A SUCCESSFUL EMPERICAL COILING OF THE SPLENIC ARTERY

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Objectives

- Pre-coiling Clinical Course.
- Acute Coiling Mangement.
- Post-coiling Clinical Course.

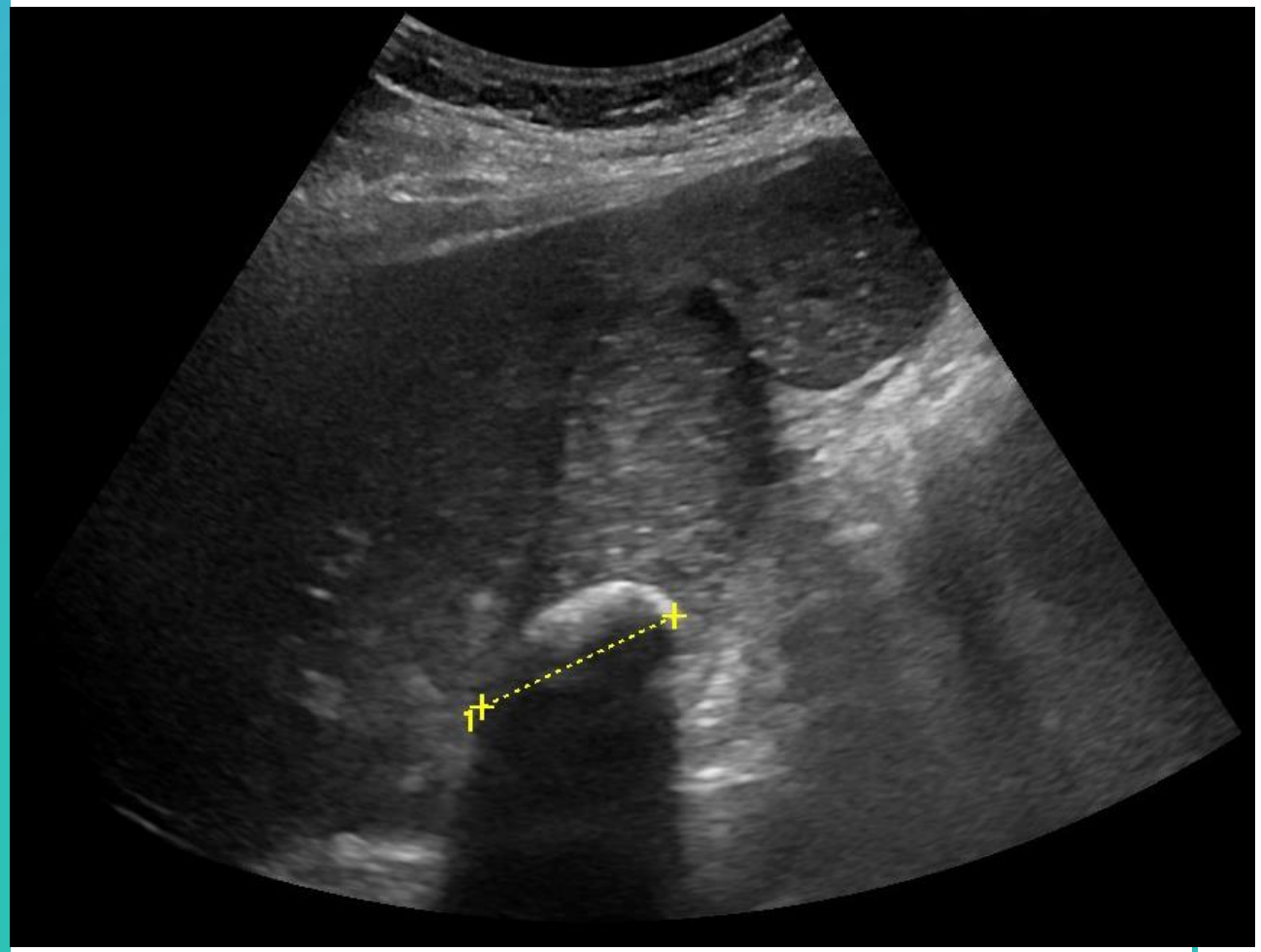
Pre-coiling Clinical Course

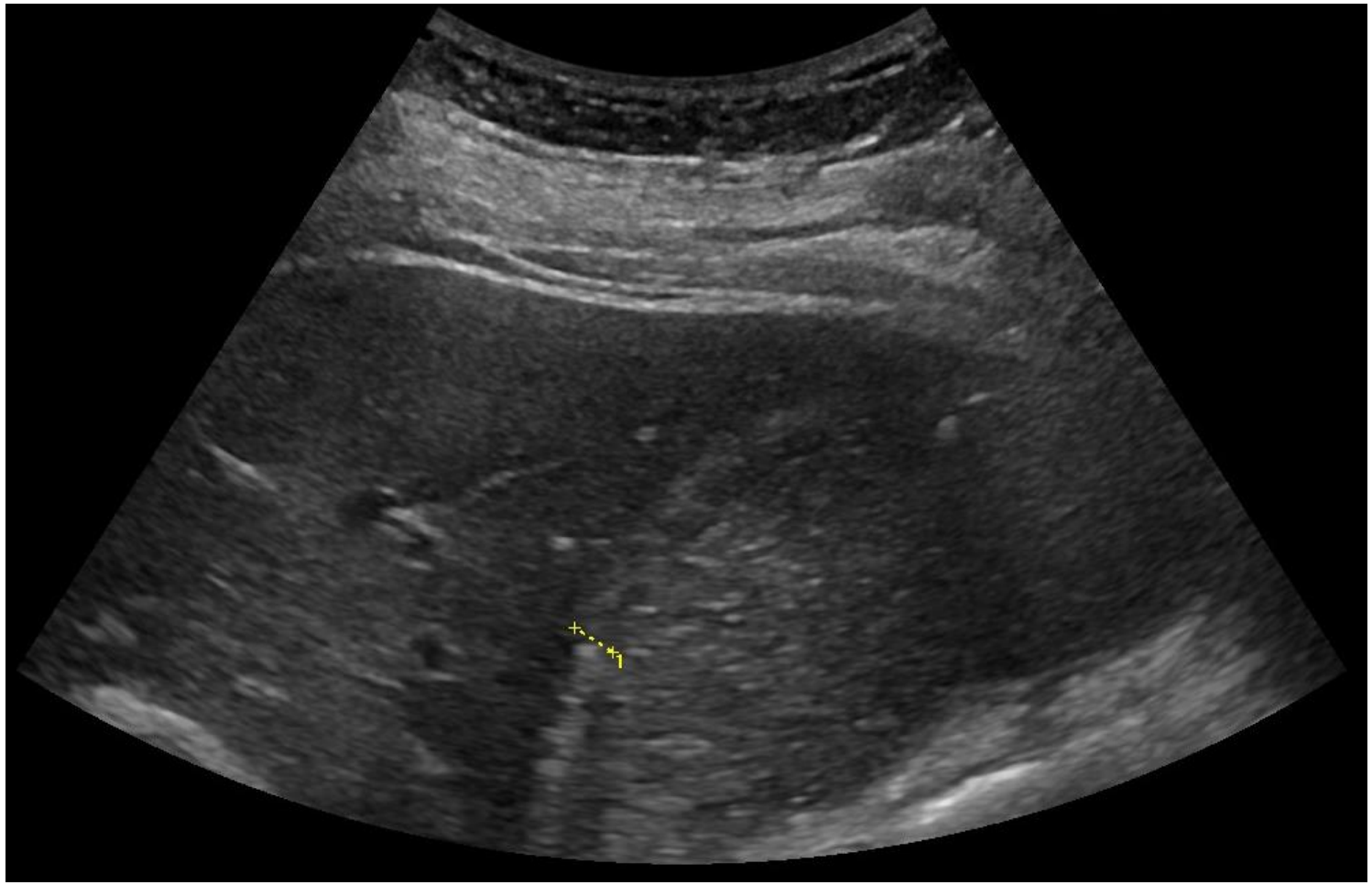
A 65-year-old Caucasian female, known with HT and HL. 2 previous caesarean sections. 48 tobacco years.

10.01.2023: admitted to the ER through the GP, Ddx → Cholecystitis

- **Ultrasound**

  A distended gallbladder with sludge and thickened wall. A hyperecchogenic 4 cm gallbladder stone lodged in the infundibulum.





11.01.2023

Lap. Cholecystectomi.

