

53M LUQ pain and vomiting

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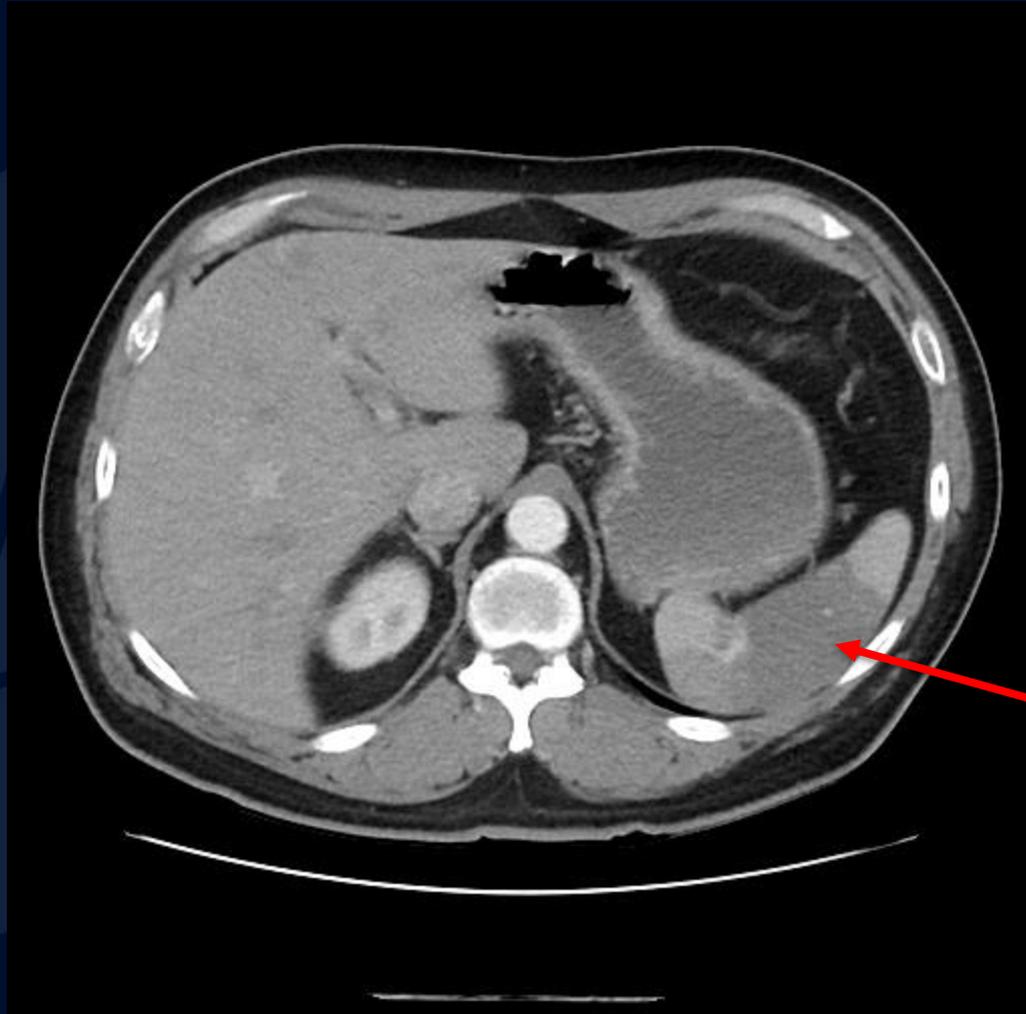




