SPLENECTOMY

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The common indications for splenectomy are: - /uni25CF trauma resulting from an accident or iatrogenic during a surgical procedure; for example, during mobilisation of the oesophagus, stomach, distal pancreas or splenic flexure of the colon; /uni25CF removal en bloc with the stomach as part of a radical gas - trectomy or with the pancreas as part of a distal or total pancreatectomy; - /uni25CF to treat anaemia or thrombocytopenia in spherocytosis, ITP or hypersplenism; /uni25CF in association with shunt or variceal surgery for portal hypertension. Summary box 70.2 - Indications for splenectomy /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF

Trauma Haematological Accidental Spherocytosis Iatrogenic Purpura (ITP) Hypersplenism Oncological Portal hypertension Part of en bloc resection Diagnostic Variceal surgery Therapeutic

In the presence of a bleeding tendency , transfusion of blood, fresh-frozen plasma, cryoprecipitate or platelets may be required. Coagulation profiles should be as near normal as possible at operation, and platelets should be available for patients with thrombocytopenia during operation and in the early postoperative period. Antibiotic prophylaxis appropriate to the operative proce dure should be given, and consideration should be given to the risk of postsplenectomy sepsis (see Postoperative com plications). splenectomy

The patient is placed on the right side with the space between the left ilium and costal margin exposed. Placement of access ports is often determined by the size of the patient and the spleen. Insu ffl ation of the abdomen can be performed once access is obtained through an incision 1 /uni00A0 cm from the costal margin at the left midclavicular line. A further trocar is inserted close to the costal margin below the xiphoid. A 12-mm trocar is inserted at a similar distance from the costal margin at the posterior axillary line. The splenocolic ligament is divided to give access to the lower splenic pole. The spleen is separated from the kidney and diaphragm before the gap between the splenic hilum and the tail of the pancreas is enlarged. The spleen is elevated to expose the splenic hilum, which is secured a - and divided with an endoscopic vascular stapler (Figure 70.16). Two or three applications of the instrument may be required to secure the hilum and the short gastric vessels. Any - remaining attachments to the diaphragm are divided before a self-retaining opening bag is introduced through the incision of the the open laparoscopy , after removal of the 12-mm port.

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