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TORSION OF THE VASCULAR WALL OF THE ACCESSORY SPLEEN IN A CHILD, COMPLICATED BY THE FORMATION OF AN ABSCESS

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Background. Introduction. The spleen is the largest gland in a child's body in terms of the content of lymphoid tissue that provides cellular immunity. It develops from mesenchymal cells in the dorsal mesogastric region in the fifth week of embryogenesis. The size of this organ is very diverse and depends on the individual characteristics and age of the patient. By the age of 10, the spleen weighs 66-70 g. Torsion of the vascular pedicle of the accessory spleen in a child is a rare developmental pathology in the practice of pediatric surgeons and can cause severe abdominal complications in emergency pediatric surgery. In the presented clinical case, the formation of an abscess occurred as a result of ischemia of the accessory tissue of the spleen, its necrosis and the formation of an abscess due to torsion of the vascular pedicle.

The purpose of the study. To present a clinical case of an 8-year-old girl with a complication that required surgical treatment due to torsion of the vascular pedicle of the additional spleen, ischemia, necrosis and abscess formation of the tissue of the additional spleen. To determine the prognostic significance of this clinical observation in emergency pediatric abdominal surgery, diagnostic issues and indications for surgical treatment in terms of prevention and treatment of complications. To summarize the existing experience in this area.

Materials and methods of research. The analysis of the medical record of an 8-year-old girl who underwent emergency diagnosis and treatment at the pediatric surgical department of the Tula City Clinical Emergency Medical Hospital named after D.Ya. Vanykin, Tula, Russian Federation, was carried out. The child's disease developed acutely after full recovery, without any provoking factors. Standard physical, clinical, laboratory studies, imaging (ultrasound, MRI, CT with contrast) and bacteriological studies were used for pre- and postoperative diagnosis.

Results and discussion. After intensive treatment and surgical intervention (laparotomy with treatment of a purulent lesion according to urgent indications), on the 14th day, the child was discharged for outpatient observation in satisfactory condition. The postoperative period was uneventful. Early results were monitored. It can be concluded that difficulties in diagnosing malformations of the spleen create a risk of complications; in the patient, this manifested itself in the form of an abscess of the accessory spleen. Conclusion. Conclusions. Diagnosis of malformations of the spleen in emergency situations has its own characteristics and difficulties. Experience in routine X-ray diagnostics is needed, first of all, to identify additional tissues of the spleen. In children with abdominal pain syndrome, emergency X-ray diagnostics in a specialized department is necessary to detect this rare pathology.

Keywords: *an extra spleen, abscess of the spleen, children, a clinical case, twist the legs of the spleen, X-ray diagnostics*.

Relevance. Introduction. The spleen is the largest lymphoid organ in a child's body; alongside the thymus, it plays a crucial role in B- and T-cell immunity. This fact alone warrants close attention to the study of its anatomy and function. Furthermore, developmental and functional anomalies of the spleen often lead to complications of varying severity–sometimes necessitating surgeries that threaten vital bodily functions–and can predispose adult patients to similar conditions later in life [1]. The organ develops from mesenchymal cells in the dorsal mesogastrium during the fifth week of embryogenesis. Its size varies considerably depending on the patient's age and individual characteristics; by the age of ten, the spleen weighs between 66 and 70 grams. This article presents a clinical case of an abscess forming in an accessory spleen due to torsion of its vascular pedicle in an eight-year-old girl. Torsion of an accessory spleen's vascular pedicle is a rare developmental anomaly in pediatric surgical practice, yet it can cause severe abdominal complications requiring emergency surgery. In the case described, the abscess resulted from ischemia of the accessory spleen tissue, followed by necrosis and abscess formation caused by the torsion of the vascular pedicle.

