchyma preservation. We present here a case of a giant splenic pseudocyst in a young male patient except history of trauma. As the patient was 16 years old spleen preserving surgery was done and postoperatively it was uneventful.

KEY WORDS: Splenic cyst, Giant, pseudocyst of spleen.

INTRODUCTION: Spleen undergoes cystic change less often than any other abdominal viscera 1. Splenic cysts are rare with around 800 cases reported in the world literature2,3,4. Pseudocysts most often follow a blunt trauma, 1, 2, 3 incidence of pseudocyst is less than 1% of all splenectomies.

CLINICAL SUMMARY: A 16 years old male patient presented with a history of upper abdominal mass for the last 3 months. The mass was progressively increasing in size. There was no history of blunt injury to abdomen and patient was not a known alcoholic. Ultrasound report of the patient showed 20x17 cms large cystic lesion with innumerable low level echoes seen in the upper two third of spleen. CT scan was suggested which showed large cystic lesion of 16x19x16 cms seen in splenic parenchyma pushing left kidney inferiorly. Lesion was crossing midline beneath left lobe of liver. No calcification or internal cysts. Patient was posted for OT, left paramedian incision was made and abdomen opened, a huge cyst arising from the spleen noted, cyst was aspirated, partial excision of cyst and omentopexy was done, spleen was preserved. Post operative period was uneventful. Histopathological examination showed cyst wall composed of fibrocollagenous tissue, muscle infiltrated by lymphocytes, eosinophils & presence of numerous blood vessels. No epithelial lining seen.
DISCUSSION: Blunt abdominal trauma is the commonest cause of pseudocyst of spleen and occurs due to resorption of hematoma with subsequent serous fluid collection. According to the classification of splenic cysts suggested by Martin et al., splenic cysts can be primary (true) or secondary (pseudo/false). The secondary cysts do not have any definite cellular lining whereas primary cysts have definite cellular lining and can be subdivided according to the etiology as parasitic and nonparasitic. Nonparasitic cysts can be either congenital or neoplastic. The formation of congenital splenic cysts results from the invagination of peritoneal mesothelial cells into the spleen during intrauterine development, followed by their proliferation and secretion of serous fluid.

Most of the splenic pseudocysts (30 – 60%) are asymptomatic and cause problem only as they enlarge. Common clinical presentation includes abdominal pain, nausea and vomiting due to compression of stomach by a large splenic cyst. Complications of pseudocysts are rupture of spleen, intracapsular hemorrhage and infection. The confirmation of diagnosis is possible only with histopathological examination. Commonly practiced treatment modality is splenectomy. Recently spleen preserving techniques including watch full waiting, percutaneous drainage, marsupialization, splenic decapsulization and complete cystectomy. In the past, splenectomy was the method of choice, considering treatment of various splenic lesions, including true (primary) cysts and pseudocysts. The understanding of the function of the spleen in the immune system and increasing knowledge concerning early and distant splenectomy complications, especially septic, such as overwhelming post splenectomy infection (OPSI), which occurs in 0.2-0.5% of patients resulted in the withdrawal from splenectomy in favor of organ-sparing operations. McColl et al., in order to prevent recurrence of primary and pseudocysts established a method consisting in the laparoscopic marsupialization of cysts, cavity lining with Surgicel and omentopexy.

CONCLUSION: Definitive diagnosis of a splenic pseudocyst is established only in some patients with a history of abdominal trauma and presence of cystic lesions in the spleen. Diagnosis of a splenic pseudocyst is based on the histopathological examinations, which show that the cyst is devoid of epithelial lining.

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FIG: 1 - Operative procedure showing pseudocyst, normal splenic parenchyma and omentopexy being done.

FIG: 2 - CT scan showing Giant Pseudocyst of spleen.
FIG: 3 – Microscopy showing pseudocyst admixed with normal splenic tissue. (Low power view)