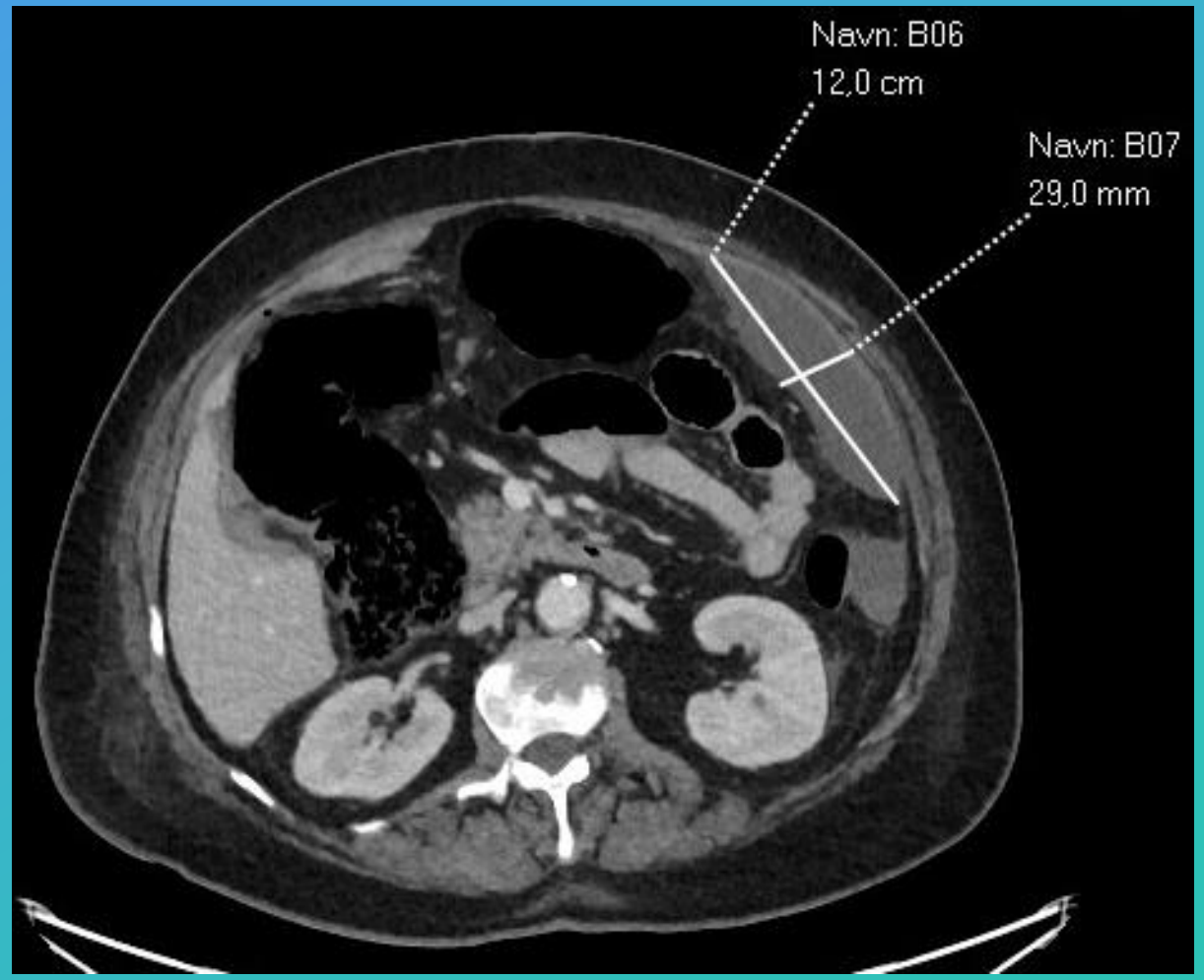
Operation time: 3.5 hours. Complicated with minor bleeding and perforation of the gallbladder and spilage of purulent bile during the procedure. A drain was applied for control.