Aim and objectives of the study. To present a clinical case of an 8-year-old girl who required surgical intervention due to torsion of the vascular pedicle of an accessory spleen, resulting in ischemia, necrosis,

and abscess formation within the accessory splenic tissue. To assess the prognostic significance of this case in pediatric emergency abdominal surgery, as well as diagnostic considerations and indications for surgery regarding the prevention and management of complications. To summarize experience regarding this issue.

Materials and methods of the study. We analyzed the medical history of an 8-year-old girl who underwent emergency diagnosis and treatment at the pediatric surgery department of the D. Ya. Vanykin Tula City Clinical Emergency Hospital (Tula, Russian Federation). The child's illness had an acute onset against a background of complete health, with no identifiable precipitating factors. Diagnostic procedures performed before and after surgery included standard physical examinations, clinical laboratory tests, imaging studies (ultrasound, MRI, and contrast-enhanced CT), and bacteriological analyses. A review of the literature revealed no publications describing an intra-abdominal complication in a child caused by torsion of the vascular pedicle of an accessory spleen resulting in necrosis and abscess formation.

The clinical presentation was characterized by intermittent, localized abdominal pain and a progressive increase in signs of systemic intoxication, accompanied by hyperthermia peaking at 39.1°C. Upon examination by a pediatric surgeon, abdominal palpation revealed a mass in the left hypochondrium. Diagnosing an intra-abdominal abscess of an accessory spleen at the early stage of the disease–which lacked specific symptoms–was understandably challenging. Based on subjective and objective findings, as well as ongoing monitoring, a decision was made to pursue an active surgical treatment strategy. Abdominal ultrasound visualized a heterogeneous anechoic mass (measuring 10.6 × 10.3 cm) located near the greater curvature of the stomach; the mass contained a central hypoechoic (solid) component (6.7 × 3.3 cm) and remained fixed during changes in body position. Color Doppler mapping (CDM) revealed intermittent blood flow within the center of the mass. Surgical intervention consisted of an emergency laparotomy and debridement of the purulent focus. The postoperative period was uneventful; the patient received antibiotic, anti-inflammatory, and detoxification therapy, as well as physical therapy.

The girl was discharged in satisfactory condition on the 14th postoperative day, with follow-up care to be provided by the outpatient clinic. A follow-up examination was recommended in four months. At the follow-up visit, the patient was active and reported no specific complaints. This case is of multidisciplinary diagnostic interest–particularly for pediatric surgeons and pediatricians–when evaluating patients presenting with intermittent, localized abdominal pain and fever.

Results and discussion. Description of a clinical case: An 8-year-old girl was admitted on an emergency basis to the pediatric surgery department of the D.Ya. Vanykin Tula City Clinical Emergency Hospital in a condition of moderate severity. According to her mother, the child developed epigastric pain, general weakness, and a fever (peaking at 38.0 °C) on February 14, 2024, prompting a call to the emergency medical service (EMS). EMS personnel recommended hospitalization for observation and evaluation due to unspecified abdominal pain; however, the patient's parents refused admission. The symptoms persisted over the following day, and the local district physician was called on February 16, 2024. Following an examination, a diagnosis of viral pharyngitis was made, and treatment with antiviral and symptomatic antipyretic drugs (Arbidol, paracetamol) was prescribed, along with outpatient follow-up. No clinical improvement was observed over the next seven days despite the ongoing treatment. The girl continued to experience hyperthermia–with daily temperature spikes reaching a maximum of 39.1 °C–as well as intermittent abdominal pain (predominantly in the epigastric region), signs of intoxication, reduced appetite, and weakness.

On February 24, 2024, the patient visited the on-duty physician at her local outpatient clinic presenting with the aforementioned complaints; an abdominal ultrasound was performed, revealing a mass of undetermined origin in the upper abdomen, in the region of the spleen. Following a specialist referral, an emergency consultation with a pediatric surgeon was conducted. Subsequently, on the same day, the patient was admitted to the Pediatric Surgery Department of the D.Ya. Vanykin Tula City Clinical Emergency Hospital.

