addition, the chronic liver disease study was completed, which provided the diagnosis of Child-Pugh stage A liver cirrhosis, probably caused by steatosis.

The pathological study of the surgical specimen reported the presence of focal ulceration of the mucosa and vascular congestion with fibrin thrombi in the *lamina propria* in the absence of inflammation, all of which were compatible with GAVE.

Our case highlights the importance of a good differential diagnosis with portal hypertensive gastropathy and chronic antral gastritis due to their different management, the frequent association of this disease with liver cirrhosis and the need for surgical treatment in cases that are refractory to endoscopic and pharmacological treatment, since, despite there being no cases reported in the literature, this is the only curative treatment.

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Torsion of a Wandering Spleen☆

Torsión de bazo ectópico

The first detailed description of this clinical entity was by Van Horne in 1667 as an incidental finding during autopsy.[1]

The ectopic spleen is a rare clinical condition characterized by an unusual position of the spleen in the lower abdomen or pelvis. The congenital form may be due to the lack of splenic ligaments or to their incorrect position caused by an abnormally developed dorsal mesogastrium, which generates the suspensory ligaments of the spleen. Cases have also been observed due to progressive splenomegaly caused by diseases such as typhoid fever, lymphoma, and especially malaria.[2]

Acute torsion is the main complication of an ectopic spleen, which is caused by torsion of the vascular pedicle. This leads to splenic infarction due to vascular compromise.[3]

We present the case of a 15-year-old male diagnosed 5 months earlier with an ectopic spleen located in the hypogastrium, who came to the emergency department with abdominal pain that had been progressively intensifying for several days. Initially starting in the hypogastrium, the pain was not alleviated with analgesics and increased with sudden movements. In recent hours, it had spread to the entire abdomen and was accompanied by fever of 38 °C, nausea, little vomiting, asthenia and anorexia.

On physical examination, the patient presented splenomegaly in the hypogastrium and mesogastrium that was immobile, hard in consistency, had smooth edges and was painful on palpation. Laboratory analysis showed a leukocytosis of 12.6×10^9/L, while other values were normal.

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Hemodynamically, the patient was stable, with a tachycardia of 110 bpm.

Abdominal ultrasound showed an enlarged spleen measuring approximately 155 mm, located in the hypogastrium. Perisplenic and hypogastric fluid was observed.

Computed tomography scan of the abdomen confirmed an ectopic spleen in the hypogastrium measuring 168 × 59 mm with abundant perisplenic fluid in Morrison's space and the paracolic gutters, with central hyperdensity in the form of cords that gave the impression of splenic torsion.

With a diagnosis of acute abdomen due to torsion of the ectopic spleen, emergency surgery was performed with a midline laparotomy, identifying splenic torsion with ischemic areas of infarction, for which splenectomy was performed.

Histology confirmed torsion of the splenic vascular pedicle with notable vascular congestion and areas of infarction.

The patient evolved satisfactorily and was discharged on the sixth postoperative day.

The incidence of torsion of an ectopic spleen in a series of 1,000 splenectomies performed by Moran et al.[4] was 0.2%. It can happen at any age, although it is more frequent in young adult women, mostly multiparous, and in males under the age of 10.[5]

The most frequent forms of presentation of ectopic spleen described in the literature are acute abdomen, recurrent abdominal pain, intestinal obstruction, abdominal mass, recurrent pancreatitis, sepsis, and upper gastrointestinal bleeding. Furthermore, it may be an incidental finding in radiological studies or in a surgical exploration for another cause.[6]

Acute abdominal pain appears in approximately 50% of cases. Associated symptoms include nausea, vomiting, and flatulence. Other less frequent symptoms are constipation, diarrhea, melena, hematemesis, anorexia, urinary retention and dysuria.[7]

During physical examination, a firm, mobile, painful abdominal mass was palpated with characteristic 'notched edges', but this is not always the case because splenic congestion can eliminate the splenic notch, and therefore the clinical diagnosis is usually difficult.[8]

The diagnosis is made based on high clinical suspicion and imaging studies. Laboratory studies are variable and not very specific. The most frequent alterations are anemia, leukocytosis and thrombocytopenia.[9]

Ultrasound and contrast computed tomography provide valuable information for diagnosis. Ultrasound detects splenomegaly, ectopic position, and heterogeneity in the parenchyma. When color Doppler ultrasound is performed, the vascular flow is reduced due to pedicle torsion. Contrast computed tomography reveals an enlarged spleen in an ectopic position in addition to the 'whirl sign', which is an important finding in case of torsion of the vascular pedicle.[10]

In symptomatic patients with splenic infarction, treatment is generally splenectomy. If there is ectopia or splenic torsion without splenic infarction, the patient can be treated with detorsion and splenopexy (often performed laparoscopically) or gastropexy.[11]

Early diagnosis provides for earlier surgery with a less deteriorated patient and a more favorable postoperative evolution.

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