LETTERS TO THE EDITOR
EDİTÖRE MEKTUPLAR
Gastrosplenic fistula due to splenic large cell lymphoma diagnosed by percutaneous drainage before surgical treatment

Cerrahi tedavi öncesi perkütan drenaj ile tanı konan splenik büyük hücreli lenfomaya bağlı gastrosplenik fistül

To the Editor

A fistulous tract between the stomach and the spleen is a very rare manifestation (1). To date, five gastrosplenic fistulas originating from splenic lymphoma were reported, of which three were spontaneous (1-3), and two occurred following chemotherapy (3, 4). This is the third case of gastrosplenic fistula due to splenic lymphoma following chemotherapy and the first case having retrograde catheter cystography.

A 25–year-old male patient diagnosed as B-type large-cell lymphoma 23 months previously and treated with six cures of CHOP and MINE chemotherapy regimens was hospitalized with fever, chills, weight loss, pain and tenderness. His physical examination revealed splenomegaly. Leukocyte count was 18,600/mm^3. Splenic large lump with thick wall, air, and echogenic fluid was detected on abdominal ultrasonography (US). He was catheterized having typical signs of splenic abscess. A conspicuous radiolucent fistulous tract was detected by giving contrast medium via the catheter on computerized tomography (CT)-cystography; subsequently splenectomy, fistula resection and gastric wedge resection were performed (Figure 1). Pathology revealed splenic abscess. He was hospitalized again with deterioration a month after discharge. Although symptomatic treatment was performed, he died two months later due to progression of lymphoma and infection due to pancreatic and gastric fistulas.

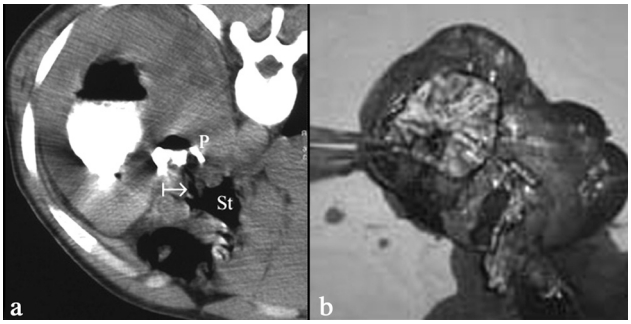

Figure 1. a) Retrograde CT-cystography performed in oblique prone position. Axial slice reveals air-contrast fluid level in the cavity and air in the gastrosplenic fistula (arrow); Contrast material and pigtail adjacent to the fistula orifice. St: Stomach lumen. P: Pigtail.
b) Operation specimen shows this fistula orifice on en-face view from the greater curvature.

Although spontaneous fistulization may occur, the successful treatment of lymphoma by radiation therapy, chemotherapy or combination has led to the development of this unusual complication (3). In combination with the tendency for large cell lymphomas (non-Hodgkin's) to cause extensive necrosis, it is hypothesized that the rapid regression of the tumor via the chemotherapy or radiation results in a track or 'fistula' between organs (4).

If there are air bubbles within the spleen, differentiation between an abscess and the fistula to the gastrointestinal tract is important for treatment planning (1). CT visualization of the fistulous tract or antegrade filling of the splenic cavity by

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orally administrated gastrointestinal contrast medium can indicate the correct diagnosis (1). The fistulous tract was visible on the CT-cystography; it is the first to be retrograde via catheter.

Perforation and fistula formation are considered unfavorable prognostic events and can result from tumor progression or treatment (3). In the event of such an occurrence, splenectomy should be performed to avoid further complications (4).

When there are typical abscess findings in a splenic large cell lymphoma, percutaneous intervention can be performed for early diagnosis and to preserve the spleen (5,6). However, if gastrosplenic fistula occurs, splenectomy must be done as early as possible.

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