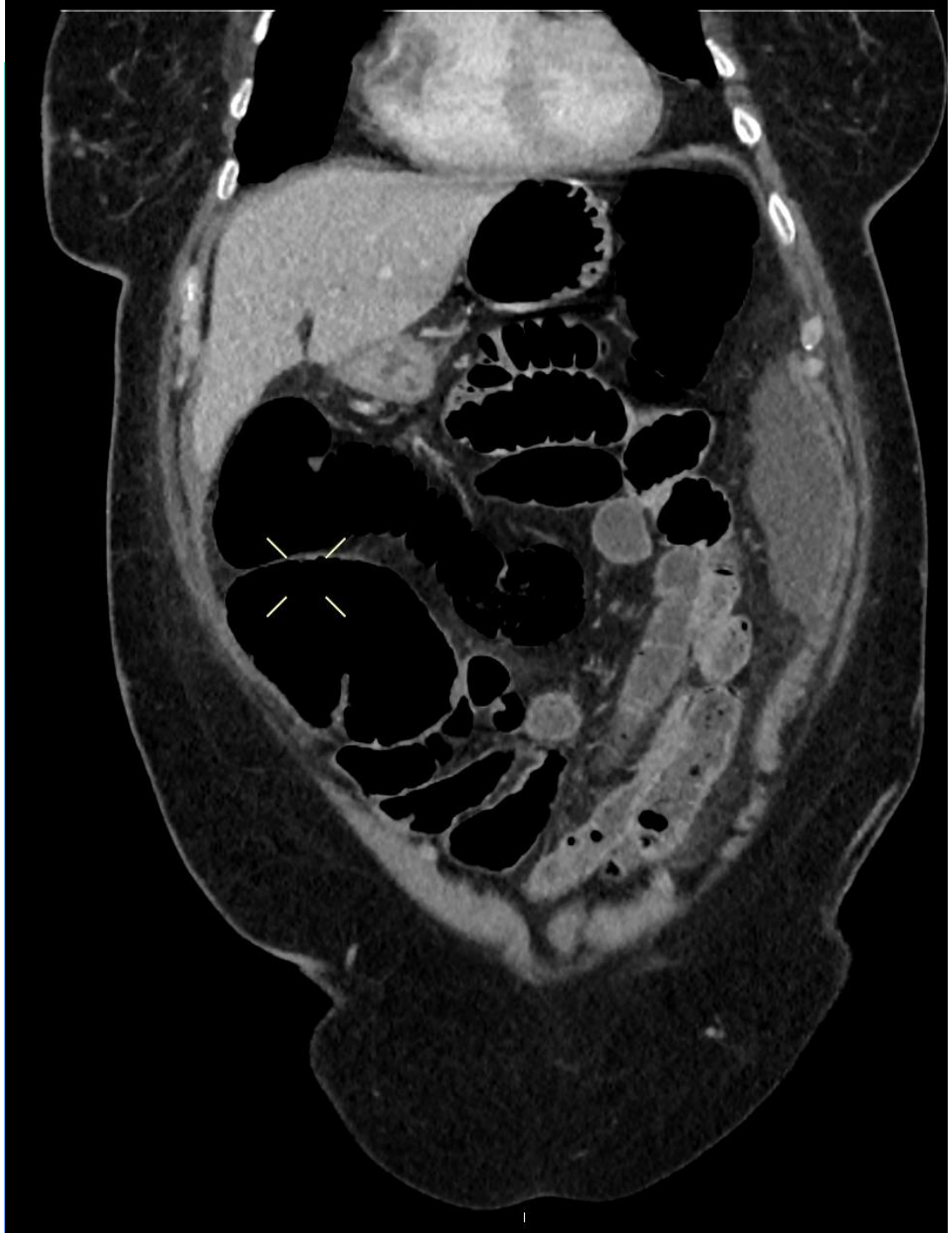
12-14: 01.2023

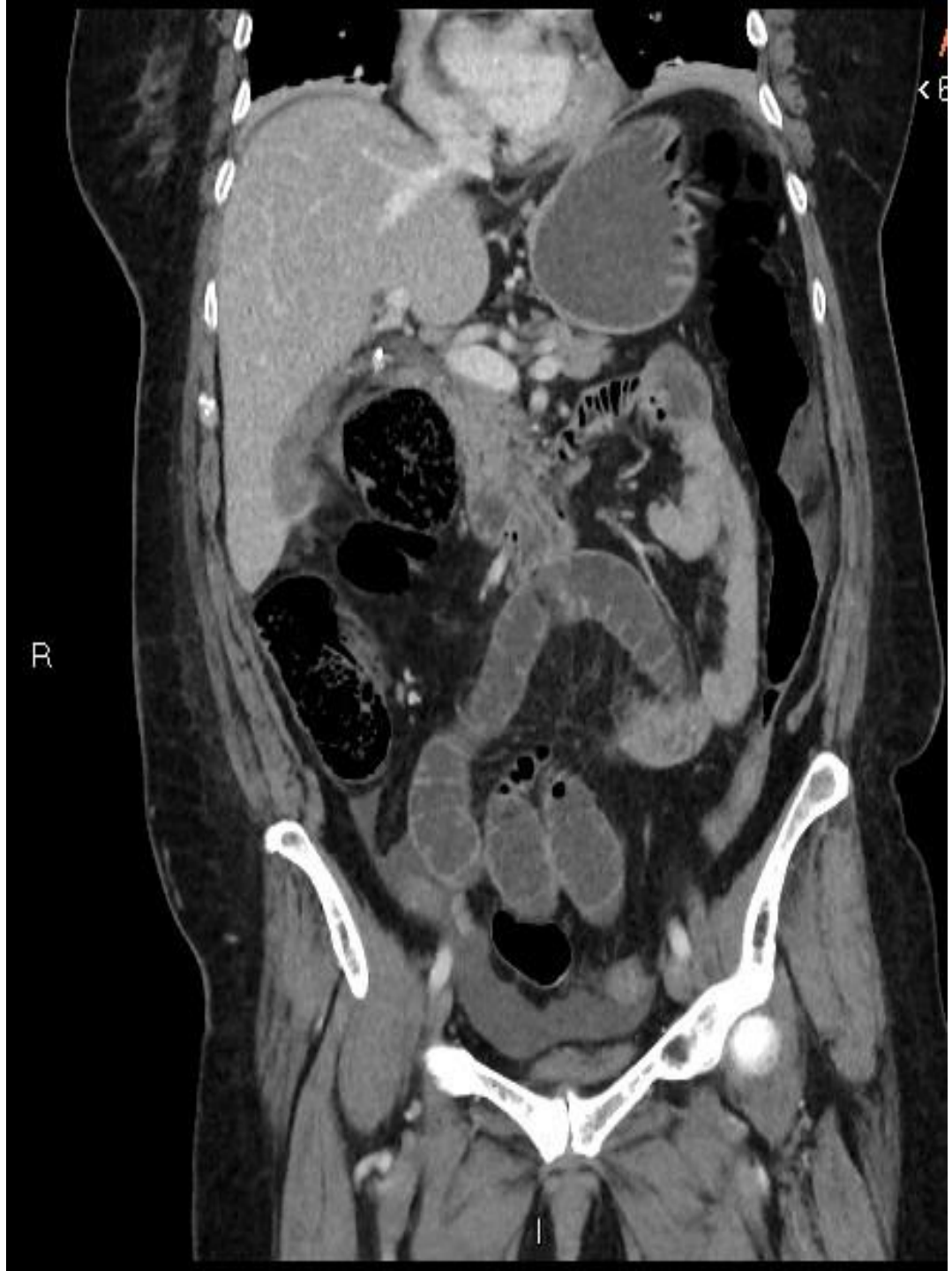
CRP 300
postoperatively, the patient began to be clinically unwell, SAT 84-91%, pain in the entire abdomen mainly upper left quadrant. No improvement → CT-abdomen.

14.01.2023

CT-scanning: Collection in the left flank→ bile? In the Pelvis→ Hematoma?



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Re-laparoscopi with ERCP to perform a salvage, place a drain in the CBD.

Severe peritonitis in all 4 abdominal quadrants with about 1 liter of bile alongside the left colon.

Multiple small gallbladder stones removed from the common hepatic duct and the common bile duct.

Stent applied in the CBD + 2 drains.

Cont.

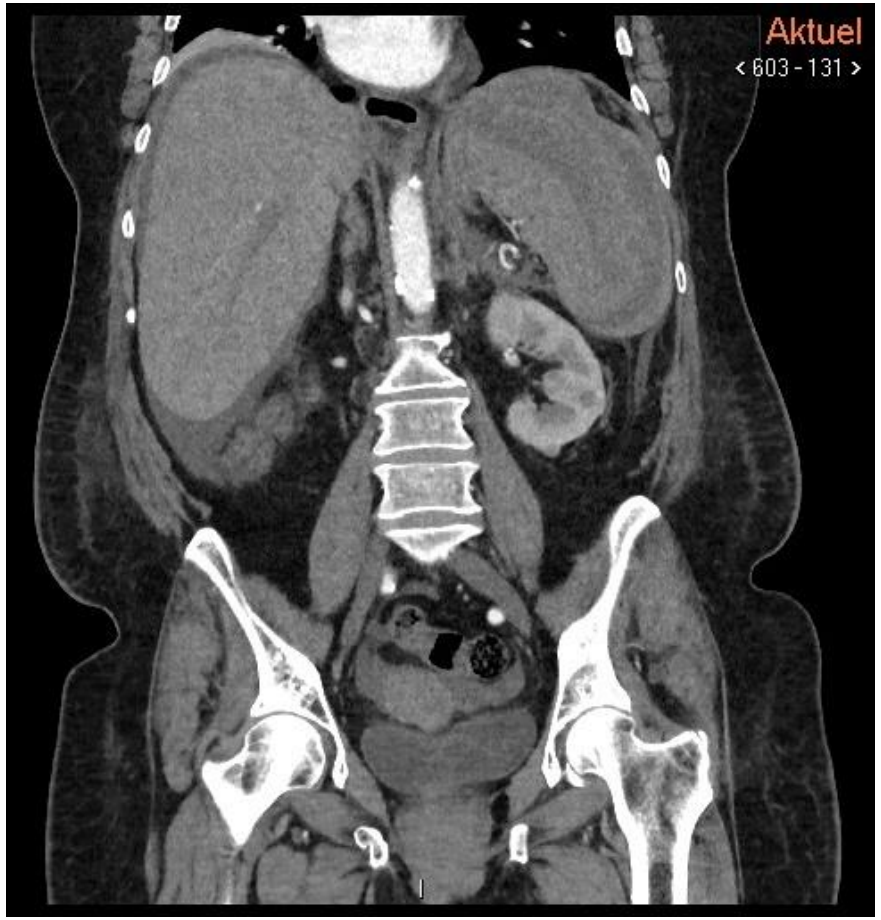
Admitted at the intensive care unit for postoperative follow-up.

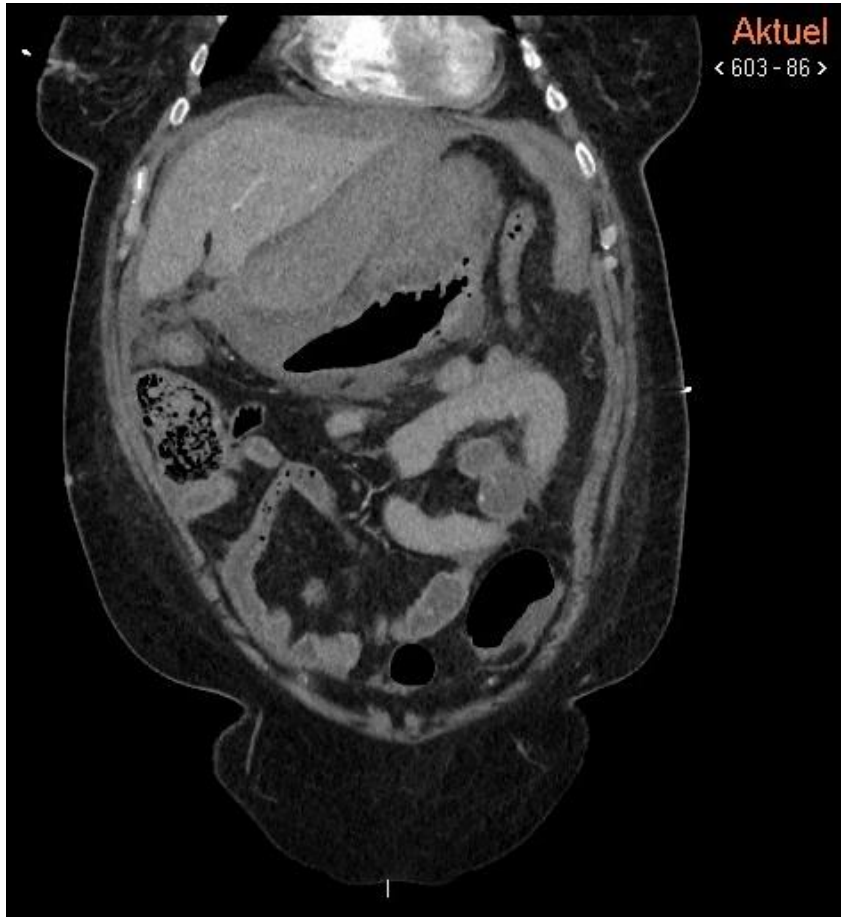
Developed post ERCP pancreatitis. Aspiration of bile during intubation.

24.01.2023

Low bloodpressure twice, lowest 64/37, No hematemisis nor malena. HB 3.8, lactate 2.3.

CT abdomen; Bleeding protocol, 3 phases→
Subcapsular hematoma in the spleen, liver, and between the the left liver lobe & stomach.
No active contrast extravasation. No pneumoperitoneum. Severe pancreatitis.