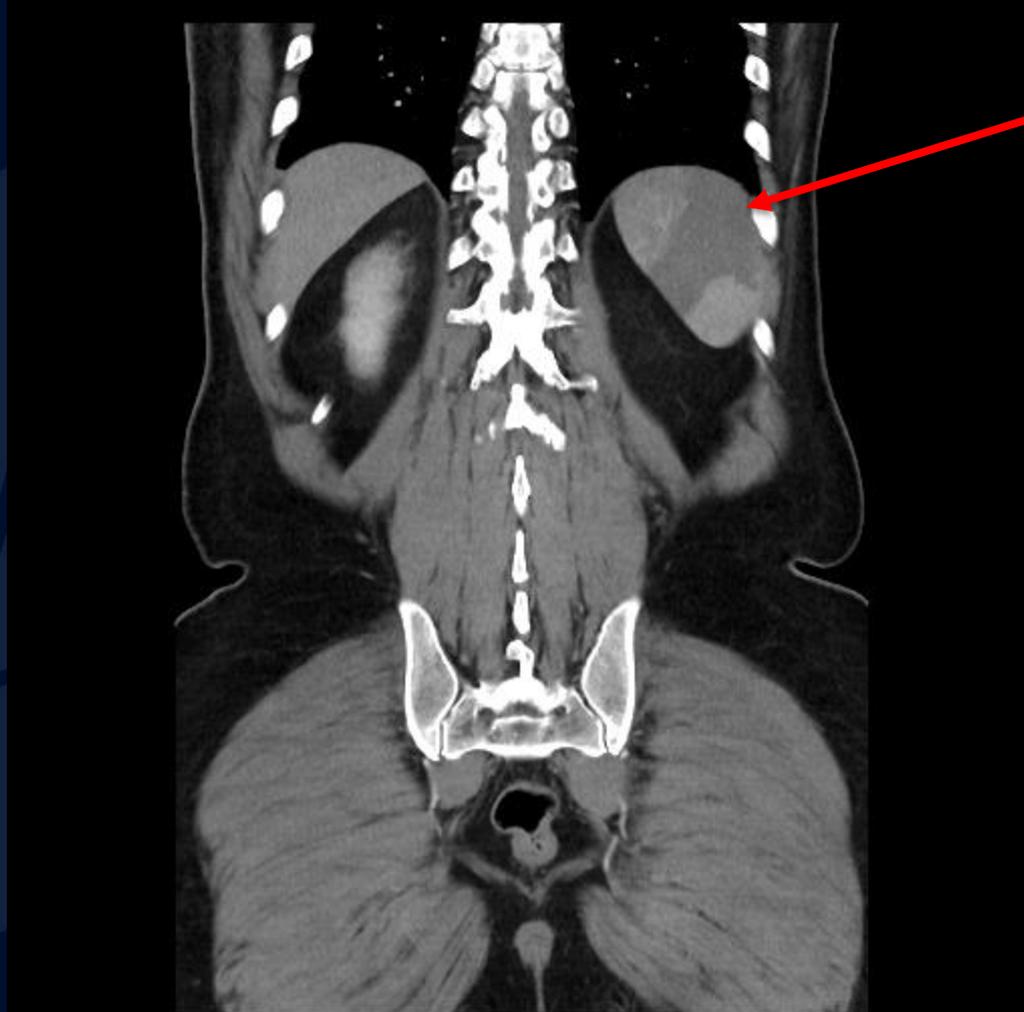
A large, stylized oak leaf graphic in a dark blue color, positioned on the left side of the slide. The leaf has a prominent central vein and several smaller veins branching off it. The edges of the leaf are slightly wavy.

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Acute Splenic Infarct



Wedge shaped
low attenuation



Wedge shaped
low attenuation

Imaging Findings

- **Acute:**

- Diagnosis best made on *portal venous phase* images
 - Do NOT confuse normal striated enhancement pattern on arterial phase CECT for splenic infarct
- Global infarction: Complete nonenhancement of spleen
 - \pm cortical rim sign: Preserved enhancement of peripheral rim of spleen in massive infarction = preserved flow from capsular vessels
- Segmental infarction: Wedge-shaped or rounded low-attenuation area
 - Usually periphery of spleen
 - Usually straight margins
- Can be multiple, especially when caused by emboli

- **Chronic:**

- scarring and volume loss
- Multiple repetitive infarcts in sickle cell disease can lead to small, calcified spleen (autoinfarcted spleen)
- Infarct can develop into splenic cyst

Splenic Infarct

- Complications (< 20% of patients):
 - Perisplenic fluid/hematoma suggests splenic rupture (often with large/global infarct)
 - Development of rim-enhancing fluid collection: Splenic abscess
- Associated findings: other infarcts (kidney/bowel)

Splenic infarction

- Presentation: 1/3 asymptomatic (when small), LUQ pain, fever, chills, malaise, nausea, vomiting
- 2-84yo, M=F
- Etiology:
 - Hematologic (Young): Sickle Cell, myelofibrosis, leukemia
 - Embolic (Old): septic emboli, cardiac emboli, atherosclerotic plaque emboli
- Rx:
 - Asymptomatic: pain control
 - Symptomatic/complications: splenectomy/drainage for abscess

References

1. Statdx
2. <http://pubs.rsna.org/doi/abs/10.1148/radiology.151.3.6718733>