

SPLenic ARTERY ANEURYSM REVEALED BY UPPER GI TRACT BLEEDING

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Acquired vascular anomalies are the cause of approximately 5% of externalized upper bleeding.^[1,2] Splenic artery aneurysms (SAA) are a rare and mostly asymptomatic pathological entity, occurring preferentially from the fifth decade onwards. Their rupture is a potentially serious complication.

The objective of this work is to review this rare cause of digestive hemorrhage through an observation of a splenic artery aneurysm revealed by upper GI bleeding.

Our patient was of 80 years old and had no previous medical history, including no history of non-steroidal anti-inflammatory drugs or aspirin use. He was initially admitted to the emergency department for the management of erysipelas of the right upper limb, for which he was treated with parenteral antibiotics. At day 4 of his hospitalization, the patient presented three episodes of moderate hematemesis with melena, without abdominal pain or other digestive or extradigestive abnormalities. Clinical examination found hypotension at 90/60 mmHg with HR at 90 beats per minute and anemic syndrome. Abdominal examination revealed a soft, depressed abdomen, epigastric tenderness and the

presence of melenas on digital rectal examination. The right upper limb showed an erythematous edematous placard corresponding to the erysipelas. The rest of the somatic examination was normal. The hemoglobin was 6.1 g/dL compared to 10.9 g/dL, the platelets were 303,000 G/L and the prothrombin rate was 76%.

After conditioning and blood transfusion, upper GI endoscopy revealed a large adherent clot extending from the antrum to D 3 that was difficult to detach, no active lesion or bleeding were found.

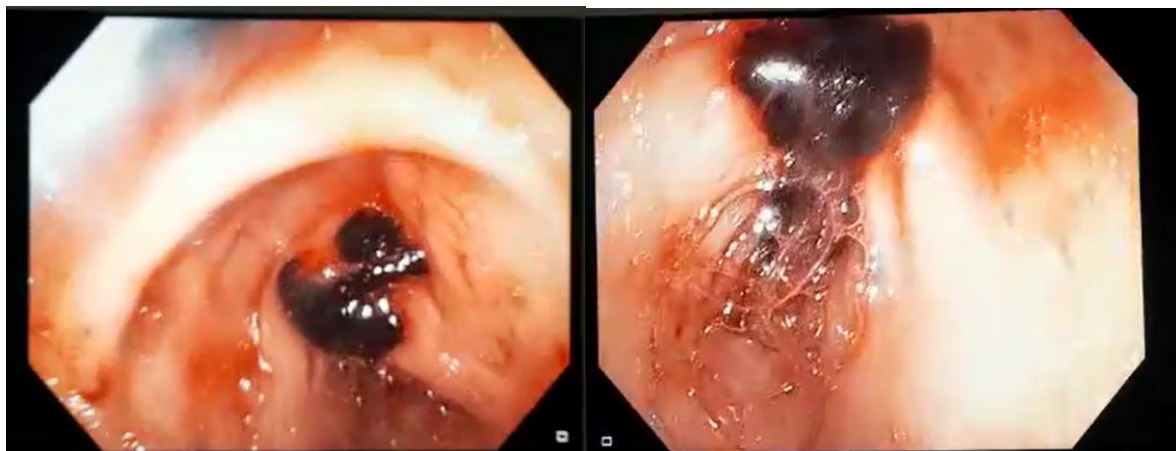


Figure 1: endoscopic findings: adherent clot in the antrum (Digestive endoscopy unit, CHU Hassan II, Fes)

An emergency abdominal angio CT scan showed a saccular aneurysm of the splenic artery ruptured in the

gastric lumen, responsible for haematomas in the gastric fundus and duodenum.

