**Incidental Splenic Lesions**

The majority of splenic lesions are incidentally detected on routine abdominal CT, typically for other indications. In an emergency room population being scanned for abdominal pain or trauma, incidental splenic lesions were seen in approximately 1% of patients and the vast majority of these were considered clinically benign. It is important to combine clinical factors with imaging findings for the most accurate evaluation. Relevant findings include abdominal pain, signs or symptoms of infection, immune status, history of malignancy, associated imaging findings or history of abdominal trauma. In this poster, we review the most common splenic lesions encountered and propose an algorithm for their diagnosis and management.

**Hematoma**

Splenic Cyst

- "True" congenital or parasitic cysts (20%) possess an epithelial lining. Pseudocysts (80%), are posttraumatic without an epithelial lining. Typically asymptomatic, cysts may enlarge or hemorrhage, causing pain or may be the sequela of prior trauma.1,2

**Figure 1.** 14 year old female with upper abdominal pain and a large splenic cyst. (a) Contrast enhanced CT demonstrates a fluid attenuation mass. MRI performed later when patient developed pain. (b-e) T2 fat-saturated FSE and post contrast fat-saturated GRE images demonstrate a uniformly T2 hyperintense, non enhancing mass. The lesion was resected for symptomatic relief. Histology demonstrated a congenital cyst with stratified squamous epithelial lining.

**Hemangioma**

- Composed of a proliferation of vascular channels, ranging from capillary to cavernous. Most commonly solitary but may be multiple. Typical findings include a hypointense bulk with delayed enhancement.

**Figure 2.** 44 year old male with history of melanoma found to have an enhancing splenic mass on a contrast enhanced staging CT (a). (b) SSFSE image demonstrates a T2 hypointense mass. (c-e) fat suppressed GRE images obtained pre, immediately and 1 minute post contrast administration demonstrate a T1 hypointense mass with initial peripheral and subsequent homogeneous enhancement, consistent with a splenic hemangioma. Follow up imaging demonstrated one year stability.

**Lymphangioma**

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**Angiosarcoma**

- Consists of disorganized vascular channels. Rare and aggressive, presenting with diffuse metastasis to liver, lung, bone, and lymphatic system. May present with abdominal pain, fatigue, weight loss, anemia, thrombocytopenia, or coagulopathy. High risk of spontaneous rupture.

**Figure 15.** 81 year old male with pulmonary findings. May be associated with liver involvement and thoracic and abdominal lymphadenopathy. Most patients with splenic involvement are asymptomatic, although hepatosplenomegaly can be present.

**Metastases**

- Only 3% of metastases are to the spleen. Occurs late in the disease, with concurrent involvement of other organs. Most common sources are breast, lung, and melanoma.

**Figure 13.** 60 year old female with history of breast cancer. Contrast enhanced CT demonstrates diffuse hypointense nodules throughout the spleen.

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