A new acute CT scanning after 7 hours. Why?

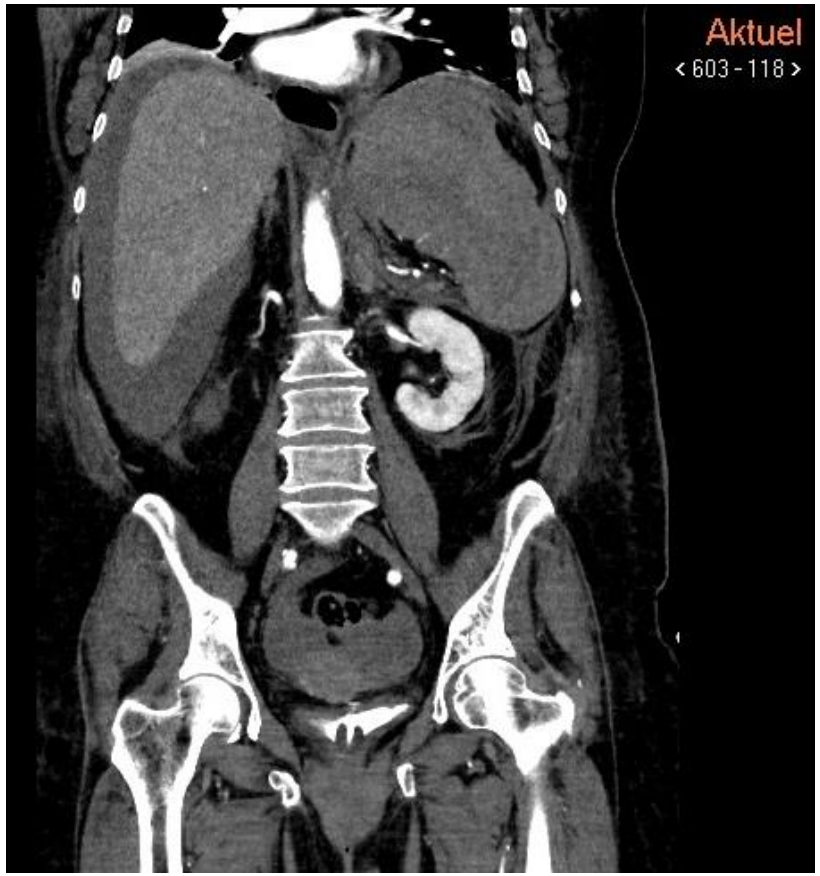
Recurring epidose of low hemoglobulin→ 7-8 portions of blood transfusion.

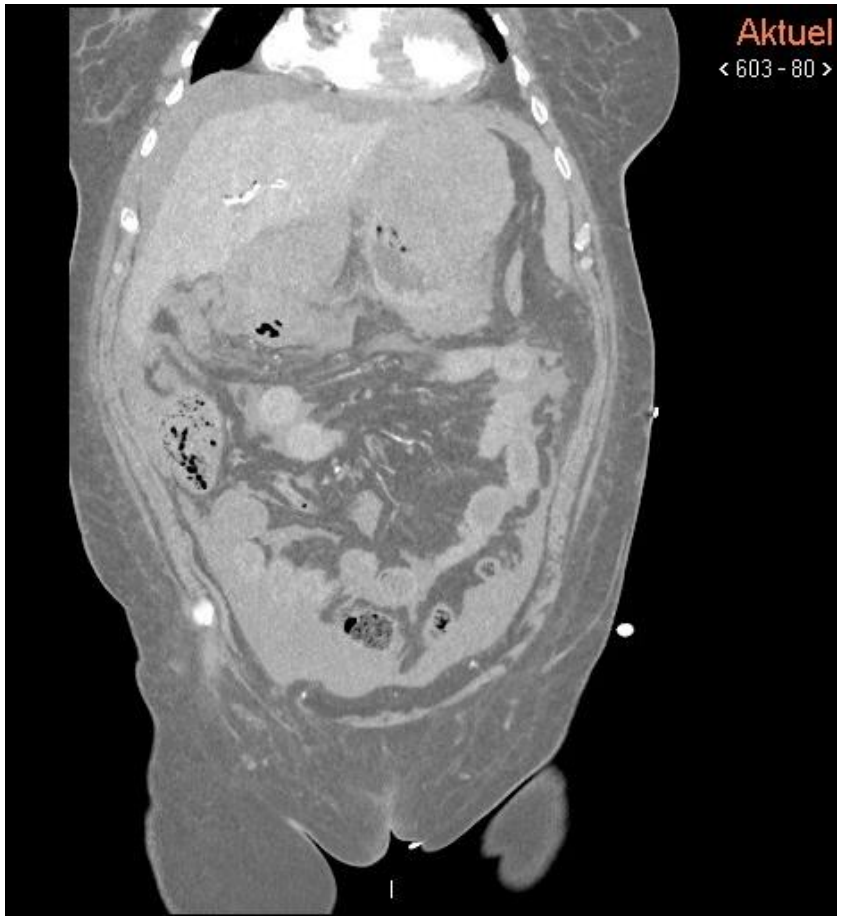
Recurrent low BT→ Recurrent administration of Vasopressors.

No hematemesis, melena or hematochezia.

Remained without operative intervention overnight.

No pneumoperitoneum, increase in hematomas→ Spleen?





Acute Coiling

25.01.2023

Avoid surgery; previously operated, intraabdominal bilary spilage, and pancreatitis--> Endovascular Intervention

Acute Coiling of the Splenic artery because of life threatening bleeding.

Angiography in arterial phases

Non active arterial bleeding identified. No bleeding from the gallbladder bed.

Cealiac truck and superior mesenterical artery were both normal

The splenic artery is irregular in its diameter which could be a sign for bleeding.

Local MDT conference with the Gastrointestinal surgeon in the operative rooms→ Emperical coiling of the splenic artery

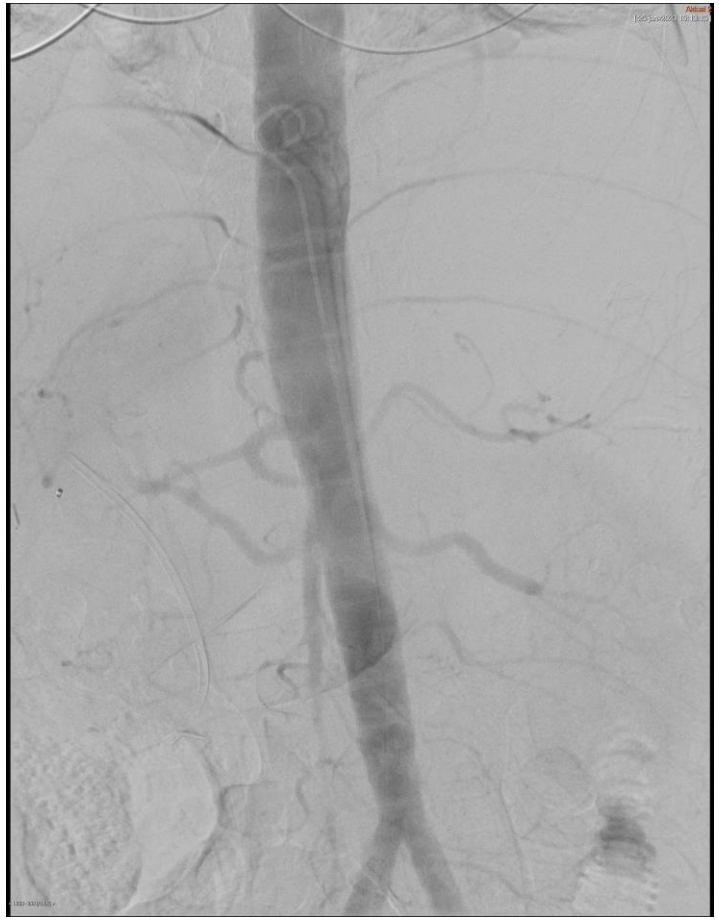
Cont.

