Introduction: Spleen

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Total splenectomy has been considered the appropriate management for splenic trauma, diseases, or disease processes that could be modified by splenectomy. This surgical truism has been supported by the belief that the spleen is not essential to life, that mortality is almost universal in non-operated splenic injury, and that delayed rupture is a significant danger.

The policy for total splenectomy has been progressively modified by a number of important observations; first, that splenectomy increases the risk of significant septic events and, second, that partial splenectomy or even splenic preservation is possible with low risk to the patient. Major advances in abdominal imaging have contributed significantly to the surgical developments.

Progress has continued with the development of laparoscopic surgery. Initially laparoscopic total splenectomy became a relatively standard procedure, particularly in the non-trauma patient. More recently the concept of partial splenectomy has been successfully implemented using laparoscopic access. As with other organ systems, laparoscopic surgery served as a stimulus for equipment development, and the benefits of this have been realized in both open and laparoscopic procedures. Particularly valuable in splenic surgery are the endovascular stapling devices and energy devices.

When considering a patient for splenectomy, decisions regarding the choice of access should take into account the experience and training of the surgeon, as well as the suitability of the patient. The size of the spleen, the nature of the problem, and previous abdominal surgery will be factors in the decision. Clearly, appropriate and specific informed consent is mandatory, including a discussion of total splenectomy when a partial procedure is planned.

In this part of the atlas a range of techniques for splenectomy, open and laparoscopic, total and partial, are discussed. Techniques for splenic preservation are described and finally some approaches for splenic cysts are presented.

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