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Splenic subcapsular hematoma following endoscopic retrograde  
cholangiopancreatography: A case report and literature review

Splenic injury after ERCP.

Chen-Yu Guo, Yu-Xia Wei

## **Abstract**

### **BACKGROUND**

Splenic injury following endoscopic retrograde cholangiopancreatography (ERCP) is a rare complication. The literature contains around 30 articles reporting various degrees of splenic injuries resulting from ERCP since the first report of splenic rupture after ERCP in 1989.

### **CASE SUMMARY**

This report describes a case of splenic hematoma and stent displacement in a 69-year-old male patient who developed these conditions 7 days after undergoing endoscopic retrograde cholangiopancreatography (ERCP) and stenting. The patient had bile duct stenosis caused by a malignant tumor that was obstructing the bile duct. The diagnosis was confirmed by epigastric computed tomography and magnetic resonance cholangiopancreatography. The patient was successfully treated with percutaneous transhepatic cholangial drainage, endoscopic pyloric stent placement, and conservative management. The causes of splenic injury following ERCP are discussed.

### **CONCLUSION**

ERCP has the potential to cause splenic injury. If a patient experiences symptoms such as abdominal pain, decreased blood pressure, and altered hematology after the procedure, it's important to be thoroughly investigated for postoperative bleeding and splenic injury.

**Key Words:** Endoscopic retrograde cholangiopancreatography; Gastroenterology; Splenic injury; Hematoma; Case report

Guo CY, Wei YX. Splenic subcapsular hematoma following endoscopic retrograde cholangiopancreatography: A case report and literature review . *World J Clin Cases* 2024; In press

**Core Tip:** There are several possible causes of abdominal pain and fever in patients who have undergone endoscopic retrograde cholangiopancreatography (ERCP). One of the potential complications that should not be overlooked is splenic injury. A clear diagnosis can be established based on laboratory and imaging examinations. It is important to closely monitor the patient's condition after ERCP and to promptly address any signs of discomfort.

## **INTRODUCTION**

Endoscopic retrograde cholangiopancreatography (ERCP) is a frequently used diagnostic and therapeutic tool for pancreatobiliary disease<sup>[1]</sup>. Complications occur in 5-10% of cases and may include pancreatitis, bleeding, and perforation<sup>[2]</sup>. Although rare, splenic injury has also been reported following ERCP. Our literature review found approximately 30 reported cases of splenic injury since the first case was reported in 1989<sup>[3]</sup>. Details of the first report and subsequent similar reports are shown in Table 1<sup>[3,9-35]</sup>. We describe a patient who developed a splenic hematoma after undergoing ERCP. The diagnosis was confirmed by objective imaging, and the condition was successfully treated using conservative methods.

## **CASE PRESENTATION**

### ***Chief complaints***

A 69-year-old male patient presented to our clinic with complaints of jaundice, accompanied by nausea, lower abdominal distension, and pain.

### ***History of present illness***

The patient's symptoms started 1 week ago with no apparent trigger.

### ***History of past illness***

Three years ago, the patient was diagnosed with multiple tumors of the sigmoid colon and underwent laparoscopic sigmoidectomy. Pathology revealed multiple malignant tumors of the sigmoid colon. The patient subsequently underwent conventional chemotherapy.

One year ago, the patient exhibited occupying lesions in the intrahepatic bile ducts of the left outer lobe of the liver near the hepatic hilum. The patient subsequently underwent a left lobe hepatectomy and cholecystectomy.

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#### *Personal and family history*

The patient reported no family history of malignant tumors and no history of smoking or drinking.

#### *Physical examination*

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The patient's vital signs were as follows: Body temperature, 36.5°C; heart rate, 80 bpm; respiratory rate, 20 breaths/min; and blood pressure, 103/77 mmHg. Additionally, there was a visible postoperative scar in the anterior midline of the abdomen, as well as abdominal and epigastric tenderness.