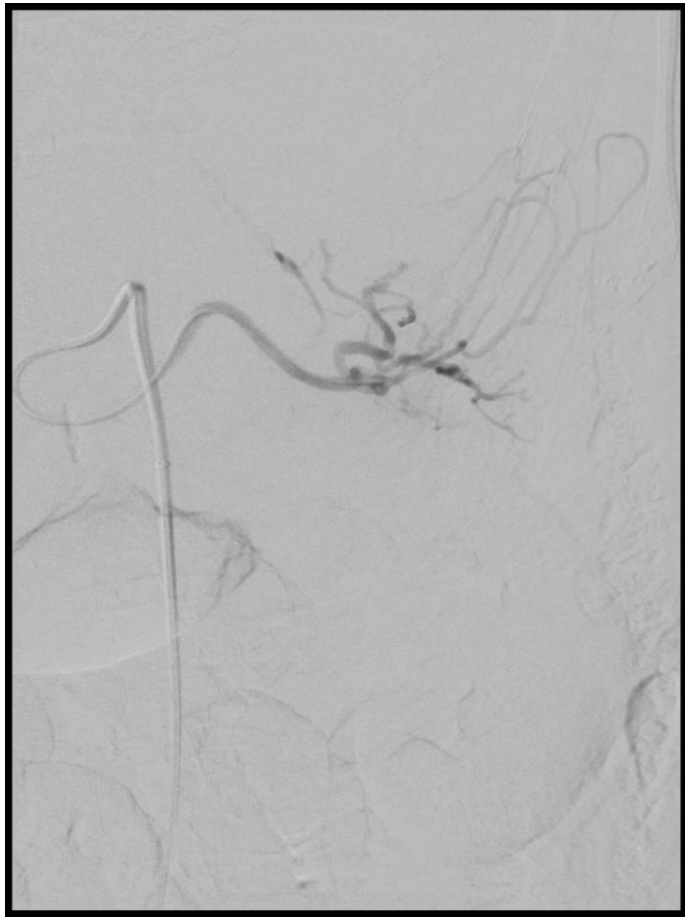
Embolizing the splenic artery at the level of the splenic hilus including the cranially located small short gastric artery.

AZUR microcoils.

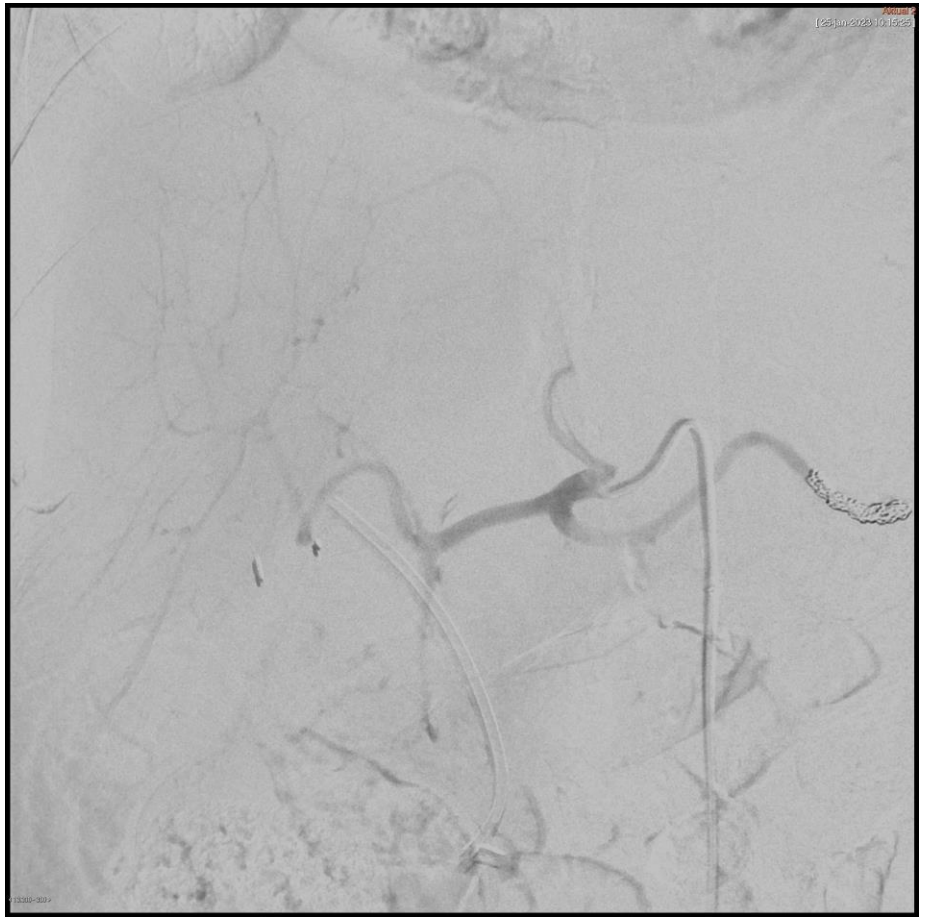
Control angiography of the common hepatic artery and the superior mesenteric artery showed no bleeding.

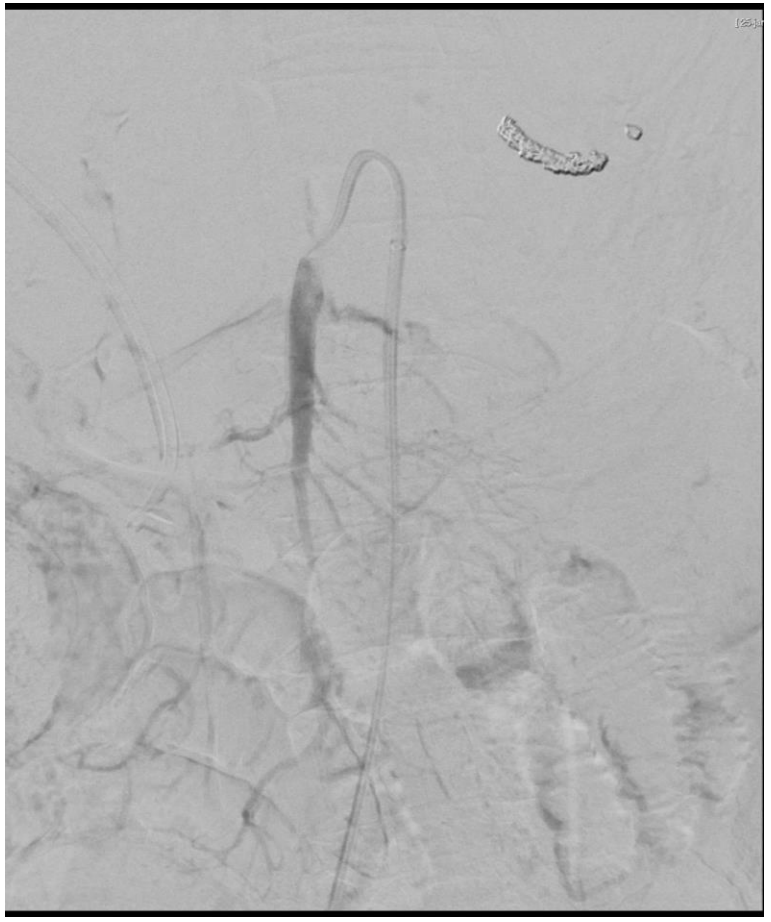
Acute CT-angiography 25.01.2023





Emperical Coiling





Post-coiling Course

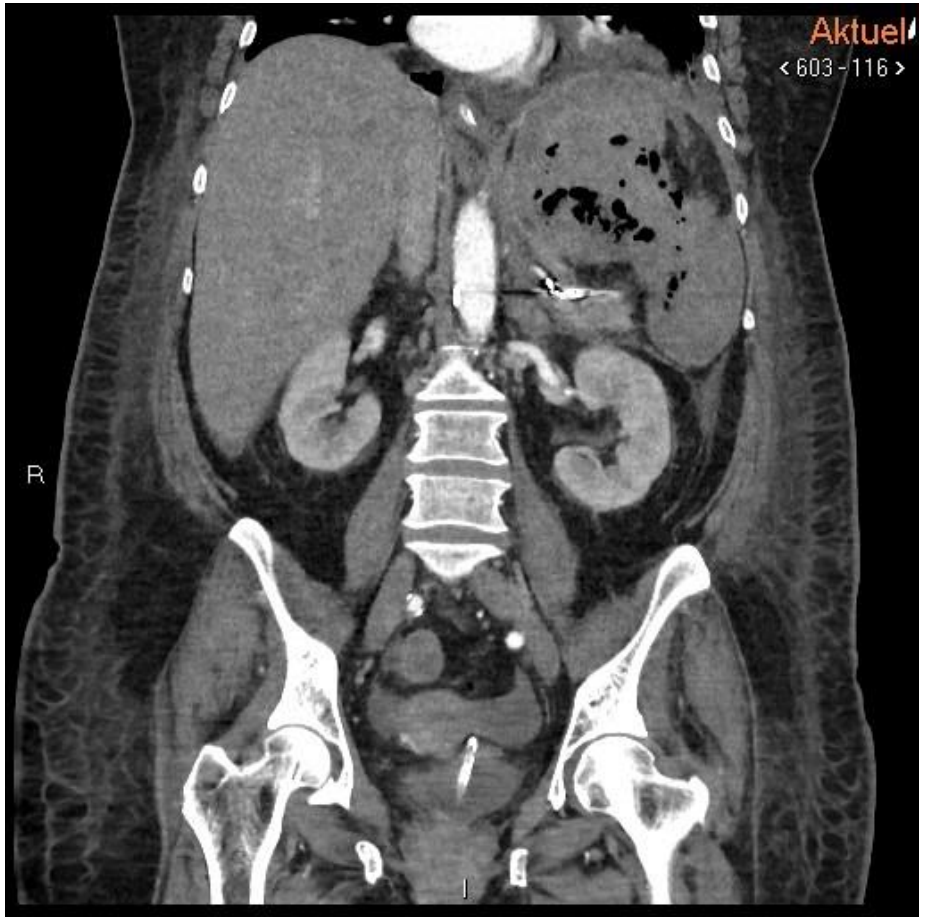
Admission to the ICU for observation.

