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/mm² 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/mm². 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.

Rupture of the spleen following trauma is well known. Spontaneous rupture of the spleen has also been described in various conditions such as certain hematological malignancies, infections (malaria, Epstein–Barr virus infection, human immunodeficiency virus infection), metabolic disorders, tumors of the spleen, pregnancy, and connective tissue diseases [1, 2]. It is also described as a complication after colonoscopy, left-sided thoracotomy, and shockwave lithotripsy [1, 2]. Some serious complications such as viscus perforation and gastrointestinal bleeding have been rarely reported after upper endoscopy [3]. However, spleen injury or rupture is an exceptional and very rare complication 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.

**Endoscopy_UCTN_Code_CPL_1AH_2AJ**

**Competing interests:** None

**F. Jabr**, **N. Skeik**

1 Hospital Medicine, Horizon Medical Center, Tennessee, USA
2 Vascular Medicine, Abbott Northwestern Hospital, Minneapolis, USA

**References**


**Bibliography**


Endoscopy 2012; 44: E206

© Georg Thieme Verlag KG

Stuttgart · New York

ISSN 0013-726X

**Corresponding author**

F. Jabr

Horizon Medical Center – Hospital Medicine
HWY 70 E, Dickson
Tennessee 37055
USA

fijabr@gmail.com