#### *Laboratory examinations*

Admission liver function tests showed the following: alanine aminotransferase (ALT) 424.4U/L, glutamic aminotransferase 210.9U/L, glutamyltransferase 1096U/L, alkaline phosphatase (ALP) 259U/L, total bilirubin 130.91  $\mu\text{mol/L}$ , direct bilirubin 71.71  $\mu\text{mol/L}$ , and indirect bilirubin 59.2  $\mu\text{mol/L}$ .

#### *Imaging examinations*

Abdominal ultrasound showed dilatation of the bile ducts in the liver. The duodenum was not peristaltic and metastasis was suspected in the duodenum and its periphery in the hepatic portal position.

Admission magnetic resonance cholangiopancreatography (MRCP) (Figure 1A) showed narrowing of the right hepatic duct was at the porta hepatis, which corresponded to a dilation of the intrahepatic bile duct in the right lobe of the liver. No dilatation or narrowing of the common hepatic duct or common bile duct was observed.

Admission magnetic resonance imaging (MRI) of the upper abdomen (Figure 1B) revealed that the spleen was morphologically normal with a homogeneous parenchymal signal. Postoperative changes were observed in the liver and gallbladder. Additionally, there was limited stenosis of the right hepatic duct in the hilar region.

### **MULTIDISCIPLINARY EXPERT CONSULTATION**

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### **FINAL DIAGNOSIS**

The patient was diagnosed with obstructive jaundice, liver tumor (metastasis of colon cancer), and liver insufficiency.

### **TREATMENT**

In conjunction with the expert opinions of other hospitals, to ensure smooth bile drainage and prevent liver failure, the patient underwent transendoscopic retrograde cholangiopancreatography (ERCP) and stent implantation 1 week after admission in our hospital. During the ERCP procedure, the lateral scope was passed smoothly under intravenous anesthesia in the prone position. The esophageal cardia entered the gastric cavity and it was difficult to pass the scope through the pylorus; thus, the anterior scope was replaced by a guide wire which was placed through the pylorus into the jejunum, and then the lateral scope was replaced by inserting a balloon through the guide wire, and repeated attempts were made to enter the descending portion of the duodenum. The balloon guidewire was removed and the main papilla was found on the medial side of the descending portion, which showed a papillary shape with a granular opening. The bile duct was difficult to intubate, the pancreatic duct was accessed, a pancreatic

duct guide wire was left in place and the bile duct was visualized by re-accessing the bile duct and administration of contrast into the bile duct. The contrast agent used was iodixanol. The X-ray showed: Bile duct stenosis in the porta hepatis, dilatation of the left hepatic duct, and the right hepatic duct was not visualized. As the bile duct was difficult to intubate, the guidewire was repeatedly entered into the pancreatic duct several times, and in order to prevent ERCP pancreatitis, the papilla was incised to 0.4 cm with an incision knife and a pancreatic stent of 5F diameter and 5 cm length was placed through the pancreatic duct guidewire and pancreatic fluid was seen to drain. After placing an 8.5F diameter, 11cm long unilateral plastic wing stent through the bile duct guidewire, bile was seen to flow out and the operation was completed. Liver function test 24 h after ERCP revealed ALT 175 U/L, glutamic aminotransferase 87 U/L, glutamyltransferase 565 U/L, ALP 142 U/L, total bilirubin 83.9  $\mu\text{mol/L}$ , direct bilirubin 60.4  $\mu\text{mol/L}$ , and indirect bilirubin 15.8 $\mu\text{mol/L}$ . These indices had significantly improved compared to the previous values.

#### **OUTCOME AND FOLLOW-UP**

On the 7th day after ERCP, the patient had worsening abdominal pain, fever (38.7°C), poor mental status, nausea, and vomiting, and a hematoma was seen under the palpated splenic hilum on CT (Figure 2) and MRCP (Figure 3) of the upper abdomen, but the etiology of the disease was not yet clarified. In addition, biliary stent displacement and poor bile drainage were observed. Liver function tests showed an upward trend, and 7 days after ERCP liver function showed the following: ALT 134 U/L, glutamic aminotransferase 107 U/L, glutamyltransferase 658 U/L, ALP 212 U/L, total bilirubin 126.8  $\mu\text{mol/L}$ , direct bilirubin 100.2  $\mu\text{mol/L}$  and indirect bilirubin 26.6  $\mu\text{mol/L}$ . Percutaneous hepatic puncture biliary drainage (PTCD) was performed, resulting in good drainage and the patient's jaundice gradually subsided. Abdominal pain and other symptoms significantly improved two days later.