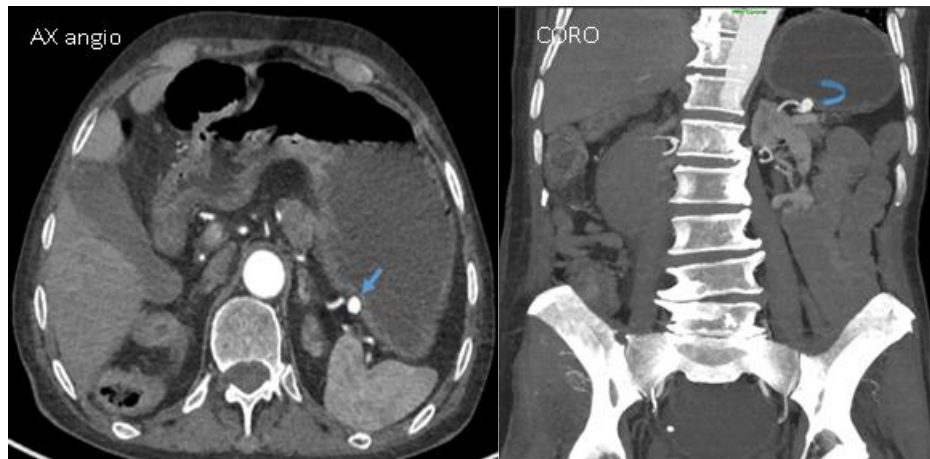


Figure 2: saccular aneurysm of the splenic artery ruptured in the gastric lumen.

The patient was transferred to the interventional radiology department where an endoaneurysmal and sandwich embolization by coiling was performed.

DISCUSSION

Splenic artery aneurysm (SAA) ranks first among visceral artery aneurysms and third among intra-abdominal aneurysms after aortic and iliac artery aneurysms: 15 cases out of a series of 31 visceral artery aneurysms in Carmeci.^[3]

ASA is four times more common in women with an average age of 50 to 60 years.^[4]

ISAs are usually asymptomatic and radiologically discovered, the main evolutionary risk is rupture. This risk reaches 28% when the size of the aneurysm is greater than 50 mm.^[7]

Gastroduodenal endoscopy can localize the site of bleeding but cannot determine the cause. In the absence of active bleeding, it is difficult to demonstrate punctate ulceration of the gastroduodenal wall, which corresponds to parietal erosion of the aneurysm.^[5,6]

Spiral CT appears to be the best referral examination to be performed after endoscopy. It can clarify the size and location and demonstrate the complication.^[8] MRI angiography can be a non-invasive alternative to angio CT scan, but it takes longer to perform, thus delaying therapeutic management.^[8] Laparoscopic angiography provides excellent anatomical details. It is of interest in the choice of the therapeutic method.^[8]

Treatment of ASA can be endovascular or surgical.^[9] Endovascular therapy includes aneurysm exclusion by covered stent grafting or coiled embolization. The tortuous course of the splenic artery and/or the possibility of incomplete exclusion explain some of the technical failures of endovascular therapy and the need for a second surgical procedure.

There is no consensus on the management of ASA. Embolization is the treatment of choice for splenic artery

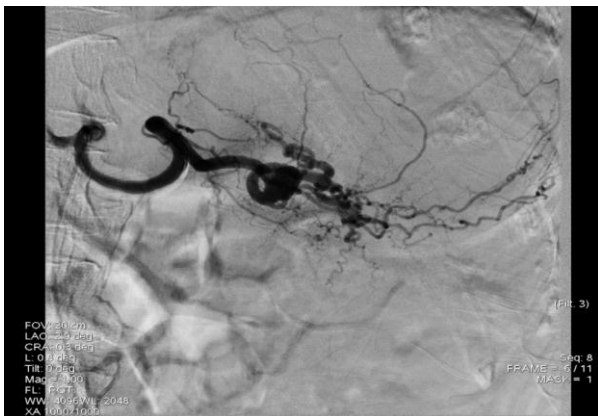


Figure 3: angiography of the splenic artery.



Figure 4: splenic artery aneurysm after embolization.

The patient was monitored in the USC for 72 hours, during which time he did not experience a recurrence of bleeding and remained hemodynamically stable.

aneurysms. Surgical treatment should be considered in the event of embolization failure or rupture with active bleeding. It differs according to the location of the aneurysm: resection-anastomosis in the proximal third, exclusion by ligation in the middle third, and splenectomy taking out the aneurysm in the distal third.^[8]

CONCLUSION

Rupture is a rare and serious complication that must be considered in case of hematemesis. After stabilizing the hemodynamic state and eliminating an intraluminal cause that can be controlled endoscopically, angioscan and laparoscopic angiography are of great diagnostic and therapeutic value.

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