A 65-year-old patient presented with a 2-month history of dysphagia and weight loss associated with a known squamous epithelial carcinoma of the esophagus. Computed tomography (CT) revealed the carcinoma of the distal esophagus (Image 1) with a liver metastasis and an intact spleen (Image 2). Forty years ago a Billroth II gastroenterostomy had been performed because of duodenal ulcers.

Computed tomography (CT) revealed the carcinoma of the distal esophagus (Image 1) with a liver metastasis and an intact spleen (Image 2). Forty years ago a Billroth II gastroenterostomy had been performed because of duodenal ulcers.

Interventional EGD may cause complications such as bleeding, pain, infection, perforation, or, during sedation, cardiopulmonary problems. Some cases of splenic rupture occurring during endoscopic retrograde cholangiopancreatography [1, 2] or colonoscopy [3, 4] have been described in the medical literature. To date only a single case of splenic rupture after diagnostic EGD has been reported [5]. Rotating the endoscope within the duodenum, mechanical traction at the gastro-splenic ligament, and the formation of loops at the greater gastric curvature exerting a direct pressure onto the spleen are suspected as possible causes of splenic rupture [1].

Our patient suffered from a splenic rupture after EGD bouginage of a malignant esophageal stenosis with a history of Billroth II operation as a risk factor. This sort of complication may initially remain hidden behind unspecific symptoms, leading to a delay in diagnosis. In cases of postinterventional ailments and previous operations, splenic rupture should be taken into consideration as a rare differential diagnosis.

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