ABCDDV/789

ABCD Arq Bras Cir Dig
2011;24(2): 186-187

Letter to the Editor

SPLENIC PELIOSIS – A CASE REPORT

Peliose esplênica – relato de caso

Marcelo A. F. **RIBEIRO-JUNIOR**, Guilherme L **ZANCO**, Marco A S **SALA**, Roberto **EL-IBRAHIM**, William A. **SAAD**

From City of São Paulo University – UNICID, São Paulo, SP, Brazil.

Correspondence:
Marcelo A. F. Ribeiro Jr,
e-mail: mribeiro@cwaynet.com.br

Source of funding: none
Conflict of interest: none

Received: 01/04/2010
Accepted for publication: 25/01/2011

INTRODUCTION

Splenic peliosis, a rare and cryptogenic disease, is characterized by polyfollicular cavities filled with blood, and the diagnosis is hystologic.

Peliosis occurs mainly in organs like the liver and spleen. Lymph nodes, bone marrow, lungs, gastrointestinal tract, kidneys, and adrenals are rarely involved. It has been associated with steroids and chemotherapy, chronic infections including HIV, diabetes, and hematological diseases.

The clinical significance of splenic peliosis is the potential for intraperitoneal hemorrhage followed by rupture of the lesion. This disease has a wide age distribution, ranging between 14 and 82 years, and the male/female ratio is 1.7/1. Damage to the sinusoid walls is considered a primary event in its pathogenesis[5,9]. Local microcirculatory disorders manifested by altered local intravascular pressure in the spleen may be responsible for peliosis associated with vascular lesions[10,12]. Treatment is based on discontinuing steroids and other drugs, treatment of underlying diseases, and splenectomy in some cases[4].

CASE REPORT

Woman 48-year-old complaining of hoarseness and occasional abdominal pain in the epigastrium looked for to medical assistance. During the evaluation, she was submitted to an abdominal ultrasound which detected multiple simple cysts in the spleen. On this occasion she was treated for acute gastritis with relief of symptoms.

After six years, she returned for a clinical evaluation due to abdominal pain and referred an increasing volume on the left side of the abdomen. The physical examination revealed significant splenomegaly with no other alterations. A CT scan was then requested and showed diffuse splenomegaly with multiple cysts. Due to the persistence of the pain and diffuse increase in the volume noted by physical examination, two months after the CT, surgery was indicated with the aim to relieve the symptoms and obtain a final diagnosis considering that other causes of splenomegaly had been investigated.

Before surgery the patient was submitted to prophylactic immunization. The surgical approach was a median supraumbilical incision and exploration of the entire abdominal cavity. No other alteration was observed. The spleen was enlarged and multiple cysts were observed on its surface. Mobilization from its ligaments was performed, followed by ligation of the splenic artery and vein, and careful dissection from the splenic hilum and the pancreas. The patient had an uneventful recovery and was discharged from the unit on the 5th postoperative day. She remains symptom-free at the moment.

Histopathological diagnosis was consistent with splenic peliosis as shown in Figures 1 and 2.

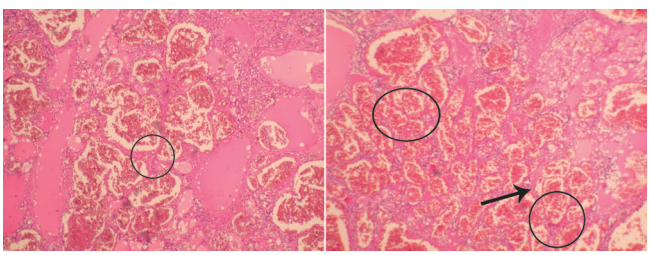

FIGURE 1 - Benign proliferation of wellformed vessels of fibrosclerotic walls with lumens filled by red blood cells

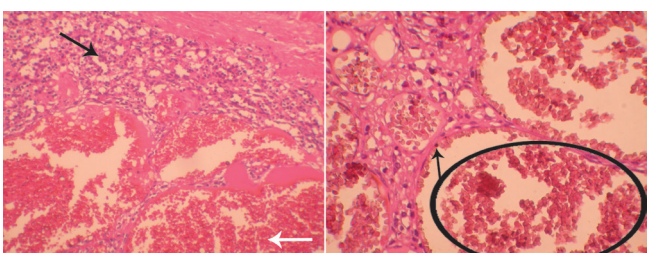

FIGURE 2 - Proliferation of endothelial cells (black arrow), vascular congestion (white arrow)

REFERENCES

1. Etzion Y, Benharroch D, Saidel M, Reisenberg K, Gilad J, Schlaeffer F. Atraumatic rupture of the spleen associated with hemo phagocytic syndrome and isolated splenic peliosis. APMIS 2005; 113: 555-557
2. Gugger M, Gebbers JO. Peliosis of the spleen: an immune-complex disease? Histopathology. 1998 Oct;33(4):387-9.
3. Javier Peñalver F, Somolinos N, Villanueva C, Sánchez J, Monteagudo D, Gallego R. Splenic peliosis with spontaneous splenic rupture in a patient with immune thrombocytopenia treated with danazol. Haematologica. 1998 Jul;83(7):666-7.
4. Joseph F, Younis N, Haydon G, Adams DH, Wynne S, Gillet MB, Maurice YM, Lipton ME, Berstock D, Jones IR. Peliosis of the spleen with massive recurrent haemorrhagic ascites, despite splenectomy, and associated with elevated levels of vascular endothelial growth factor. Eur J Gastroenterol Hepatol. 2004 Nov;16(12):1401-6.
5. Lashbrook DJ, James RW, Phillips AJ, Holbrook AG, Agombar AC. Splenic peliosis with spontaneous splenic rupture: report of two cases. BMC Surg. 2006 Jun 26;6:9.
6. Ortega Deballon P, Ferńandez Lobato R, Ortega Muñoz P, Artuñedo Pé P, Ferńandez Luengas D, Moreno Azcoita M. Splenic peliosis: a cause of spontaneous splenic rupture. Surgery. 1999 Sep;126(3):585-6.
7. Parmar H, Patankar T, Prasad S.A lady with chronic left hypocondrial pain. The British Journal of Radiology, 73; 673-674 (2000)
8. Pomp A, Gagner M, Salky B, Caraccio A, Nahouraii R, Reiner M, Herron D. Laparoscopic splenectomy: a selected retrospective review. Surg Laparosc Endosc Percutan Tech. 2005 Jun;15(3):139-43.
9. Raghavan R, Alley S, Tawfik O, Webb P, Forster J, Uhl M. Splenic peliosis: a rare complication following liver transplantation. Dig Dis Sci. 1999 Jun;44(6):1128-31.
10. Shimono T, Yamaoka T, Nishimura K, Naya M, Hojo M, Yamamoto E, Mukaihara S, Hayakawa K. Peliosis of the spleen: splenic rupture with intraperitoneal hemorrhage. Abdom Imaging. 1998 Mar-Apr;23(2):201-2.
11. Tsokos M, Erbersdobler A. Pathology of peliosis. Forensic Sci Int. 2005 Apr 20;149(1):25-33.
12. Tsokos M, Püschel K. Isolated peliosis of the spleen: report of 2 autopsy cases. Am J Forensic Med Pathol. 2004 Sep;25(3):251-4.
13. Warfel KA, Ellis GH. Peliosis of the spleen. Report of a case and review of the literature. Arch Pathol Lab Med. 1982 Feb;106(2):99-100.