Physical and laboratory examination. General inspection reveals the patient to be in an active position with clear consciousness; she is of normosthenic build, and her skin is of normal color. The abdomen is not distended, is symmetrical, and moves with respiration; superficial palpation reveals it to be soft but tender in the epigastric region, with mild involuntary guarding. Deep palpation elicits marked tenderness and muscle guarding in the left hypochondrium; signs of peritoneal irritation are absent. Deep palpation identifies an ill-defined mass in the projection of the lower pole of the spleen. Laboratory test results are presented in Tables 1, 2, and 3.

Table 1. Dynamics of complete blood count (CBC) parameters during diagnosis and treatment

HOW	26.02.24	04.03.24	07.03.24	11.03.24	14.03.24
erythrocytes	4.1	3.61	3.7	4.25	4.06
hemoglobin	111	100	100	120	115
leukocytes	15.8	13.3	7.6	3.7	5.8
п/я	4	3	3	1	1
с/я	58	60	62	67	68
lymphocytes	25	25	26	25	26
monocytes	10	8	7	5	3
platelets	683	665	668	501	505

Table 2. Dynamics of biochemical blood parameters during diagnosis and treatment

TANK	28.02.24	14.03.24
total bilirubin	11	12
indirect bilirubin	9	12
cholesterol	3.6	4.4
creatinine	54	52
SRB	187	6
ACT	16	31
ALT	22	24
Alkaline phosphatase	241	191
GGPT	22	
amylase	17	39
total protein	62	63
triglycerides	0.9	1.05
HDL	1.26	
LDL	2.0	
glucose	4.5	3.6

Table 3. Monitoring of urinalysis (UA)

Urinalysis	27.02.24
color	жёлтый
relative density	1020
leukocytes	1-2 в поле зрения
squamous epithelium	2-4
mucus	++++
urates	+
pH	6.0

Instrumental studies: Abdominal ultrasound (26.02.24): no free fluid detected in the abdominal cavity or pelvis. A heterogeneous anechoic mass measuring 10.6 x 10.3 cm is visualized projecting from the greater curvature of the stomach; it contains a central hypoechoic (solid) component measuring 6.7 x 3.3 cm and is immobile upon changes in body position. Color Doppler imaging shows partially preserved blood flow that terminates at the level of the central hypoechoic zone. EGD (26.02.24): moderate localized hypertrophy and hyperemia of the gastric mucosa along the greater curvature, with duodenogastric reflux. No signs of esophagitis. Abdominal CT (26.02.24): inflammatory mass in the left abdominal cavity, external to the greater curvature of the stomach. Suspicion of an abscess of indeterminate organ origin. Accessory spleen? Abdominal MRI (28.02.24): MRI findings show an area of abnormal signal intensity in the upper left abdomen; this may represent an inflammatory process, with no conclusive evidence regarding its organ of origin. Moderate amount of free fluid in the left abdominal cavity and left pleural space.

On February 29, 2024, based on the patient's complaints, objective findings, and laboratory diagnostic data, a preliminary diagnosis was established: torsion of the vascular pedicle of an accessory spleen, resulting in the formation of an intra-abdominal infiltrate and subsequent abscess

formation. Given the purulent-inflammatory nature of the suspected complication and the patient's prolonged febrile state, additional tests were performed: stool analysis for dysentery-group bacteria and *Salmonella* (March 7, 2024)–no dysentery-group bacteria or *Salmonella* were detected; and a bacteriological culture of venous blood from the cubital vein for sterility (March 7, 2024)–the culture was sterile.

Based on the patient's assessment, a decision was made to perform surgery. The procedure consisted of: laparotomy; exploration of the abdominal cavity; adhesiolysis of loose adhesions; drainage and debridement of the abscess; resection of the abscess capsule and a portion of the inflamed greater omentum; splenectomy of an accessory spleen and its pedicle with secure ligation; appendectomy due to secondary changes in the appendix; and lavage and drainage of the abdominal cavity.

