Postoperative complications

Postoperative complications

- Immediate complications specific to splenectomy include haemorrhage resulting from a slipped ligature. Left basal

Figure 70.16 Photograph showing a stapling device across the splenic hilus for division of the splenic vessels during laparoscopic splenectomy.

Adjacent structures at risk during the procedure include the stomach and pancreas. A fistula may result from damage to the greater curvature of the stomach during ligation of the short gastric vessels. Damage to the tail of the pancreas during liga tion of the splenic vessels at the hilum may result in pancreatitis, a localised abscess or a pancreatic fistula. Haematemesis from gastric mucosal damage and gastric dilata tion are uncommon. Postoperative thrombocytosis may arise and, if the blood 6 platelet count exceeds 1 /uni00A0×/uni00A0 10 /mL, prophylactic aspirin is rec ommended. Long-term surveillance programmes have empha sised an increased risk of deep vein thrombosis and pulmonary embolism. The relative risk and benefit of thromboprophylaxis in this setting has not been assessed adequately . Postsplenectomy septicaemia may result from S. pneumo niae, Neisseria meningitides, Haemophilus influenzae or Escherichia coli. Long-term surveillance programmes have suggested that the risk of pneumonia, meningitis and major sepsis following splenectomy is increased threefold. However, the risk is greater in the young patient, in splenectomised patients treated with chemoradiotherapy and in patients who have undergone sple nectomy for thalassaemia, sickle cell disease and autoimmune anaemia or thrombocytopenia. Opportunist postsplenectomy infection (OPSI) is a major concern. Published guidelines emphasise that most infections after splenectomy could be avoided through measures that include o ff ering patients appropriate and timely immunisa tion, antibiotic proph ylaxis, education and prompt treatment of infection. The benefit of prophylactic antibiotics in this set ting remains controversial. It is thought that children who hav undergone splenectomy before the age of 5 years should be trea ted with a daily dose of penicillin until the age of 10 /uni00A0 years. Prophylaxis in older children should be continued at least until the age of 16 years, but its use is less well defined in adults. Furthermore, compliance is problematic in the long term but, as the risk of overwhelming sepsis is greatest within the first 2–3 years after splenectomy , it seems reasonable to give prophy laxis during this time. However, all patients with compromised immune function should receive prophylaxis. Satisfactory oral prophylaxis can be obtained with penicillin, erythromycin, amoxicillin or co-amoxicla v . Suspected infection can be treated intravenously with these same antibiotics and cefotaxime or ceftriaxone, or chloramphenicol in patients allergic to penicil lin and cephalosporins. If elective splenectomy is planned, consideration should be given to vaccinating against pneumococcus, meningococcus C (both repeated every 5 years) and H. influenzae type b (Hib) (repeated every 10 years). The last two vaccines are commonly delivered as a combined preparation. Y early influenza vacci nation has been recommended, as there is some evidence that it may reduce the risk of secondary bacterial infection. Such vaccinations should be administered

at least 2 weeks before Albert Ludwig Siegmund Neisser , 1855–1916, Director of the Dermatological Institute, Breslau, Germany (now Wroc ł aw , Poland). Theodor Escherich , 1857–1911, Professor of Paediatrics, Vienna, Austria. surgery but before discharge from hospital. Pneumococcal vaccination is recommended in those patients aged over 2 /uni00A0 years. Hib vaccination is recommended irrespective of age. - Asplenic patients should carry a medical alert and an up-to - date vaccination card. They require specific advice regarding travel and animal handling. OPSI due to Capnocytophaga canimorsus may result from dog, cat or other animal bites. Vaccination can be given in the postoperative period fol - - lowing splenectomy for trauma, and the resulting antibody lev - - els will be protective in the majority of cases. Antibody levels are, however, less than 50% of those achieved if vaccination is given in the presence of an intact spleen. Protection following vaccination is not always guaranteed. - Summary box 70.3 Splenectomy /uni25CF - /uni25CF /uni25CF /uni25CF -

Remember preoperative immunisation Prophylactic antibiotics in children and immune compromised adults Opportunistic postsplenectomy infection is a real clinical danger Splenic conservation should be considered

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