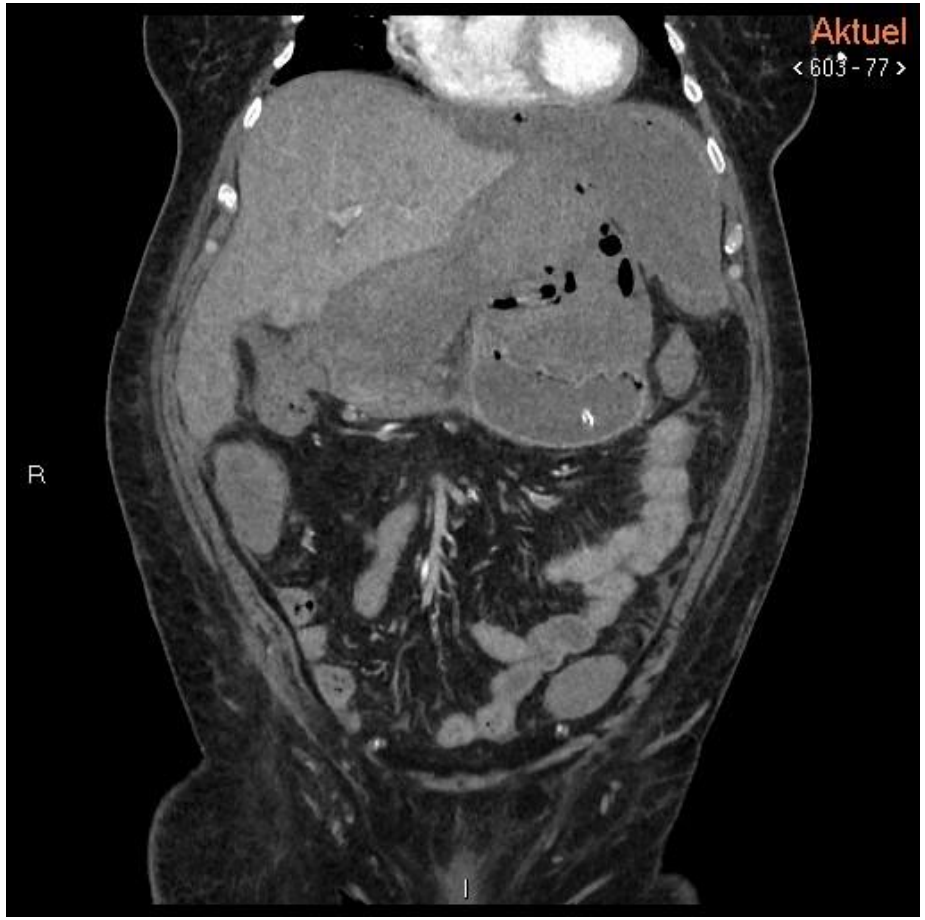
Hemodynamically stable postoperatively. Stabilized HB at 5.5.

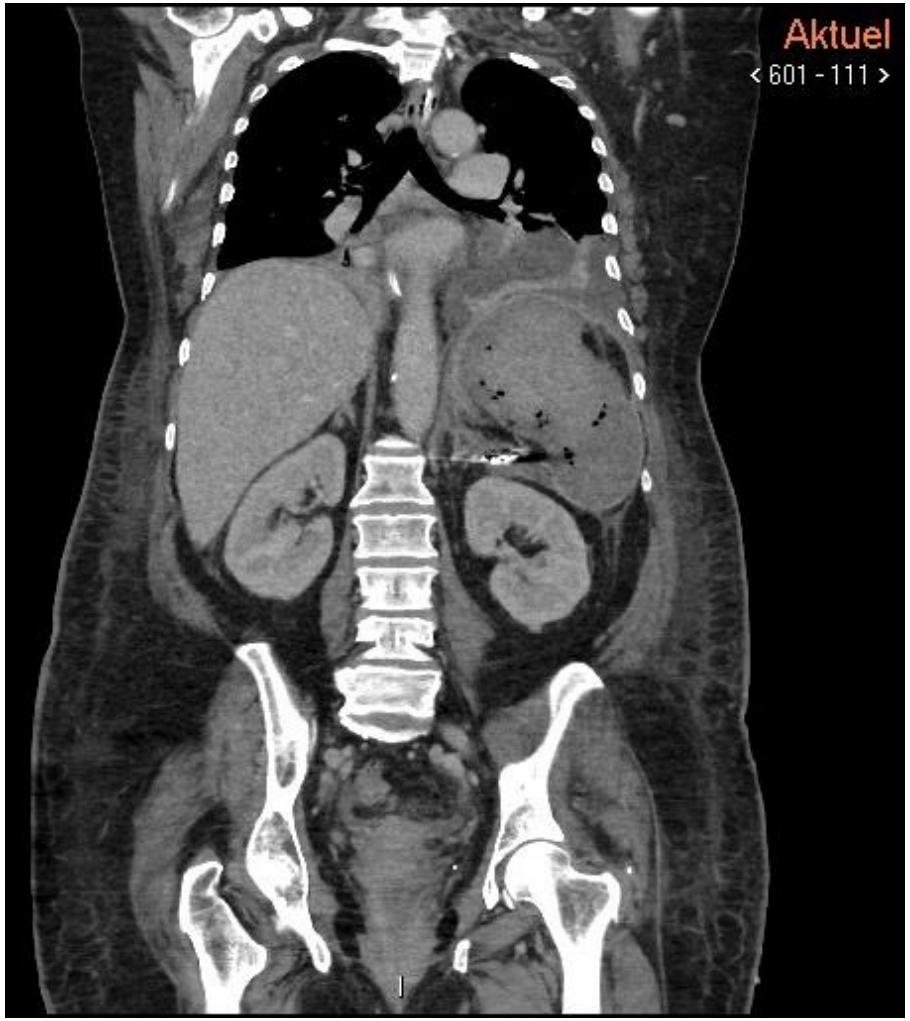
31.01.2023: Increase need for noradrenalin, CT-abdomen → Ddx: infected abscess or perforation.

02.02.2023: 2, 10 French drains applied by UL-guidance; 1 drain in the epigastrium, 1 drain the left upper quadrant.

CT-status: 01.02.2023, 6 days post-coiling.