Operative procedure: An upper midline laparotomy was performed under endotracheal anesthesia. A moderate amount of clear, odorless effusion with a slight hemorrhagic component was encountered. Initial exploration of the abdominal cavity revealed collapsed, pink loops of small intestine with no signs of microcirculatory impairment; the intestinal serosa appeared glistening and free of hemorrhages. The large intestine showed no visible pathology. A mass was visualized and palpated in the region of the splenic flexure of the colon, the spleen, and the proximal third of the greater curvature of the stomach; the mass was situated inferior to the greater curvature, displacing the gastric wall superiorly. It was enveloped by a segment of the greater omentum–which was muddy-brown in color–and was bound by a combination of dense and loose adhesions to the mesentery and wall of the distal transverse colon. Stepwise adhesiolysis and mobilization were performed on the inferior and left lateral aspects of the mass, which measured 13 × 10 × 9 cm. During the mobilization process near the splenic flexure, a fibrous band–suspected to be a vascular pedicle–was identified; it appeared to originate independently of the splenic hilum and exhibited a 360° torsion. After freeing the mass from adhesions, an impending perforation was observed on its anterolateral wall, located near the distal end of the twisted pedicle (Figs. 2, 3). The blades of a "Mosquito" hemostatic clamp were inserted through this opening, resulting in the discharge of purulent-necrotic contents mixed with blood–resembling "meat-washings" fluid–and characterized by an unpleasant *E. coli*-like odor. A sample of the pathological exudate was collected for bacterial culture. (Intraoperative bacterial culture of the wound contents: no pathogenic or opportunistic microflora detected.) Subsequently, the perforation opening was enlarged; the tip of the suction device was introduced into the abscess cavity, and 50.0 ml of purulent-necrotic material was aspirated. The abscess walls collapsed, and a grayish-brown area of necrotic tissue–measuring approximately 3 × 3.5 × 2.5 cm and resembling splenic tissue–was found within the cavity.

Upon further exploration of the abscess area, the anterosuperior wall of the abscess capsule was found to be intimately adherent to the posterolateral wall of the stomach. The capsule was separated from the gastric wall using a combination of sharp and blunt dissection, without causing injury. The abscess capsule was extensively mobilized from surrounding tissues and excised, along with the inflamed section of the greater omentum and the necrotic vascular pedicle; subsequent ligation for hemostasis was performed. A final inspection of the abdominal cavity and an examination of the small and large intestines were carried out. Inspection of the ileocecal region revealed secondary inflammatory changes in the appendix. To prevent the potential spread of inflammation postoperatively, a decision was made to remove the appendix. A standard appendectomy was performed, involving stump inversion and the placement of a purse-string suture. The abdominal cavity was lavaged with antiseptic solution (aqueous chlorhexidine), dried, and drained. A drainage tube was inserted through a counter-incision in the left lateral abdominal wall and secured to the skin with interrupted sutures. The laparotomy wound was closed in layers using interrupted sutures, and skin sutures were applied.

Postoperative pharmacological management included systemic antibiotic therapy (ceftriaxone 1 g intramuscularly twice daily for 7 days) and baseline infusion therapy with glucose-saline solutions on the first postoperative day. A nasogastric tube was inserted. Early enteral tube feeding commenced on the second postoperative day (Diet 0), followed by tube removal. A liquid, pureed diet was prescribed starting on the third postoperative day. Gastroprotection and gastritis treatment (omeprazole and pancreatin) were initiated on the third postoperative day. A gentle diet was introduced on the sixth or seventh postoperative day. Daily care of the laparotomy wound involved cleansing the suture site and changing the aseptic dressing. From the tenth day onwards, the patient was placed on Pevzner's Diet 1.



