

The classic presentation of splenic infarction includes left upper abdominal pain, nausea, vomiting and early satiety. CT angiography with contrast is the modality of choice for diagnosing splenic infarction, revealing a hypodense, wedge-shaped region as illustrated above. Leukocytosis and anemia are commonly found. Standard management of splenic infarction includes hydration, oxygenation and pain control. Depending on the size of the infarct, symptoms typically resolve within 7-14 days.

Complications of splenic infarction include abscess formation, pseudocyst development, hemorrhage, subcapsular hematoma or splenic rupture; however, all of these complications are uncommon. In the majority of cases, the ischemic tissue undergoes fibrosis and heals completely, thus precluding the need for splenectomy. Preserving the spleen is especially important due to its role in preventing infections; following splenectomy, patients are at significant risk for overwhelming infections, including sepsis, from encapsulated bacteria such as *Streptococcus pneumoniae*, *Haemophilus influenzae* and *Neisseria* species; patients who have massive splenic infarcts and/or must undergo splenectomy should thus be vaccinated against these organisms.

CONCLUSION: This case highlights a rare complication of IV drug abuse and demonstrates the value of CT angiography in the diagnosis of splenic infarction. As discussed above, splenectomy is not often necessary and should be avoided to prevent medical complications associated with hyposplenism.

REFERENCES:

Devitt et al., *An Unusual Cause of Abdominal Pain*, *Ir Med J*, 2005 Mar; 98(3): 88-89

Salvi et al., *Splenic Infarction, Rare Cause of Acute Abdomen, only seldom requires splenectomy*, *Ann Ital Chir.*, 2007; 78: 529-532

Ahmet et al., *A rare cause of Acute Abdomen: Splenic Infarction*, *Hepato-gastroenterology* 2001; 48(41):1333-6

Edwards et al., *Acute Splenic Infarction*, *CMAJ* 2006 Aug; 175(3): 247

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NEW INSIGHTS ON AORTIC STENOSIS

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SOCIETY OF HOSPITAL MEDICINE, ST. LOUIS CHAPTER, FEBRUARY 23, 2012

See listing in *Hospitalist Calendar*, page 7

FROM THE JOURNALS

KATE AHMED, MD

Clostridium difficile infection in patients with inflammatory bowel disease

Saidel-Odes, L et al., Annals of Gastroenterology, North America, November 24, 2011

<http://www.annalsgastro.gr/index.php/annalsgastro/article/view/1010/739>

This review focuses on the epidemiology, pertinent clinical aspects, standard and newer diagnostic methods, established and novel therapies and prevention of infection. Emphasis is placed on clinical awareness, rapid detection and appropriate therapy.

Rheumatological manifestations in inflammatory bowel disease

Voulgari, P, Annals of Gastroenterology, North America, July 24, 2011

<http://www.annalsgastro.gr/index.php/annalsgastro/article/view/915/720>

Rheumatologic manifestations of inflammatory bowel disease are frequent and include peripheral arthritis, axial involvement, peripheral enthesitis, secondary osteoporosis and hypertrophic osteopathy; septic arthritis may also be a complication. This article discusses diagnostic and treatment modalities as well as potential adverse effects of the therapeutic agents.

Alcoholic Liver Disease: Pathogenesis and New Therapeutic Targets

Bin Gao, Ramon Bataller, Gastroenterology, Vol 141, Issue 5, November, 2011, pages 1572-1585

[http://www.gastrojournal.org/article/S0016-5085\(11\)01228-5/abstract](http://www.gastrojournal.org/article/S0016-5085(11)01228-5/abstract)

Hepatic cirrhosis is the 12th leading cause of death in the U.S. and 48% of cases are alcohol related. This article reviews new data on the pathogenesis of alcoholic liver disease and identifies some promising therapeutic targets.

AGA technical review on the evaluation of liver chemistry tests

Green, RM and S Flamm, Gastroenterology, Vol 123, Issue 4, October 2002, pages 1367-1384

[http://www.gastrojournal.org/article/S0016-5085\(02\)00241-X/abstract](http://www.gastrojournal.org/article/S0016-5085(02)00241-X/abstract)

Abnormal liver chemistries occur in 1-4% of asymptomatic patients. Their interpretation must be in context with the patient's history, risk factors, physical findings and other lab data.

ID CORNER

WILLIAM SALZER, MD

C DIFF....AGAIN

The AHRQ commissioned a systemic review of C diff. Bottom line....vancomycin (\$1300) is probably not better than metronidazole (\$20); also, fidaxomicin (\$3400) appears to reduce relapse vs vancomycin for non-NAP1 strains.

Drekonja, DM et al., Comparative effectiveness of Clostridium difficile treatments. A systemic review. Annals Intern Med 2011; 155:839-847

<http://www.annals.org/content/155/12/839.full.pdf+html>