An 81-year-old woman with history of chronic lymphocytic leukemia and recent diagnosis of *Clostridium difficile* colitis, and maintained on oral vancomycin, presented for generalized weakness, persistent nausea, and a long history of difficulty swallowing (food hangs in her chest and does not move down to her stomach). Workup revealed low potassium and white blood cell count of 41,000/mm with lymphocytes predominance. Renal function and liver enzyme levels were within normal. The patient received intravenous fluids and electrolytes replacement. A diagnostic upper endoscopy was done to delineate the cause of the dysphagia, and the findings were tortuous esophagus, slight narrowing of the esophageal sphincter, and an enormous intrathoracic stomach. Most of the stomach except for the antrum was above the diaphragm. The scope was passed through the hiatus entering the antrum. Below the hiatus, there was acute angulation into the antrum and fair maneuverings were required to reach the pylorus and into the duodenum. Biopsies were taken and esophageal sphincter balloon dilatation was done. Shortly after the procedure, the patient became diaphoretic, hypotensive, and tachycardic, requiring fluid resuscitation and vasopressors. She also developed abdominal pain and marked tenderness, predominantly at the right upper quadrant.

A blood workup revealed slight drop in hemoglobin but increase in the white blood cell count up to 70,000/mm. An immediate computed tomography (CT) scan without contrast showed massive hemothorax and into the duodenum. Biopsies were taken and esophageal sphincter balloon dilatation was done. Shortly after the procedure, the patient became diaphoretic, hypotensive, and tachycardic, requiring fluid resuscitation and vasopressors. She also developed abdominal pain and marked tenderness, predominantly at the right upper quadrant.

A blood workup revealed slight drop in hemoglobin but increase in the white blood cell count up to 70,000/mm. An immediate computed tomography (CT) scan of abdomen in an 81-year-old woman with generalized weakness, persistent nausea, and difficulty swallowing, showing hemoperitoneum, subcapsular spleen hematoma, and blood around the liver.

**Fig. 1** Computed tomography (CT) scan of abdomen in an 81-year-old woman with generalized weakness, persistent nausea, and difficulty swallowing, showing hemoperitoneum, subcapsular spleen hematoma, and blood around the liver.

Spleen rupture complicating upper endoscopy

following gastroscopy [3]. To our knowledge, only few cases have been reported in the medical literature [3-5]. We think that the excessive stretching of spleno-diaphragmatic ligaments and of spleno-peritoneal lateral attachments during endoscopy and possibly the location of most of the stomach in the thoracic cavity had contributed to the spleen rupture [5,6]. Rapid diagnosis in the presence of suggestive symptoms of hemodynamic instability and abdominal pain following upper endoscopy is life-saving.

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**Competing interests:** None

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