Fig. 1

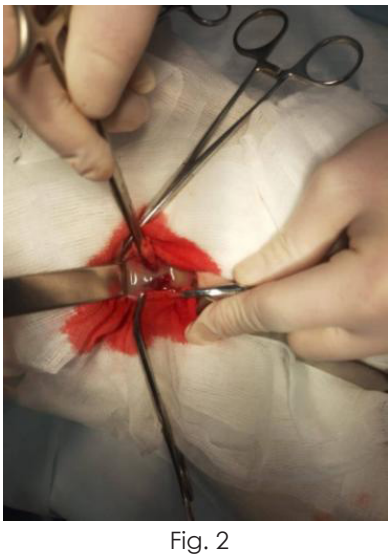


Fig. 2



Fig. 3

Fig. 1. Stage of isolating an inflammatory abdominal mass during laparotomy
Fig. 2. Exposed abscess wall at the site of impending perforation, prior to evacuation
Fig. 3. Stage following abscess evacuation, excision of the abscess capsule and vascular pedicle, and resection of a portion of the greater omentum. Prior to peritoneal lavage

Postoperative instrumental assessments: Abdominal ultrasound (01.03.24) – no free fluid detected in the abdominal cavity or pelvis; gastric and intestinal peristalsis visualized but sluggish. Pleural ultrasound (01.03.24) – left-sided pleural effusion (approx. 100 ml); diagnostic puncture was deemed unnecessary due to the clinically insignificant volume. Abdominal ultrasound (07.03.24) – a conglomerate of bowel loops measuring 3.2 x 1.6 cm visualized in the left hypochondrium at the site of the postoperative scar; peristalsis significantly sluggish. Abdominal ultrasound (14.03.24) – no free fluid detected in the abdominal cavity or pelvis; active peristalsis. Uncomplicated early postoperative course. Drain removed on postoperative day 4. Sutures removed on postoperative day 10. Surgical wound healing by primary intention.

February 16, 2024 – February 23, 2024: lack of positive response to ongoing treatment; persistence of fever, pain, and intoxication syndromes.

February 24, 2024: Visit to the local primary care physician at the outpatient clinic; abdominal ultrasound performed (revealing an abdominal mass of undetermined etiology). Consultation with a pediatric surgeon. Admitted on an emergency basis to the Pediatric Surgery Department of the D.Ya. Vanykin Tula City Clinical Emergency Hospital.

February 25–28, 2024: Laboratory and instrumental examinations were performed due to persistent complaints of intermittent epigastric pain and fever (up to 39.1°C). Blood analysis revealed leukocytosis (15.8 × 10^9/L) and an elevated CRP level (187 mg/L). Abdominal ultrasound, CT, and MRI were performed, revealing a mass in the left abdomen, lateral to the greater curvature of the stomach, and confirming the presence of accessory spleens.

February 29, 2024: Based on persistent clinical symptoms, physical examination findings, and laboratory and instrumental test results, a preliminary diagnosis was established: "Torsion of the vascular pedicle of an accessory spleen with abscess formation." Emergency surgery was performed on the same day, consisting of laparotomy, exploration of the abdominal cavity, adhesiolysis, and abscess drainage and debridement. Approximately 50.0 ml of purulent-necrotic contents was evacuated. The preoperative diagnosis was confirmed: a necrotic fragment of an accessory spleen was found within the abscess cavity. The abscess capsule, a section of the inflamed greater omentum, and the necrotic vascular pedicle of the accessory spleen were excised, followed by ligation. To prevent the spread of observed secondary changes to the vermiform appendix, an appendectomy was performed, along with lavage and drainage of the abdominal cavity. The patient emerged from anesthesia, was extubated on the operating table, and resumed spontaneous breathing.

