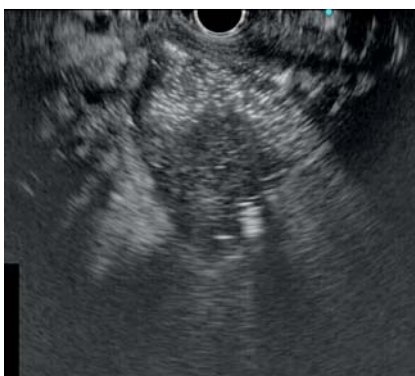


## Endoscopic ultrasound-guided drainage of a splenic abscess using lumen-apposing metal stent

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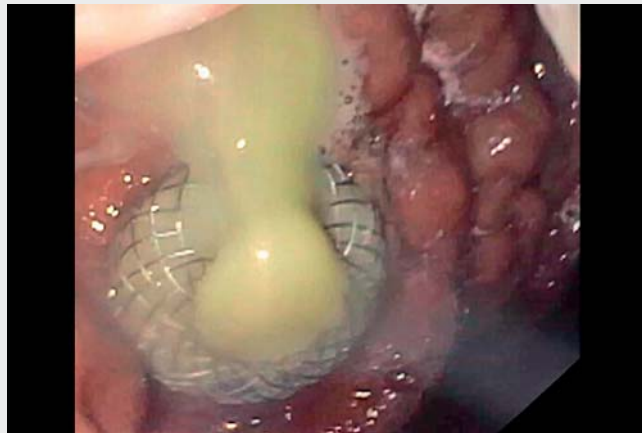
► **Fig. 1** The splenic abscess ruptured in the epiploon retrocavity on computed tomography scan.



► **Fig. 2** Endoscopic ultrasound evaluation revealed a hypo-anechoic collection containing air bubbles with a demarcated wall.



► **Fig. 3** The double cavity of the abscess confirmed by fluoroscopy.



► **Video 1** Splenic abscess with signs of anaerobic infection treated by endoscopic ultrasound-guided transgastric drainage using a lumen-apposing metal stent.

Splenic abscesses can be a rare complication of pancreatic tail adenocarcinoma [1].

The management of a splenic abscess includes antimicrobial therapy, percutaneous drainage, and surgery [2]. Since its first description in 2006 [3], a few cases of endoscopic ultrasound (EUS)-guided splenic abscess drainage have been reported in the literature [4]. In one case, Nieto et al. used a lumen-apposing metal stent (LAMS) [5].

A 55-year-old man with a history of locally advanced pancreatic tail cancer developed multiple splenic abscesses after 4 months from diagnosis and three chemotherapy cycles. The initial computed tomography (CT) scan showed spontaneous rupture of the major splenic abscess in the epiploon retrocavity (► **Fig. 1**). The patient was referred for EUS evaluation.

On EUS imaging, the abscess was visible from the gastric body and appeared as a hypo-anechoic collection (6×8 cm) containing air bubbles with a demarcated wall (► **Fig. 2**). SonoVue injection showed no enhancement within the col-

lection, with hyperemia of the abscess wall.

EUS-guided aspiration of purulent fluid was performed using a 19-gauge needle for microbiological tests. The fluoroscopic image after contrast injection through the needle confirmed a well-defined cavity (► **Fig. 3**). In consideration of signs of anaerobic infection, we performed EUS-guided transgastric drainage using a 10×10-mm LAMS over the guidewire (► **Video 1**). A large amount of purulent fluid passed into the gastric cavity after LAMS release. The patient recovered quickly from sepsis, and endoscopic evaluation 12 days later showed clearance of the abscess cavity and the LAMS was removed.


This case demonstrates the efficacy of an EUS-guided intervention in a complex non-conventional setting. In the hands of an expert endoscopist, EUS-guided drainage of a splenic abscess with a LAMS could be considered on a case-by-case basis as an alternative to percutaneous drainage or surgery.

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## Competing interests

The authors declare that they have no conflict of interest.

## The authors

Elia Armellini<sup>1</sup>  Flavio Metelli<sup>1</sup>, Maria Grazia Sauta<sup>2</sup>, Michele Marini<sup>3</sup>, Fabio Pace<sup>1</sup>, Gianluigi Patelli<sup>4</sup>, Giuseppe Nastasi<sup>2</sup>

- 1 ASST Bergamo Est, Gastroenterology Department, Seriate, Bergamo, Italy
- 2 ASST Bergamo Est, Oncology Department, Seriate, Bergamo, Italy
- 3 ASST Bergamo Est, Surgery Department, Seriate, Bergamo, Italy
- 4 ASST Bergamo Est, Radiology Department, Seriate, Bergamo, Italy

## Corresponding author

### Flavio Metelli, MD

ASST Bergamo Est, Gastroenterology Department, Via Paderno, 21, 24068 Seriate, BG, Italy  
flaviomet90@gmail.com

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