Spleen

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Splenic injury occurs from direct blunt trauma. Most isolated splenic injuries, especially in children, can be managed non-operatively . However, in adults, especially in the presence of other injury or physiological compromise, laparotomy should be considered. The spleen can be theoretically packed, repaired or placed in a mesh bag. However, in reality , splenec tomy is the safer option, especially in the compromised patient with multiple potential sites of bleeding. In certain situations, selective angioembolisation of the spleen can play a role. Following splenectomy there are significant, though tran sient, changes to blood physiology . The platelet and white count rise and may mimic sepsis. Inoculation against Pneumo coccus is advisable within 2–3 weeks, by which time the patient’s immune system has recovered. Allen Oldfather Whipple , 1881–1963, V alentine Mott Professor of Surgery , The College of Physicians and Surgeons, Columbia University , New Y ork, NY , USA. Most pancreatic injury occurs as a result of blunt trauma. The major problem is that of diagnosis because the pancreas is a retroperitoneal organ. CT remains the mainstay of accurate diagnosis. Amylase or lipase estimation is insensitive. In pene - trating trauma, injury may only be detected during laparotomy . Classically the pancreas should be treated with conser - vative surgery and closed, low-suction drainage. Injuries are treated according to the ISS system of the AAST . Injuries to the pancreatic body to the left of the superior mesenteric ves - sels and to the tail are treated by closed drainage alone, with distal pancreatectomy if the duct is involved. Proximal injuries (to the right of the superior mesenteric artery) are treated as conservativ ely as possible, although partial pancreatectomy may be necessary . The role of pyloric exclusion remains con - troversial and remains surgeon dependent. A Whipple’s proce - dure (pancreaticoduodenectomy) is rarely needed and should not be performed in the emergency situation because of the very high associated mortality rate . A damage control proce - dure with packing and drainage should be performed and the patient referred for definitive surgery once stabilised. Spleen

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