March 1, 2024 – March 13, 2024: The early postoperative period proceeded uneventfully. The patient complained of generalized weakness and pain in the upper abdomen and the surgical wound area. Physical examination revealed mild tenderness in the upper abdomen and at the surgical wound

site; the abdomen moved with respiration and was soft on palpation, with active bowel sounds. Motor function recovery followed the standard timeline. During this period, the patient received comprehensive treatment, including antibiotics (Ceftriaxone, Amikacin, Metronidazole), standard IV fluid therapy, and gastroprotective agents (omeprazole, pancreatin) for 6–7 days. Intranasal gastric intubation (drainage) was performed on the first postoperative day, and the nasogastric tube was removed on the second day. Bowel transit was restored following the initiation of early enteral nutrition. Changes in the small intestine observed on March 7, 2024–attributed to surgical trauma and associated peristaltic dysfunction–did not adversely affect the recovery of intestinal function. The abdominal drain was removed on the fourth day (March 4, 2024). Spontaneous bowel movement occurred on the eighth postoperative day. A follow-up abdominal ultrasound on March 1, 2024, showed no free fluid. Moderate left-sided reactive pleurisy, noted on the March 1, 2024 ultrasound, resolved without additional interventions or treatment. A positive trend in laboratory parameters was observed: a decrease in leukocyte count to 7.6 × 10^9/L by March 7, 2024, and normalization by March 14, 2024 (5.8 × 10^9/L), as well as a significant reduction in CRP to 6 mg/L by March 14, 2024. Sutures were removed on day 10; the wound healed by primary intention.

March 14, 2024: The patient's condition upon discharge is satisfactory; she reports no complaints, is in good spirits, and is active. A follow-up ultrasound of the abdominal cavity and pleural spaces was performed; no pathology of the abdominal or pleural organs was detected. She is being discharged with the following final diagnosis: Primary condition: Torsion of the vascular pedicle of an accessory spleen. Complication: Necrosis of the accessory spleen with abscess formation.

July 1, 2024: long-term follow-up examination; no complaints. The postoperative scar is pink, firm, and well-healed, with no signs of inflammation or hypertrophy; abdominal palpation is painless, and the abdomen is soft. Ultrasound of the abdominal cavity and pleural spaces revealed no abnormalities in the abdominal or pleural organs.

When analyzing the disease's progression, diagnosis, and outcome, it is worth noting that key challenges, shortcomings, and errors in the patient's management strategy can be identified at various stages of the process. This aspect is rarely addressed in contemporary publications.

February 14, 2024: Upon the onset of the patient's initial symptoms–specifically epigastric pain and a body temperature rising to 38.0°C–the child required hospitalization in a specialized facility. The parents' refusal of inpatient monitoring created additional difficulties for diagnosis and treatment.

On February 15, 2024, as symptoms persisted, a district physician was called to the patient's home; a preliminary working diagnosis of "viral pharyngitis" was established, and antiviral and symptomatic therapy was initiated. The patient was not evaluated by a pediatric surgeon despite the persistence of abdominal symptoms–a situation that in itself posed a risk of surgical complications. The erroneous working diagnosis delayed the detection of the splenic anomaly. Diagnostic imaging could have helped establish the correct diagnosis at this earlier stage, before an inflammatory infiltrate involving adjacent organs (stomach, transverse colon, omental bursa) had formed; the subsequent course of the disease confirmed this. Ultrasound, CT, and MRI scans were performed only after the infiltrate had developed, which complicated visualization. It should also be noted that, at this stage of the clinical case, there was a persistent risk of the purulent-inflammatory process spreading across the peritoneum (progressing from infiltrate to abscess) and the development of peritonitis.

Early, successful diagnosis of an accessory spleen is possible if the patient is admitted to the hospital for observation in a timely manner and undergoes emergency ultrasound and CT scanning–including additional preparation and the use of contrast agents. Many authors have noted this [1, 12]. See Figs. 4 and 5.

In our case, abdominal ultrasound visualized a heterogeneous anechoic mass (measuring 10.6 × 10.3 cm) with a central hypoechoic (solid) component (6.7 × 3.3 cm) located along the greater curvature of the stomach; the mass remained fixed during changes in body position. Color Doppler imaging revealed intermittent blood flow within the center of the mass. Diagnosing an accessory spleen at this early stage–characterized by an infiltrative process lacking specific symptoms–was understandably challenging. Furthermore, following the child's admission to a specialized hospital, diagnostic laparoscopy could have aided in confirming the initial diagnosis and determining the surgical approach, while also providing an objective assessment of the surgical site.

