Intestinal obstruction caused by splenosis at the rectosigmoid junction, mimicking malignant pelvic tumor

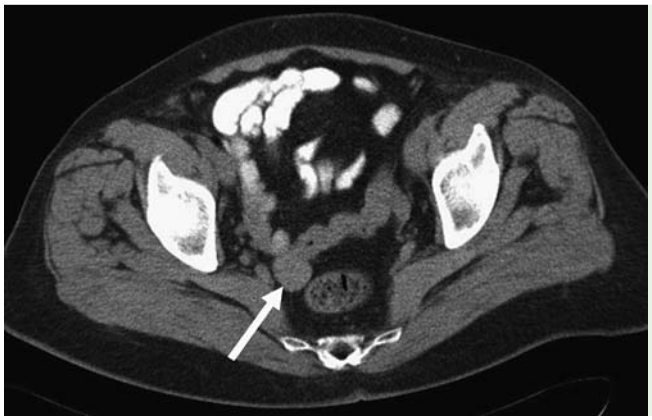

Fig. 1 Contrast-enhanced computed tomography (CT) scan showing a smooth-edged, clearly demarcated, solid, expansive process with marked contrast enhancement.

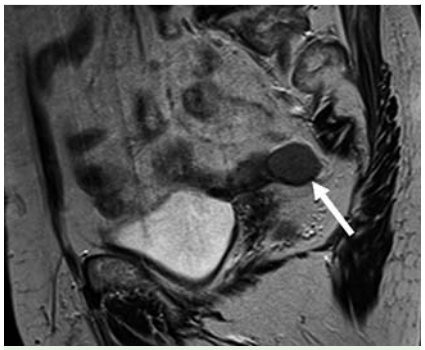

Fig. 2 T2-weighted magnetic resonance imaging (MRI) showing a solid, clearly demarcated, smooth-edged expansive process.

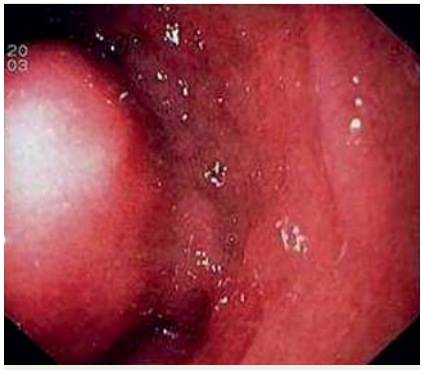

Fig. 3 Colonoscopic view showing stenosis of the lumen at the rectosigmoid junction.

A 74-year-old woman presented with an incidental finding on computed tomography (CT) scanning of a tumor in the lesser pelvis of unclear origin. Questioning of the patient revealed a history of long-term, intermittent constipation and splenectomy 18 years previously after a car accident. A contrast-enhanced CT scan showed a solid expansive process with marked contrast enhancement (**Fig. 1**). Magnetic resonance imaging (MRI) revealed a 2.5-cm clearly demarcated nodular lesion at the rectal fold, directly adjacent to the rectum (**Fig. 2**). Our suspicion was that this lesion was a neoplasm.

Colonoscopy showed a stenosis of the lumen due to extramural compression (**Fig. 3**). This luminal compression, together with the unknown origin of the expansive process, the symptoms of intermittent constipation, and the risk of possible bowel obstruction were clear indications for surgery.

A circumscribed tumor in tight contact with the proximal third of the lumen was removed without opening the lumen. The final histological examination revealed splenic tissue of typical appearance, consistent with a diagnosis of splenosis. The patient recovered uneventfully and was discharged after 5 days.

Splenosis is defined as autotransplantation of ectopic splenic tissue following splenic trauma, iatrogenic injury, or splenectomy [1]. It is an uncommon diagnosis and very often an incidental finding. If correctly diagnosed and asymptomatic, it requires no further treatment or surgery. The challenge lies however in reaching the correct diagnosis, which is often complicated by the similarity of the splenosis to a malignant process. This difficulty is confirmed by the large number of reports in which splenosis has been confused with a variety of other processes including abdominal lymphoma [2], hepatocellular carcinoma [3], and even a thoracic schwannoma [4].

The problem of differentiating between benign and malignant lesions increases even more the importance of the preoperative investigations and a detailed patient history. Although splenosis usually does not require surgical exploration, the dimensions of a lesion or its positioning within a critical area, as in our case, can carry a high risk of potential complications.

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Competing interests: None

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