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Marked perisplenitis in gastric carcinoma

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We report a patient with gastric carcinoma with marked perisplenitis, on gross appearance resembling secondary deposit. On sectioning, the spleen showed a solitary metastasis in the red pulp. [Indian J Gastroenterol 1998; 17: 66-67]

Key words: Splenic metastasis

Perisplenitis is rare in gastric carcinoma.

A 65-year-old man presented with hematemesis and burning pain in the epigastrium, relieved by vomiting, for 2 days. Past and family history were not significant. On examination there was no lymphadenopathy. Systemic examination was normal.

Routine laboratory investigations and ultrasonography of the abdomen were normal. Endoscopy revealed a polypoidal growth on the lesser curvature, 3 cm from the gastroesophageal junction. Laparotomy revealed a proliferating growth in the stomach, 10 cm x 10 cm. Irregular in shape, extending from the gastroesophageal junction to the middle third of the stomach. The lymph nodes near the stomach were not enlarged. The liver appeared normal. The capsule of the spleen was thick and pale; hence partial gastrectomy and splenectomy were done. The postoperative period was uneventful.

On gross examination the spleen measured 5 cm x 4 cm and weighed 150 grams. On cut section, a subcapsular pale area of 3.5 cm length was noticed in the upper pole; this was thought to be a secondary deposit (Fig). Histology of the growth in the stomach revealed adenocarcinoma infiltrating all the layers, with evidence of vascular tumor emboli. Examination of the pale area in the spleen revealed perisplenitis. There was a focal area of adenocarcinomatous tumor deposit in the red pulp 1.5 cm away from the subcapsular pale area. The gastric tumor was 4 cm away from this subcapsular pale area.

Perisplenitis usually occurs in infection, trauma and infarction. In the present case no evidence of such etiology was seen. Marked perisplenitis is rare. The large subcapsular pale area in the spleen due to perisplenitis in this patient was mistaken for a secondary deposit.
Wandering spleen is a rare condition characterized by abnormal laxity or absence of the supporting ligaments of the spleen. It commonly presents as asymptomatic abdominal mass but may present as emergency due to torsion of the splenic pedicle. Compression of the abdominal viscera with resulting obstruction is rare.

A 48-year-old woman presented with colicky pain in the periumbilical area and obstipation for 2 days. She had one episode of bilious vomiting. There was history of recurrent episodes of abdominal pain and constipation for 2 years. The patient was on antitubercular treatment for a pulmonary lesion for 4 months. On examination there was distension of the abdomen with visible bowel loops. There was a smooth, freely mobile, firm lump in the left lumbar and iliac regions which was not moving with respiration. Per rectal examination was normal.

X-ray showed dilated gas-filled colonic loops with massively dilated splenic flexure; there was no gas in the colon beyond. The small bowel loops were also dilated, some showing a concertina appearance with multiple gas-fluid levels.

Exploration revealed an enlarged spleen in the left paracolic gutter extending into the pelvis; it had multiple pale areas suggestive of infarction. The splenic vein was thrombosed. Splenectomy was performed. The gastrosplenic ligament was present but splenorenal, splenocolic and phrenocolic ligaments were absent. There was abnormal hypermobility of the ascending and descending colon. The left subdiaphragmatic area was occupied by a massively distended splenic flexure which had undergone partial volvulus. The splenic pedicle compressed the transverse and descending colon, causing closed-loop obstruction of the splenic flexure.

In the postoperative period the patient had ileus for three days. The excised spleen revealed congestion secondary to splenic vein thrombus. The patient is asymptomatic four months later.

Wandering spleen is more common in young women and children. The absence of the gastrosplenic and splenorenal ligaments and association with visceroptosis suggest a congenital cause. Intestinal hypermobility has been described. The condition being more common in women lends credence to the belief that it is acquired; hormonal effects on the ligaments and abdominal wall weakness may result from multiple pregnancies.

The clinical presentations include a mass with (55%) or without (25%) pain or gastrointestinal symptoms, and acute abdomen (18%). Torsion of the splenic pedicle may be acute or chronic. Chronic torsion leads to splenic vein thrombosis. At operation a majority of the spleens are enlarged. Gastric compression, gastric volvulus and intestinal obstruction have been described. Colonic obstruction has also been described.

Diagnosis is possible by imaging techniques; a whorled appearance of the splenic pedicle has been described on CT scan. Decreased splenic arterial flow on doppler indicates splenic pedicle torsion. Masing's recommendation of splenectomy for all cases of wandering spleen. Others believe in treating only symptomatic patients; splenectomy is recommended in them. Splenectomy is indicated when there is splenic vein thrombosis, infarction or hypersplenism.