Twelve days after PTCD, the patient had no obvious discomfort. We planned to perform ERCP again to reposition the stent, remove the PTCD drain, and achieve

intrahepatic biliary drainage. During the operation, a large mass was observed on the posterior wall of the gastric sinus and the greater curvature of the external pressure side. This caused a narrowing of the gastric sinus lumen and severe deformation of the pylorus, making it impossible to pass an endoscope. To address this, the operation mode was changed and endoscopic pyloric stent placement was performed (Figure 4). The stent was successfully positioned.

The patient's abdominal CT was reviewed 3 days before discharge (Figure 5), and the splenic hematoma had resolved. Subsequently, the patient attended our hospital every 3 months to have the PTCO drain changed and received radiotherapy at the same time, The patient's abdominal CT was reviewed several times during the year, and the splenic morphology was normal.

## **DISCUSSION**

ERCP is a vital tool for diagnosing and treating pancreatic and bile duct diseases. In this case, a tumor in the hepatic hilum was compressing the bile duct, causing obstructive jaundice. Stent placement *via* ERCP provided a palliative intervention. Postoperative complications, such as pancreatitis, perforation, and hemorrhage, are common<sup>[4,5]</sup>. Rare complications have also been reported internationally, such as death caused by air embolism<sup>[6]</sup>, duodenal perforation due to biliary stent displacement<sup>[7]</sup>, and hepatic hematoma<sup>[8]</sup>. It is important to note that these complications are infrequent. Splenic injuries include splenic subcapsular hematoma, splenic hematoma, splenic capsular avulsion, peri-splenic hematoma, intrasplenic hematoma, splenic laceration, splenic rupture, splenic abscess, and short gastric vessel avulsion.

The risk factors for splenic injury after previous ERCP include calcification and fibrosis of the supporting ligaments, such as the splenocolic and gastrosplenic ligaments, which can cause decreased mobility of the viscera. These risk factors are particularly relevant for patients with cirrhosis and chronic pancreatitis. Excessive traction on the ligaments can result in splenic injury<sup>[9]</sup>. Abdominal adhesions can also develop after abdominal surgery<sup>[10,11]</sup>. If a patient experiences abdominal pain,

decreased blood pressure or hematocrit, and hemodynamic instability after ERCP, it is important to consider the possibility of splenic injury<sup>[12,13]</sup>. Depending on the severity of the injury, conservative management<sup>[14,15,16]</sup>, splenectomy<sup>[13,17,18]</sup>, or splenic artery embolization<sup>[11,12,19]</sup> may be employed to control bleeding after a splenic injury.

