Technique of open splenectomy

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Most surgeons use a midline or transverse left subcostal incision for open splenectomy with the patient in the supine position. Rarely , a thoracoabdominal incision may be necessary for a massive spleen that is adherent to the diaphragm. Passage of a nasogastric tube following induction of the anaesthetic enables the stomach to be emptied. In elective splenectomy , the gastrosplenic ligament is opened and the short gastric vessels are divided. The splenic vessels at the superior border of the pancreas are suture ligated. Division of the posterior leaf of the lienorenal lig ment with long curved scissors on the posterior surface of the spleen helps to rotate and deliver the spleen medially into the laparotomy wound along with the tail and body of the pan creas. The posterior surface of the spleen is exposed and the spleen rotated medially along with the tail and body of pancreas (Figure 70.15). The pancreas is separated from the hilar vessels, which ar e normally doubly ligated separately and divided. Accessory splenic tissue in the splenic hilum or omen tum should be excluded by a careful search at operation. There is no need to drain the wound. Myron Firth Metzenbaum , 1876-1944, surgeon, Cleveland, OH, USA. possible to undertake limited resection of the parenchyma. Haemostasis can be achieved by ligation of, or application of metal clips to, intrasplenic v essels and by careful application of topical haemostatic agents. Conservative splenic surgery is therefore possible in some cases of splenic trauma and other pathology such as splenic cysts. -

Figure 70.15 Diagrammatic view of the approach to mobilise the spleen at open surgery with division of the peritoneal fold of the lienorenal ligament posteriorly using Metzenbaum scissors, enabling delivery of the spleen into the laparotomy wound.

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