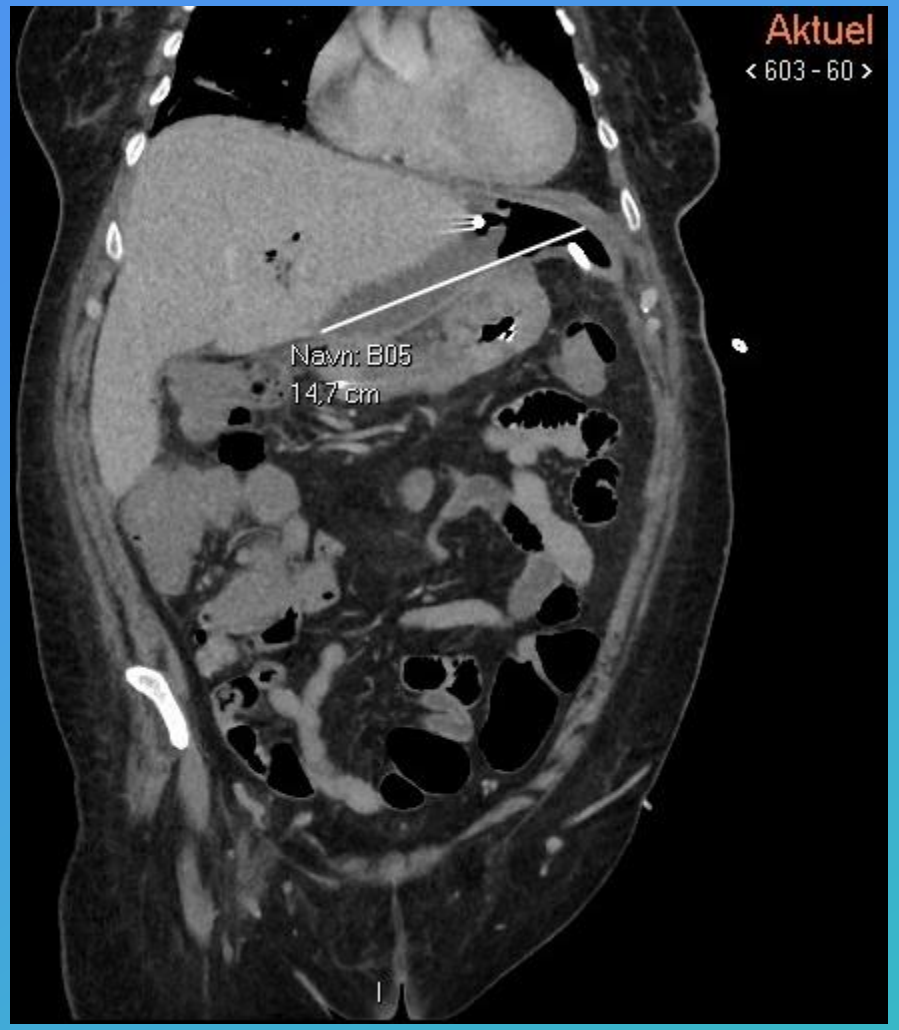




CT abdomen 08.02.2023: non changed abscess intrabdominally. A necrotic spleen.

08.02.2023: Left pleuradrain.

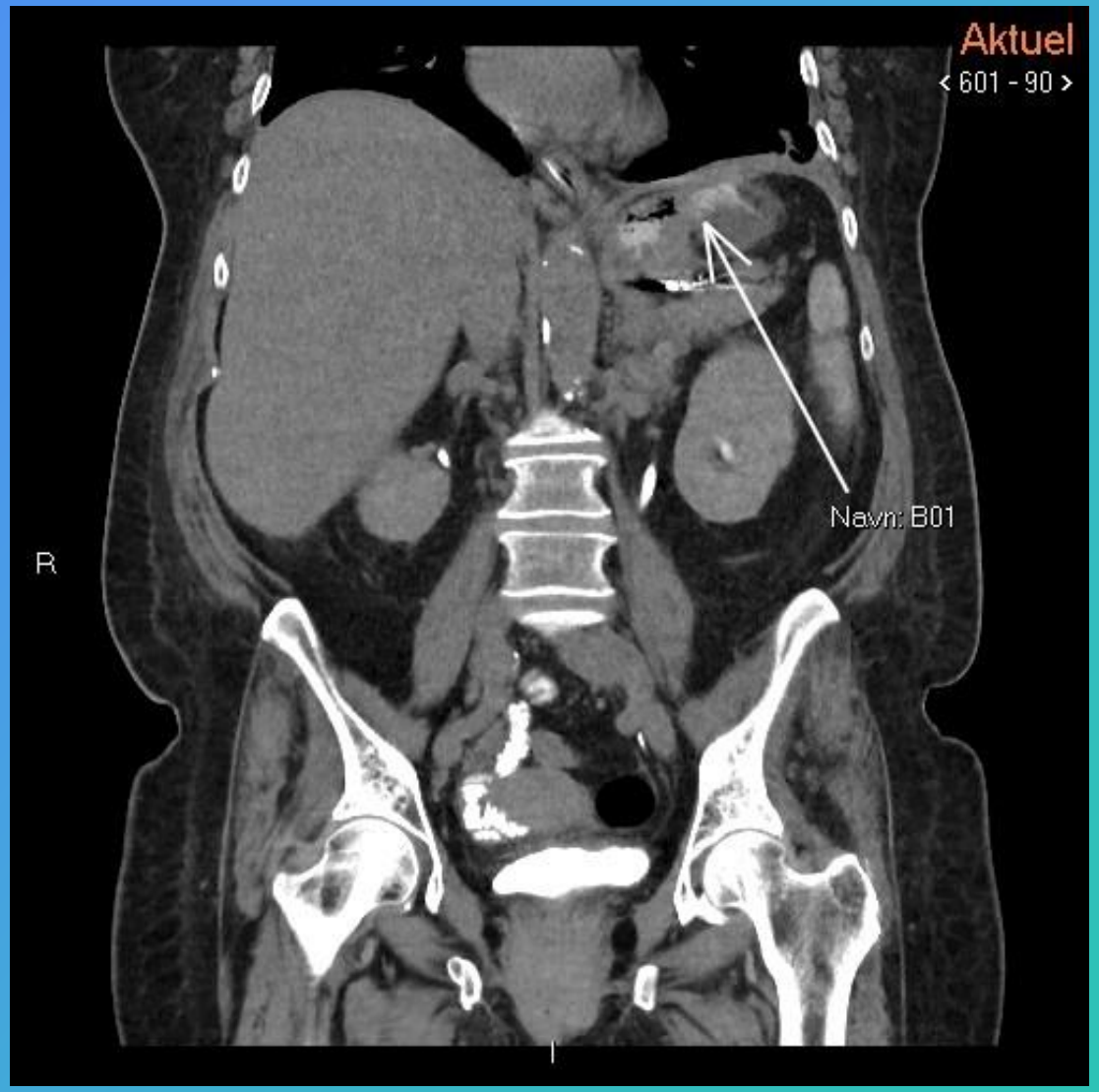
10.02.2023: Change of the 2 drains into 14 French drains via fluroscopy guidance.



20.02.2023: Brilliant Blue in the drains.

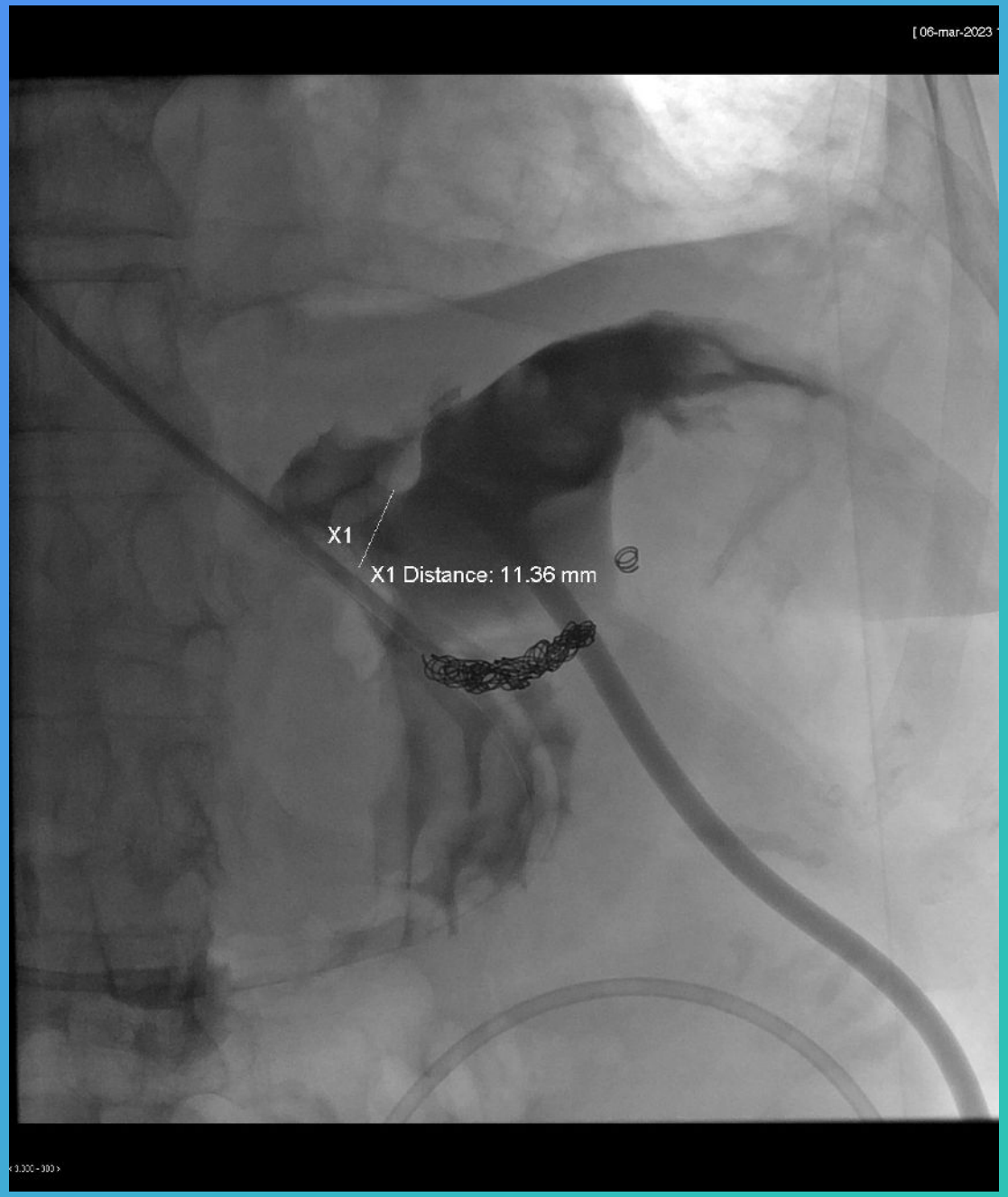
21.02.2023: CT abdomen with both i.v. and Peroral Contrast shows a probable communication between the abcess and the GIT canal.