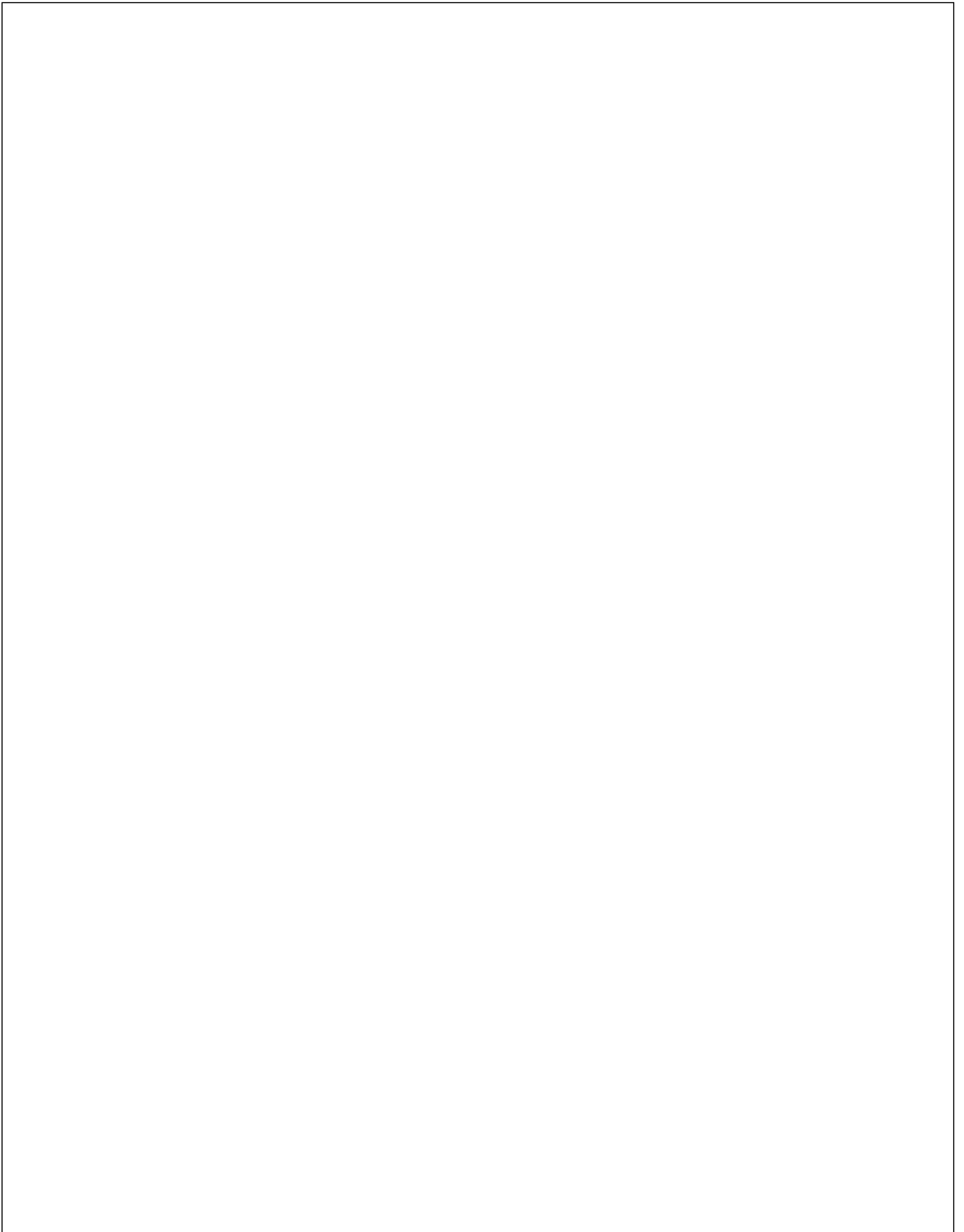
Our patient had stenosis of the pylorus and bile ducts due to compression by a hepatic tumor. The endoscope caused excessive traction or shear force when passing through the pylorus and bile ducts, which caused the greater curvature of the stomach to twist and led to splenic injury following excessive traction of the splenic colonic ligament. The patient underwent two major abdominal surgeries, including a left lobe hepatectomy and cholecystectomy. These procedures may have resulted in calcification of the peri-splenic ligament and vascular adhesions, which ultimately contributed to the splenic injury. The clinical symptoms of both biliary stent displacement and splenic haematoma can manifest as abdominal pain and fever, so the symptoms of patient on day 7 after ERCP may have been caused by both of these conditions. Stent displacement can be caused by excessive external compression or oblique vectorial compression resulting from a change in position. This report indicates that there is no correlation between stent displacement and splenic hematoma, suggesting that the latter does not cause stent displacement.

## **CONCLUSION**

Splenic injury is a rare complication of ERCP that requires attention. <sup>5</sup> The onset of symptoms can occur rapidly, within minutes, or may be delayed for up to a week. The severity and type of injury may also vary. Therefore, it is essential to be vigilant, conduct a careful investigation, and appropriately treat or manage patients who present with symptoms after ERCP to treat such complications.

## **ACKNOWLEDGEMENTS**

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