Attention should also be paid to certain terminological issues and definitions relevant to this specific clinical case. During abdominal surgeries, surgeons frequently encounter–for various reasons–anomalies in the shape, structure, or position of the spleen that do not require surgical intervention on

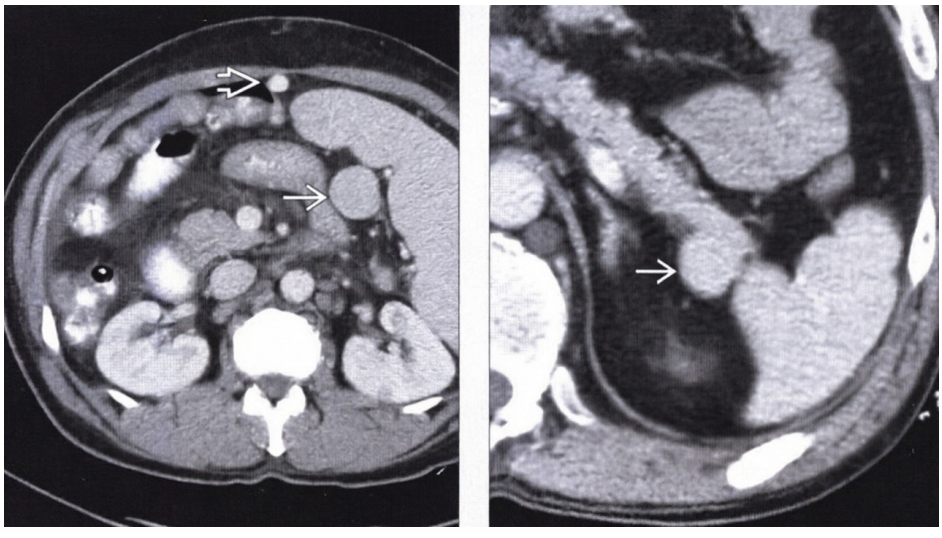


Fig. 4 Fig. 5

Fig. 4, 5. MRI of the abdominal organs. Arrows indicate an accessory spleen

the organ itself. Autopsy data indicate that an accessory spleen is found in 10–15% of the population [10]. The organ's mobility within the abdominal cavity is attributed to an excessively long vascular pedicle and the absence or elongation of supporting ligaments resulting from disrupted embryogenesis [5]. Terms such as "auxiliary spleen" and "accessory splenic lobe" are frequently encountered in the literature [1, 13].

Normal human anatomy indicates that the human spleen does not have a lobular structure [9].

A formation can likely be considered an accessory organ–or, in our case, an accessory spleen–if it exhibits the key characteristics: an autonomous blood supply, a ligamentous apparatus forming a splenic pedicle, and an identical tissue structure. All these features were present in our clinical case. In other instances, one might be dealing merely with fragmented splenic tissue (resulting from a failure of fusion during embryogenesis). However, this classification issue requires further study.

The prevalence of splenic anomalies ranges from 18.8% to 30.7% [13, 14]. According to several authors, the development of an "accessory lobe" and the occurrence of accessory spleens are associated with developmental anomalies or result from the traumatic implantation of parenchymal cells onto adjacent organs [3].

Morphofunctional analysis of the accessory spleen confirmed that it possesses all the structural elements of the organ and performs all its functions [4]. The most common locations for an accessory splenic "lobe" are the splenic hilum (75% of cases) and the tail of the pancreas, the splenic artery, or the gastrosplenic ligament (20% of cases) [8]. However, the authors do not specify whether the anomalies observed in all instances exhibited the essential characteristics of the organ; it is probable that the tissue in question was merely fragmented splenic tissue.