22.02.2023: Gastroscopy, perforation in the fundus near the cardia. Applying a 3 way sonde. A previous ventricular diverticle?



CT-Status 06.03.2023

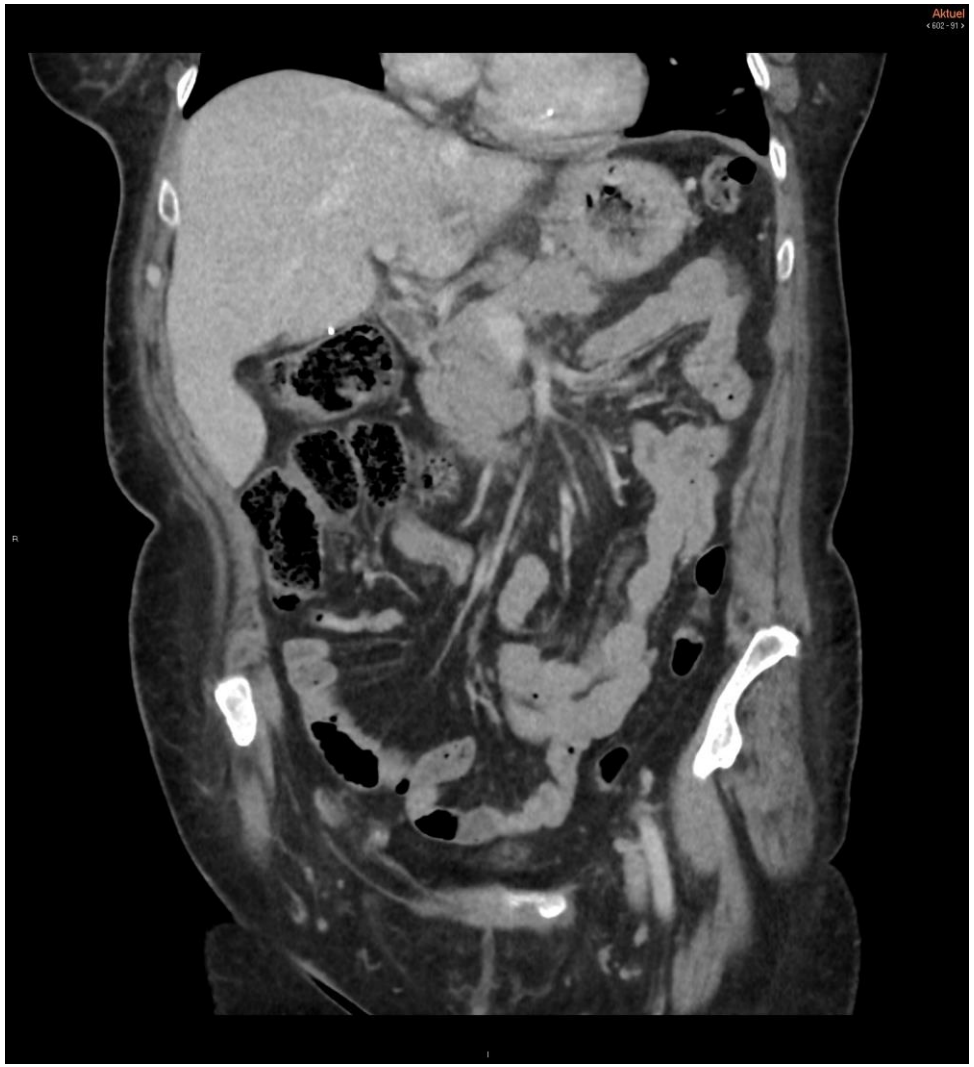
- Peroral Contrast in the collection- confirming the previous perforation.



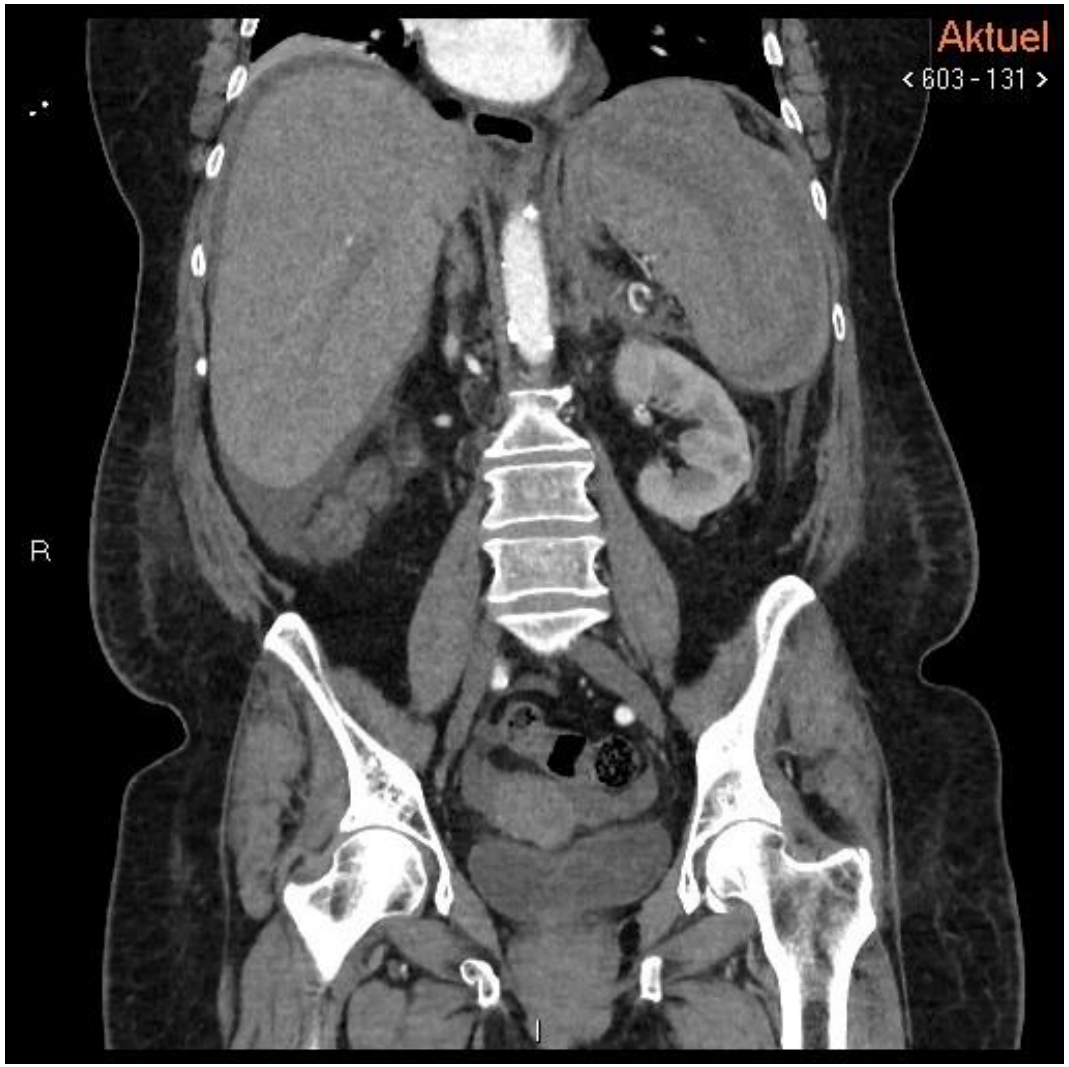
Fluroscopy-guided percutaneous abscess drainage 06.03.2023

- The stomach fills with contrast after injecting contrast in the abscess collection
- Defect in the fundus of the stomach about 1 cm.

Control CT 24/05



Pre-coiling Acute CT 25/1



CONCLUSION

- We still do not know whether the bleeding was primarily from a stomach perforation or a spleen lesion.

  However, we must mention that initially, the patient improved clinically after coiling. Secondly, the stomach's perforation is not typical of an ulcer, nor did the perforation appear macroscopically as an ulcer when treated gastroscopically.

THANK YOU