We report a rare case of ruptured splenic artery pseudoaneurysm (SAP) that presented with both gastrointestinal bleeding and hemoperitoneum.

**Patient History**

- 26yoM transferred for necrotizing pancreatitis with an abscessed pseudocyst.
- Two Jackson-Pruitt drains were placed in the abscess collections and he was treated with IV antibiotics.
- Several weeks after his initial presentation, the drains suddenly drained a large volume of blood and the patient passed large clots from rectum simultaneously.
- The patient was sent for CT and transferred to the medical ICU and underwent massive transfusion with pressor support.
- No active bleeding was seen on CT and he was not a surgical candidate due to instability, risks of complications, and unclear source of bleeding.
- He remained in the hospital for a few weeks and was ultimately discharged to a rehab facility.

**Clinical Course**

Patient bled again with further hemodynamic instability, so interventional radiology was consulted to identify the source of the bleeding and potentially control it.

He received the following transfusions while in the medical ICU:

7 units pRBC, 3 units FFP, 3 units PLT

Angiography demonstrated a large hole in the splenic artery, likely a ruptured pseudoaneurysm. The proximal splenic artery was embolized and the patient had no further major bleeding.

He remained in the hospital for a few weeks and was ultimately discharged to a rehab facility.

**Discussion**

SAP is a rare complication of pancreatitis.

- When ruptured, they carry a high mortality rate of up to 90% (1) and present with gastrointestinal bleeding via drainage into the main pancreatic duct, fistula formation, or with hemoperitoneum.
- Surgical management carries a high mortality rate of up to 50% (1), and thus endovascular managemen is increasingly the treatment of choice. (2)
- They are often not well visualized on CT studies as they may have a narrow base that intermittently receives flow. (3)

**Conclusion**

To the best of our knowledge, this is the first case of a ruptured SAP presenting with simultaneous gastrointestinal bleeding and hemoperitoneum. This case also demonstrated the difficulties in diagnosing pseudoaneurysms on imaging (3) and the importance of pursuing complementary imaging modalities.

This case also supports the increased role of VIR intervention for SAP.

While a rare complication, it is important to maintain a high degree of suspicion for pseudoaneurysm as a potential cause of upper or lower GI bleeding in pancreatitis.

**References**