A congenital accessory spleen has a long pedicle that is prone to torsion [2]. Impaired blood supply leads to necrobiotic processes and intense microbial proliferation, which, in turn, results in abscess formation [10].

Splenic abscess is a rare and potentially dangerous condition, occurring in 0.2% of the population. Conditions associated with this complication include trauma, endocarditis, urinary tract infections, malignant neoplasms, immunodeficiency, and splenic tissue ischemia of various etiologies [2]. The microbiological profile of an abscess in an accessory spleen is often characterized by saprophytic microflora [12].

Основным методом лечения абсцесса добавочной доли является операция: ревизия брюшной полости, дренирование абсцесса с последующим удалением некротических тканей и резекцией воспалительно вовлечённых тканей. Операцией выбора в данном клиническом случае являлась открытая лапаротомия.

In summary, given the radical surgery performed–during which the pathological focus (an abscessed, twisted vascular pedicle of an accessory spleen) was confirmed and removed–the absence of intraoperative complications, and the favorable postoperative course, the patient's health prognosis is favorable, and there are no impairments in social adaptation.

A favorable outcome was ensured by the appropriate choice of an active surgical strategy: the timely performance of a radical surgical intervention via laparotomy, which allowed for an adequate exploration of the abdominal cavity, assessment of the pathological changes at the site of the lesion, and confirmation of the definitive diagnosis. This made it possible to prevent the development and spread of the purulent-inflammatory process across the peritoneum, its extension beyond the primary purulent focus, and the generalization of the abdominal surgical infection (diffuse peritonitis, sepsis, and septic abdominal shock).

To ensure a favorable long-term outcome, the following are recommended: 1. A follow-up consultation in 4 months to monitor postoperative changes and rule out complications; 2. Restriction of physical activity for 2 months; 3. Adherence to a specific diet and a course of multivitamins (2-month duration, twice a year); 4. Anti-scar therapy using "Imoferaza" ointment twice daily for 1 month, and electrophoresis with Longidaza (two courses per year, 10 sessions each).

Conclusion. Findings. A study of a clinical case involving an 8-year-old girl, supported by literature data, indicates that accessory spleens with a separate vascular pedicle are extremely rare in children. Abscess formation arises as a complication resulting from torsion of the vascular pedicle and subsequent necrosis of the accessory lobe tissue; it presents no specific, distinct clinical signs. Diagnosing this condition involves both objective and subjective challenges and relies on standard laboratory and instrumental investigations performed according to established protocols. Most often, these conditions and their complications are detected incidentally. The simultaneous presence of these complications–an accessory splenic lobe with a separate vascular pedicle, its torsion, and abscess formation–constitutes a unique case. Treating such complications invariably requires urgent or emergency surgical intervention. Postoperative follow-up focuses on preventing purulent-septic complications during both the early and late recovery periods.

Despite the low prevalence of the condition in the population, its clinical presentation and the symptoms of associated complications require study and classification, as well as the accumulation of diagnostic and therapeutic experience, so that they can be mastered in the daily practice of a pediatric surgeon.

1. Diagnosing the nature of splenic developmental anomalies in an emergency setting presents specific challenges. Recognizing accessory splenic tissue requires experience, particularly with elective diagnostic imaging.

2. In children presenting with abdominal pain, urgent diagnostic imaging in a specialized department is necessary to identify potential splenic anomalies.

3. This case is of multidisciplinary diagnostic interest, primarily for pediatric surgeons, pediatricians, and radiologists. Patients complaining of intermittent localized abdominal pain and fever should be admitted to a specialized hospital.

The primary treatment for an accessory spleen abscess is surgery: exploration of the abdominal cavity, abscess drainage, and detorsion of the splenic pedicle, followed by the removal of necrotic tissue and resection of inflamed tissue. Open laparotomy was the procedure of choice in this clinical case.

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