REPORT OF A CASE OF SUBCUTANEOUS RUPTURE OF THE SPLEEN.

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CASES of rupture of the spleen, while not uncommon, are generally not recognized until the abdomen is opened. The symptoms indicating operation are those pointing to a severe injury of the abdominal contents, associated with signs of marked internal hemorrhage.

Berger¹ states that 51.8% of all cases of splenic rupture prove fatal from hemorrhage within the first hour.

On the other hand, in subcutaneous rupture of the spleen without a tear in the capsule itself, there may be no signs of hemorrhage, and the patient make an uneventful recovery without operation. Naturally, in such cases the diagnosis of rupture of the spleen cannot absolutely be made. A certain number of this class later come to operation for an infected hematoma within the capsule, or for cyst of the spleen. In these, the bleeding within the capsule must have been gradual and ceased entirely when the pressure within the capsule became sufficiently great to shut off the bleeding points. Occasionally, as in the case cited below, the bleeding within the unruptured capsule continues until the pressure becomes so great that the capsule can no longer hold. The latter then suddenly bursts and, with it, the peritoneal covering, setting free a large hematoma and allowing a profuse hemorrhage from the torn spleen into the general peritoneal cavity.

This accident may occur from a few hours up to several days following the trauma and is quite sure to be fatal unless surgical measures are quickly resorted to.

Male, Italian, age 34, teamster.

P. H. Not taken.

P. H. Not important except for fact that patient never had malaria.

P. I. Sept. 10, 1918, at about 10 A.M., was kicked by a horse, in the upper abdomen. Continued to work, loading and unloading coal wagon until noon when a fellow workman told him to stop as he did not look well. His only complaint was slight pain in the abdomen.

Patient walked into the office of Dr. E. J. Powers of Chelsea, about 2 P.M. The latter, as a precautionary measure, took the patient home and put him to bed. He also strapped his left

chest and gave codeine for what appeared to be a slight diaphragmatic pleurisy. There was nothing further found on examination except slight tenderness over the left upper abdomen. The pulse, temperature, and respiration were normal and remained so during the next few days. Patient remained in bed, without other symptoms, until September 13, when, without permission, he sat up to eat his dinner. On the morning of September 14, patient was seen by Dr. Powers who found him comfortable. About 11 P.M. on September 14, while lying on bed, patient suddenly felt "something give way" in the upper abdomen, and at once sent for Dr. Powers. The latter found the patient in a state of collapse, pulse 130, temperature 97, respiration 30. There was marked pallor and thirst. The abdomen was considerably distended with rigidity and spasm on the left side, especially on the upper half. There was also shifting dullness in the flanks.

The diagnosis of rupture of some viscus, with internal hemorrhage was made, and immediate operation advised.

Further examination made by me about midnight of September 14, at the Frost Hospital, revealed no further symptoms. Under ether, the abdomen was opened through a high left rectus incision. There was at once an escape of large amounts of old and fresh blood. Quick exploration revealed a ruptured spleen which was bleeding profusely. Splenectomy was done. Further exploration was negative. Two gauze drains were placed to the former site of the spleen and the wound closed in layers. At the end of the operation the patient's condition was poor. Transfusion of blood was considered but no donor could be obtained. Salt solution was given intravenously and the patient stimulated. His condition on the morning of September 15 was slightly improved. He refused to allow transfusion at this time. From then on his condition gradually failed and he died at 10 A.M., September 16.

Examination of the spleen, after removal, showed the capsule loosened from the surface as if it had been lifted by a slow extravasation of blood from beneath. The peritoneal covering, capsule and spleen itself were torn through the middle, in a line running from the hilus backward to the posterior aspect, practically dividing the organ into two pieces.

REFERENCE.

¹ Berger: *Archiv. klin. Chir.*, lxxviii, 865.