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IMAGES IN EMERGENCY MEDICINE

Trauma/gastrointestinal

Female with abdominal pain

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PATIENT PRESENTATION

A previously healthy 51-year-old woman presented to the emergency department with severe abdominal pain. The pain progressively worsened after she had a routine colonoscopy performed earlier in the day and was associated with lightheadedness. One small polyp was removed from the ascending colon during the procedure. She described the pain as diffuse but most severe in the left upper quadrant, 10/10 in severity, radiating to the left shoulder. The physical examination revealed diffuse abdominal tenderness with guarding. A portable chest x-ray revealed no free air. A bedside focused assessment with sonography in trauma (FAST) examination was performed and was positive for free fluid (Figure 1). Computed tomography (CT) confirmed the diagnosis (Figure 2).

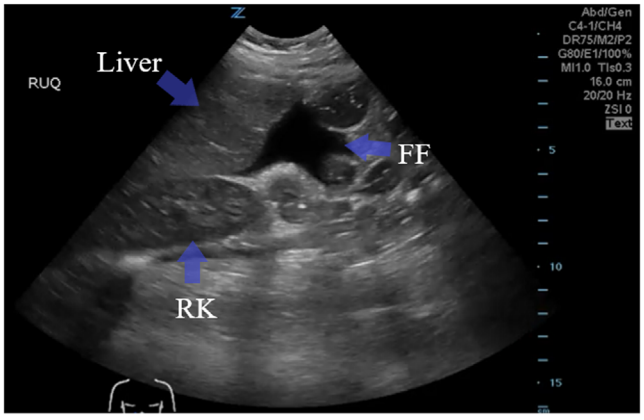

FIGURE 1 Right upper quadrant (RUQ) ultrasound view showing free fluid (FF)

DIAGNOSIS

Splenic laceration following colonoscopy

The patient sustained a splenic laceration after a routine colonoscopy. Surgical and interventional radiology consultation was obtained.

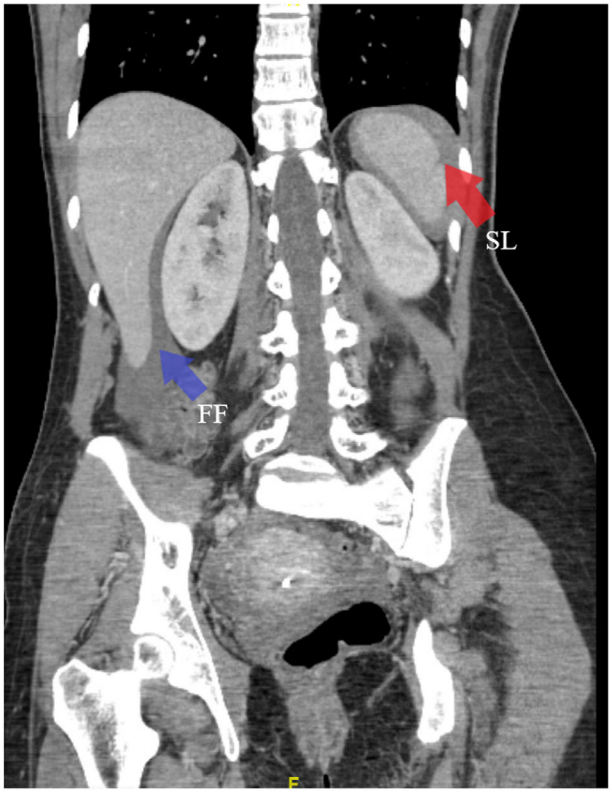

FIGURE 2 CT scan of the abdomen and pelvis with contrast (coronal view) showing hemoperitoneum (FF, blue arrow) and splenic laceration (SL, red arrow)

Patient was managed nonoperatively and admitted to the ICU for close monitoring. Her hemoglobin remained stable during admission and patient was discharged after 3 days of bedrest.

Splenic injury after colonoscopy is exceedingly rare and is estimated to occur in 1 in 10,000 cases. The mechanism of spleen injury is not fully understood but is believed to be related to traction on the splenocolic ligament or on prior adhesions. It could also be due to blunt splenic trauma by the colonoscope while navigating the splenic flexure.[1] It carries a relatively high mortality rate of around 5%.[2] Most cases present within 24 hours. However, delayed presentation is also possible, and symptoms may be more subtle. Patients may be managed with observation, embolectomy, or laparotomy with splenectomy depending on hemodynamic status, comorbidities, and extent of splenic injury.[3]

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